WALTERS
INSURANCE SERVICES

Employer: **Last Name:**
Desired Effective Date:
Level of Coverage: **Plan Chosen:**

Employee Health Evaluation & Enrollment Form

INSTRUCTION: THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

Employer Information

Employer Name:	Date of Hire:	Effective Date of Coverage:

Employee Information

Last name	First Name	Middle Initial	Date of Birth		Social Security #	
Home Mailing Address	Street	Apt #	City		State	Zip Code
Home Phone #	E-Mail Address	Gender	Height	Weight	Tobacco User ☐ Yes ☐ No	
Level of Coverage Chosen :	**Marital Status:** ☐ Single ☐ Married (date: _____) ☐ Divorced (date: _____) ☐ Separated (date: _____) ☐ Widowed (date: _____)					

***Deductible Plans Available: circle your choice and write your answer under plan selection above**

~$0 ~$500 ~$1000 ~$1500 ~$2000 ~$3000 ~$3500HSA ~$5000 ~$6350 Value Plan

If Applying for Dependent Coverage, Complete Section Below for all Dependents to be Covered:

(Common Law spouses are NOT eligible for coverage, unless required by law. Use additional paper if necessary.

	First Name & Middle Initial	Last Name *(if different from applicant)*	Step-Child	Gender	Date of Birth	Height	Weight	Tobacco User (Yes or No)	Social Security Number
Sp									
Ch1									
Ch2									
Ch3									
Ch4									

Medical Information

To the best of your knowledge, answer the following questions for yourself and all dependents you are enrolling. The information on this form is designed to assist in *VEBA Trust Plan* evaluation of your group.

1. In the past three (3) years has any person enrolling consulted a health care provider, received treatment (including prescription medications), or been hospitalized for any of the following conditions, disorders, or diseases?

	Yes	No		Yes	No
Brain or Nervous System	☐	☐	Thyroid or Pituitary Disorder	☐	☐
Nervous, Mental, or Emotional Disorder	☐	☐	Diabetes or Sugar in Urine	☐	☐
Drug or Alcohol Abuse	☐	☐	Disease of the Muscles	☐	☐
Epilepsy or Cerebral Palsy	☐	☐	Bone or Joint Disorder	☐	☐
Abnormal Blood Pressure	☐	☐	Arthritis, Rheumatism, Bursitis	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Lungs or Respiratory System	☐	☐
Blood Disorder or Varicose Veins	☐	☐	Emphysema, Tuberculosis, Chronis Obstructive		
Digestive or Gastrointestinal Tract	☐	☐	Pulmonary Disease, or Asthma	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Liver, Pancreas, or Kidney	☐	☐	Skin or Collagen Disease	☐	☐
Rectum, Prostate or Hernia	☐	☐	Cancer, Leukemia, or Hodgkin's Disease	☐	☐
Genitourinary System	☐	☐	Lymphatic Vessels or Glands	☐	☐
Breast or Reproductive Organs	☐	☐	Any Physical Deformity or Defect	☐	☐
Endocrine or Adrenal Disorder	☐	☐			

2. Are you or any dependent currently pregnant or undergoing fertility treatment?	☐	**Yes**	☐	**No**
3. Are you or any dependent anticipating surgery?	☐	**Yes**	☐	**No**
4. Are you or any dependent an organ or tissue transplant donor, recipient or candidate?	☐	**Yes**	☐	**No**
5. Is anyone applying for coverage currently disabled, restricted, or unable to perform the normal activities of daily living or self care?	☐	**Yes**	☐	**No**
6. Is anyone currently taking medication?	☐	**Yes**	☐	**No**
7. Have you been diagnosed, whether treated or untreated, with any condition, whether mentioned above or not?	☐	**Yes**	☐	**No**

For any "Yes" answers provided in the above section, list the details for each "yes" answer in the section below. Use additional paper if necessary.

Question No.	Person	Age	Medical Condition or Reason for Treatment	Type of Treatment	Medications & Dosages	Treatment Date(s)	Recovery Status

WALTERS
INSURANCE SERVICES

Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 months? Yes ☐ No ☐ If yes: a) Who was covered? ☐ Employee ☐ Spouse ☐ Child(ren)
b) Name of Carrier: _____ c) Carrier Phone #: _____ d) Policy/ID #: _____
e) Effective Date: _____ f) Termed Date: _____ g) Reason: _____

Signature (This form must be signed and dated)
I, the Applicant, understand, to the best of my knowledge, the information provided on this Employee Health Evaluation & Enrollment Form is complete and accurate. I, the Applicant, understand that if I have misstated or omitted any information on this form, *VEBA Trust Plan* reassess premium applied to my employer group and/or me, deny claims, or terminate *VEBA Trust Plan* coverage in accordance with applicable law. *VEBA Trust Plan*, its reinsurers, and their authorized representatives are authorized to obtain medical information in order to evaluate the information contained in this Employee Health Evaluation & Enrollment Form.

