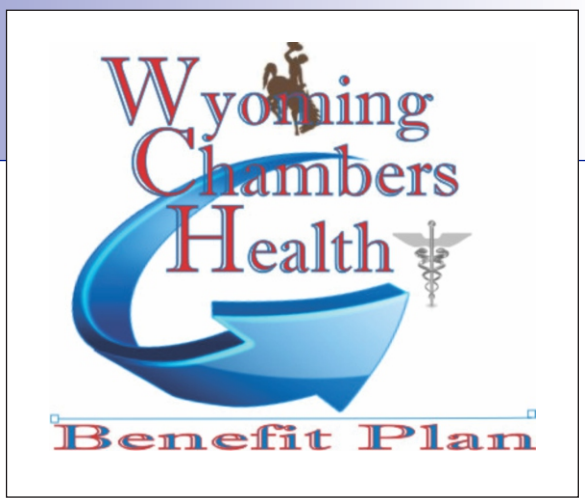


Wyoming strong

2022 Plan Year

sponsored by:
Your Local Chamber
and
The Wyoming Chamber
Welfare Benefits Association

PROUD MEMBER OF 307 FIRST

Plan Description

A Summary of the Wyoming Chambers Health Benefit Plan

The Wyoming Chambers Health Benefit Plan is a non-grandfathered benefit Plan under the Patient Protection and Affordable Care Act of 2010. This means the Plan includes the mandated coverage(s) as required in the law for the benefit of Plan participants. For additional information regarding the benefits provided due to this legislation, as well as all other available coverage levels limitations, please refer to the Plan Declaration and the Summary Plan Document.

Participating Chambers

Campbell County Chamber of Commerce
Sheridan County Chamber of Commerce
Douglas Chamber of Commerce
Powell Chamber of Commerce
Thermopolis Chamber of Commerce
Lander Area Chamber of Commerce
Casper Area Chamber of Commerce
Newcastle Chamber of Commerce
Star Valley Area Chamber of Commerce
Goshen County Economic Development Corporation
Laramie Chamber Business Alliance
Sublette County Chamber of Commerce
Worland / Tensleep Chamber of Commerce
Cody Country Chamber of Commerce
Rock Springs Chamber of Commerce
Riverton Chamber of Commerce

Wyoming Chambers Health Benefit Plan

The Wyoming Chambers Health Benefit Plan is:

▶ A Welfare Benefit Plan established under Internal Revenue Service Code and applicable Department of Labor regulations.
▶ A Plan where contributions are held in a Trust that is directed by a Board of Trustees chosen from the member participants of the Plan.
▶ A Plan governed by the Wyoming Chambers Health Benefits Association Board, the Plan Sponsor, and its Board of Directors who assigns a Plan Administrator, retains Legal Counsel, Accounting & Auditing Services and other Administrative Services as needed for the management of the Plan; all working for the benefit of the participants.
▶ A Plan where claims are paid by the contracted Claims Administrator (TPA) as directed by applicable State and Federal laws, the Trust Document, the Plan Declaration and the Summary Plan Description(s) of the benefit programs offered and administered by the Association.
▶ A Trust which contracts with insurance and/or reinsurance companies in order to ensure the overall financial stability of the Trust and of the benefits offered. These contracts may change from time to time and are voted upon and approved by the Association Board and the Trust Board or its designee.
▶ A Plan where the benefits offered are reviewed annually to determine their viability for the members and participants. The Wyoming Chambers Health Benefit Association, with available contracted counsel and advice, may alter these benefits, remove a plan of benefits completely and/or add new plans for consideration, without the consent of participating employers or participating employees.
▶ A Trust that is participant-owned along with any surplus or deficits incurred.

Wyoming Chambers Health Benefits Association
Jim Shellinger, President
Gail Lofing, Plan Administrator
Campbell County Chamber of Commerce
314 South Gillette Ave.
Gillette, WY 82716
(307) 682-3673

Claims Administered by:

Allegiance Benefit Plan Management, Inc.