Applicant Signature: _____ Date: _____

Complete if you are WAIVING MEDICAL Benefits for you and/or your dependents

I waive medical benefits for: Employee Spouse Child(ren) Employee and Family
Reason for waiving benefits: Spouse's employer plan Medicare/Medicaid Military COBRA Individual
Other:_____

If I have waived benefits for myself and/or my dependents (including my spouse) because of other health benefits, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other benefits end because of involuntary loss of benefits (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period.

Applicant Signature:_____ ***Date:*** _____

Employee Statement / Authorization to Release Medical Information

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date indicated by *VEBA Trust Plan*.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to *VEBA Trust Plan* or its designee. This authorization includes information about drug abuse, alcoholism, or mental health. I agree that a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to copy this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required towards benefits.

I understand that the plan is an employee health & welfare plan created under the Employee Retirement Income Security Act (ERISA) of 1974 and subject to the rules and regulations adopted by the United States Department of Labor and is not insurance subject to laws of the state in which I work or reside. This application will be part of the contract. Benefits are effective only after approval by *VEBA Trust Plan* or its designee and satisfaction of any probationary period.

Applicant Signature:_____ ***Date:*** _____

Beneficiary Information

Beneficiary Name: Relationship to Member:

Complete Address: Birthdate of Beneficiary:

Phone:

WALTERS
INSURANCE SERVICES

Walters Insurance Services
PO Box 3665, Charleston WV 25336
P: 1-304-346-4823 F: 1-304-342-8342
E: cwalters@sfainc.com

WALTERS
INSURANCE SERVICES

EMPLOYER INFORMATION

Company Information

Company Name _____ Tax ID Number _____

Specify how the company name should appear on the permanent card.

Are you a DBA? Yes No

Are you a staffing agency? Yes No

Are you a PEO? Yes No

Description of Your Business Operation:

Primary Industry _____ SIC Code: _____

Location Address _____

Mailing Address if different _____

Phone Number _____ Fax Number _____

Do you have multiple locations? Yes No

Identify all locations by city, state.

Owner & Trustee Information

Only one Trustee is needed. The Trustee can be the owner.

Owner Name _____ Title _____

Email _____ Phone _____

VEBA Trustee _____ Title _____

VEBA Trustee _____ Title _____

VEBA Trustee _____ Title _____

Contact Person Information

Who do we contact for employee information?

Contact Name _____ Title _____

Email _____ Phone _____

Address: PO Box 3665 Charleston, WV 25336
Phone: 304-346-4823 F: 304-342-8342 E: cwalters@sfainc.com

WALTERS
INSURANCE SERVICES

Billing Information Who should receive the emailed invoice? More than one recipient is possible.

Contact Name _____ Title _____

Email _____ Phone _____

CC Email _____ Name _____

CC Email _____ Name _____

If multiple invoices are needed to be sent to different locations, fill out a form for each location.
A billing fee will be charged per location invoice.

Employee Information

Established Trial Period for all Employees- When are employees eligible for the health plan?

1 On Date of Hire

2 First of the month following hire

3 First of the month following 30 days

4 First of the month following 60 days

Total Number of Employees on Payroll: _____ Full Time: _____

Part Time: _____

Total Number of Employees enrolled in the Health Plan: _____

What plans will you be offering to your employees? Check all that apply.

Zero Deductible	$1500 Deductible	$3500 Deductible*
$500 Deductible	$2000 Deductible	$5000 Deductible
$1000 Deductible	$3000 Deductible	$6350 Value Plan

*Will be managed by a different TPA than the others.

Current Health Carrier Information _____ Renewal Date: _____

Is your current plan Self-Funded? Yes* No

* Include your loss run with your group application.

Broker Information Who recommended this program to you?

Name _____ Agency Name _____

Email _____ Phone _____

A. List any <u>current</u> <u>participants</u> in COBRA / State Continuation (use additional paper if necessary):

❑ **NONE**

Name of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)

B. List any participants currently <u>eligible</u> for COBRA who have *not yet elected* coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date (use additional paper if necessary):

❑ **NONE**

Name	Date Eligible	Activating Event/Date

C. List any employees and/or dependents who are on the health plan that are disabled:

❑ **NONE**

Name	Disability	Qualifying Event

II. RATE HISTORY	(if more than 3 plans, include the 3 most popularly-elected plans)			
Plan 1 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 2 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 3 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION (Individual, in-network only)			
Current Plan Names:	**1:**	**2:**	**3:**
Current Plan Types:	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Annual Deductible			
Co-Insurance (as %)			
Out-of-Pocket Max (excluding deductible)			
Office Visit Copay			
Prescription Drug Copay generic / brand formulary / brand non-formulary	/ /	/ /	/ /

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (by $ or %)				

- **Attach a copy of your benefit summary for each plan and year listed above.**
- **Include carrier claims report if available.**

Next, please answer the following questions on behalf of your company <u>to the best of your knowledge</u>. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

GENERAL ILLNESS QUESTIONS:	To the Best of My Knowledge (any or all):
a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability? c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? ***(If yes to any or all, please provide details in the table below.)***	❑ YES ❑ NO

SPECIFIC ILLNESS QUESTION:

Is anyone currently being treated or been advised to seek treatment for any of the following?

<u>Please check all that apply</u>:

❑ AIDS or testing HIV Positive
❑ arthritis
❑ back disorder
❑ cancer
❑ diabetes
❑ heart disease
❑ kidney disorder
❑ liver disease
❑ mental illness
❑ muscular disorder
❑ nervous system disorders
❑ respiratory disease
❑ stroke
❑ substance dependency
❑ transplants
❑ tumor
❑ other serious conditions

(If any boxes are checked, please provide details in the table below.)

Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

Known Medical Conditions <u>to the best of your knowledge</u>

(continued):

IS ANYONE CURRENTLY PREGNANT? If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy. *This includes employees, dependents or COBRA participants.*	To the Best of My Knowledge: ❑ YES ❑ NO

Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

I certify that the statements herein are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify the entity collecting this information of any changes that occur after signing this Group Health Questionnaire and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement may be terminated for breach. In such cases, my company may be liable to Black Wolf or the Trust or an employee for damages.

This information is gathered for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

In compliance with requirements for GINA, the entity collecting this information is not requesting genetic information. No information regarding the height or weight of any Michigan employees has been provided.

Authorized Signature	**Title**	**Date**
Print Name	**Print Name of Company**	
Broker / Sales Signature	**Broker / Sales Print Name**	**Date**

Client Privacy Notification

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detail health information (protected health information) that you provide via hard copy or through the online enrollment will be used solely for the purpose of providing risk assessment to the Trust that will provide a health insurance quote to the employer. Black Wolf is acting as a Business Associate to the Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations. Black Wolf will not sell, license, transmit or disclose this information outside of the Trust unless: a) necessary for Black Wolf to provide the services on behalf of the Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$0 Deductible**	**$500 Deductible**	**$1000 Deductible**
Annual Deductibles (Does not include Co-payments)	Individual $0.00 Family $0.00	Individual $500 Family $1,000	Individual $1,000 Family $2,000
Non-Network Providers	Individual $3,000 Family $6,000	Individual $3,000 Family $6,000	Individual $3,000 Family $6,000
Annual Co-Insurance Out of Pocket Maximums (Includes Medical Deductibles, Medical and Rx Co-payments and Co-insurance)	Individual $1,500 Family $3,000	Individual $2,000 Family $4,000	Individual $2,500 Family $5,000
Non-Network Providers	Individual $6,000 Family $12,000	Individual $6,000 Family $12,000	Individual $6,000 Family $12,000
Office Visits - Primary Care (exams or consultations)	$25 Co-payment, then Plan pays 100%	$25 Co-payment, then Plan pays 100%	$25 Co-payment, then Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Office Visits - Specialist (exams or consultations)	$45 Co-payment, then Plan pays 100%	$45 Co-payment, then Plan pays 100%	$45 Co-payment, then Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Office Services - basic services with exam (does not include pain mgmt., chemo, surgical)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Wellness Care - Adult	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Wellness Care - Children	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Allergy Treatment - Injections & Serums	**No Benefit**	**No Benefit**	**No Benefit**
Allergy Treatment - Testing	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Ambulance: up to $5000	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Birth Control / IUD	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Chiropractic Services: Limit of 20	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Emergency Room - Facility (Co-payment waived if admitted)	$200 Co-payment, then Plan pays 100%	$200 Co-payment, then Plan pays 100%	$200 Co-payment, then Plan pays 100%

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$0 Deductible**	**$500 Deductible**	**$1000 Deductible**
	Generic - $10 Co-payment Brand Formulary - $30 Copay Br/Non-form - $60 Co-pay Spec Drugs $100 Co-pay	Generic - $10 Co-payment Brand Formulary - $30 Copay Br/Non-form - $60 Co-pay Spec Drugs $100 Co-pay	Generic - $10 Co-payment Brand Formulary - $30 Copay Br/Non-form - $60 Co-pay Spec Drugs $100 Co-pay
Non-Network Providers	No Benefit	No Benefit	No Benefit
	Generic - $25 Co-pay Brand Form - $75 Co-pay Br / Non-form - $150 Co-pay	Generic - $25 Co-pay Brand Form - $75 Co-pay Br / Non-form - $150 Co-pay	Generic - $25 Co-pay Brand Form - $75 Co-pay Br / Non-form - $150 Co-pay
Non-Network Providers	No Benefit	No Benefit	No Benefit

Cigna PPO Choice Fund	**$0 Deductible**	**$500 Deductible**	**$1000 Deductible**
EE-EMPLOYEE ONLY	$752	$700	$648
EC-EMPLOYEE CHILD(REN)	$1,246	$1,141	$1,038
ES-EMPLOYEE SPOUSE	$1,488	$1,383	$1,278
FAM- EMP & SP & CHILD(REN)	$1,565	$1,462	$1,358

These rates do not include the monthly $20 per invoice fee or the annual $100 fee.

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$1500 Deductible**	**$2000 Deductible**	**$3000 Deductible**
Annual Deductibles (Does not include Co-payments)	Individual $1,500 Family $3,000	Individual $2,000 Family $4,000	Individual $3,000 Family $6,000
Non-Network Providers	Individual $3,000 Family $6,000	Individual $5,000 Family $10,000	Individual $6,000 Family $12,000
Annual Co-Insurance Out of Pocket Maximums (Includes Medical Deductibles, Medical and Rx Co-payments and Co-insurance)	Individual $3,000 Family $6,000	Individual $6,000 Family $12,000	Individual $6,000 Family $12,000
Non-Network Providers	Individual $6,000 Family $12,000	Individual $12,000 Family $24,000	Individual $12,000 Family $24,000
Office Visits - Primary Care (exams or consultations)	$25 Co-payment, then Plan pays 100%	$40 Co-payment, then Plan pays 100%	$40 Co-payment, then Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Office Visits - Specialist (exams or consultations)	$45 Co-payment, then Plan pays 100%	$60 Co-payment, then Plan pays 100%	$60 Co-payment, then Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Office Services - basic services with exam (does not include pain mgmt., chemo, surgical)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Wellness Care - Adult	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Wellness Care - Children	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Allergy Treatment - Injections & Serums	**No Benefit**	**No Benefit**	**No Benefit**
Allergy Treatment - Testing	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Ambulance: up to $5000	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Birth Control / IUD	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Chiropractic Services: Limit of 20	Plan pays 80%	Plan pays 80%	Plan pays 80%
Non-Network Providers	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount	Deductible, then Plan pays 60% of ***allowed*** amount
Emergency Room - Facility (Co-payment waived if admitted)	$200 Co-payment, then Plan pays 100%	$300 Co-payment, then Plan pays 100%	$300 Co-payment, then Plan pays 100%

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$1500 Deductible**	**$2000 Deductible**	**$3000 Deductible**
	Generic - $10 Co-payment Brand Formulary - $30 Copay Br/Non-form - $60 Co-pay Spec Drugs $100 Co-pay	Generic - $10 Co-payment Brand Formulary - $40 Copay Br/Non-form - $70 Spec Drugs 25% Co-pay up to $300 maximum	Generic - $10 Co-payment Brand Formulary - $40 Copay Br Non-form - $70 Spec Drugs 25% Co-pay up to $300 maximum
Non-Network Providers	No Benefit	No Benefit	No Benefit
	Generic - $25 Co-pay Brand Form - $75 Co-pay Br / Non-form - $150 Co-pay	Generic - $25 Co-pay Brand Form - $100 Co-pay Br / Non-form - $175 Co-pay	Generic - $25 Co-pay Brand Form - $100 Co-pay Br / Non-form - $175 Co-pay
Non-Network Providers	No Benefit	No Benefit	No Benefit
Cigna PPO Choice Fund	**$1500 Deductible**	**$2000 Deductible**	**$3000 Deductible**
EE-EMPLOYEE ONLY	$603	$557	$470
EC-EMPLOYEE CHILD(REN)	$945	$846	$748
ES-EMPLOYEE SPOUSE	$1,186	$1,088	$886
FAM- EMP & SP & CHILD(REN)	$1,260	$1,160	$1,071

These rates do not include the monthly $20 per invoice fee or the annual $100 fee.

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$5000 Deductible**	**$6350 Value Plan Ded**	**$3500 H.S.A.**
Annual Deductibles (Does not include Co-payments)	Individual $5000 Family $10,000	Individual $6,350 Family $12,700	Individual $3,500 Family $7,000
Non-Network Providers	Individual $10,000 Family $20,000	Individual $12,700 Family $25,400	Individual $14,000 Family $28,000
Annual Co-Insurance Out of Pocket Maximums (Includes Medical Deductibles, Medical and Rx Co-payments and Co-insurance)	Individual $6,350 Family $12,700	Individual $6,350 Family $12,700	Individual $6,000 Family $12,000
Non-Network Providers	Individual $20,000 Family $40,000	Individual $25400 Family $50,800	Individual $18,000 Family $36,000
Office Visits - Primary Care (exams or consultations)	$50 Co-payment, then Plan pays 100%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Office Visits - Specialist (exams or consultations)	$75 Co-payment, then Plan pays 100%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Office Services - basic services with exam (does not include pain mgmt., chemo, surgical)	Plan pays 100%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Wellness Care - Adult	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Wellness Care - Children	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Network Providers	No Benefit	No Benefit	No Benefit
Allergy Treatment - Injections & Serums	**No Benefit**	**No Benefit**	**No Benefit**
Allergy Treatment - Testing	Deductible, then Plan pays 70%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Ambulance: up to $5000	Deductible, then Plan pays 70%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Birth Control / IUD	Plan pays 100%	Deductible, then Plan pays 100%	Plan pays 100%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Chiropractic Services: Limit of 20	Deductible, then Plan pays 70%	Deductible, then Plan pays 100%	Deductible, then Plan pays 70%
Non-Network Providers	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 50% of ***allowed*** amount	Deductible, then Plan pays 40% of ***allowed*** amount
Emergency Room - Facility (Co-payment waived if admitted)	$400 Co-payment, then Plan pays 100%	Deductible, then Plan pays 100% **OON: Dec, plan pays 50%**	Deductible, then Plan pays 100%

2017 Overview of Medical Benefits

Cigna PPO Choice Fund **Lifetime Max: None**	**$5000 Deductible**	**$6350 Value Plan Ded**	**$3500 H.S.A.**
	Generic - $15 Co-payment Brand Formulary - $50 Copay Br/Non-form - $90 Spec Drugs 25% Co-pay up to $300 maximum	Generic -Deductible, then Plan pays 100% Brand Formulary - Deductible, then Plan pays 100% Br/Non-form - Deductible, then Plan pays 100% Spec Drugs-Deductible, then Plan pays 100%	Generic - Ded, then $10 Co-pay or 30% whichever is greater. Br Form- Ded, then $30 Co-pay or 30% whichever is greater. Br/Non-form- Ded, then $60 Co-pay or 30% whichever is greater, plus the cost of the difference between Non-form and generic. Specialty Drugs - Deductible, then 30% or $300 whichever is less.
Non-Network Providers			No Benefit
	Generic - $37.50 Co-pay Brand Form - $125 Co-pay Br / Non-form - $225 Co-pay	Generic -Deductible, then Plan pays 100% Brand Formulary - Deductible, then Plan pays 100% Br/Non-form - Deductible, then Plan pays 100%	Gen - Ded, then $25 Co-pay or 30% whichever is greater. Brand Formulary - Ded, then $75 Co-pay or 30% whichever is greater. Brand / Non-form - Ded, then $150 Co-pay or 30% whichever greater, plus the cost of the difference between Non-form and generic.
Non-Network Providers	No Benefit	No Benefit	No Benefit
Cigna PPO Choice Fund	**$5000 Deductible**	**$6350 Value Plan Ded**	**$3500 H.S.A.**
EE-EMPLOYEE ONLY	$425	$345	$297
EC-EMPLOYEE CHILD(REN)	$673	$651	$602
ES-EMPLOYEE SPOUSE	$812	$735	$624
FAM- EMP & SP & CHILD(REN)	$958	$944	$949

These rates do not include the monthly $20 per invoice fee or the annual $100 fee.