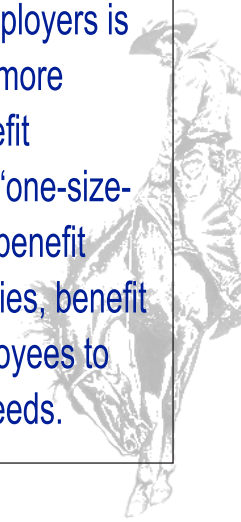
(406) 721-2222

Program Objectives

- ☑ More stability in insurance premiums, now and in the future
- ☑ Broader accessibility to health insurance and coverage options within the community
- ☑ Creation of a community-wide wellness mind-set and culture
- ☑ Education about access to a broader range of choices to promote better healthcare decision making

Defined Contribution Healthcare

For years, employers have provided benefits for employees and planned for those benefits to meet the needs of those employees and their families. The challenge for employers is that healthcare has become much more specialized and variable while benefit programs have adhered to a more "one-size-fits-all" model. Due to the evolving benefit needs of employees and their families, benefit choices must be available for employees to choose from to fit their individual needs.



One benefit plan **DOES NOT** fit all employees' healthcare needs!

In a Defined Contribution Benefit Plan ...

EMPLOYERS CHOOSE the amount of money to allocate towards benefits. It may be a different amount for coverage level(s) (Single, Family, etc.) and the amount does not need to change annually.

EMPLOYEES CHOOSE the benefit program that best fits their needs and their ability to afford the premiums for that benefit plan choice. The amount of premium for coverage, which is more than the employer contribution, is withheld from employee compensation.

Enrollment Requirements/Contingencies:

◆ The employer must be a current member in good standing for at least 60 days, of at least one participating Chamber of Commerce, prior to Effective Date of coverage.

◆ Each employer must have a minimum of 75% of eligible employees participating for groups of 5 or more, and 100% participation for groups of 4 or less (after Qualified waivers). Minimum group size is 2 employees. Husband and Wife groups of two are eligible as long as both are full-time employees and can verify both work full-time.

◆ Completed Employee Enrollment/Waiver Applications are required from each employee in order to qualify. Following underwriting, the entire employer group will either be accepted or denied coverage.

◆ The PLAN's renewal date is July 1st of each calendar year. Regardless of when enrollment is completed, any changes to the PLAN rates and/or benefits will take place on July 1st. Open enrollment (the ability to add employees who waived coverage or dependents which had previously waived) is the month of June of each year for each participating employer (subject to HIPAA Qualifying Event rules).

◆ Premium Contributions are made by the employer directly into the Trust Account and are used as described in the Trust Document, Summary Plan Description and Plan Declaration. The Trust is governed by a Board of Trustees, elected as described in the Trust Document.

◆ Employer must contribute a minimum of 50% of the employee's premium, or equivalent if multiple plans are offered. Paying too little of employee's premium may have tax implications under the ACA (for Applicable Large Employers).

Benefit

Notes:

Plans 4, 5 and 7 are Qualified High Deductible Plans, meaning they are qualified insurance Benefits for Health Savings Account rules and participation

In Plans 4, 5 and 7, the Rx Discount Card is where 100% of the discounted price applies to deductible and co-insurance and is processed as any "other" type of claim.

IT IS IMPORTANT to seek care with a PPO Member physician and/or facility in order to protect financial exposure. This includes services from standalone laboratory services and physical therapy service entities. Do not assume ... check and make sure.

	Plan - 1		Plan - 3		Plan - 4	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible Amount						
Single	$1,500	$3,000	Plan pays 60%	Plan pays 40%	$3,000	$6,000
Family	$3,000	$6,000			$6,000	$12,000
Co-Insurance	70%	50%	60%	40%	70%	50%
Out-of-Pocket Maximum	Single $8,000 / Family $16,000	Single $16,000 / Family $32,000	Single $7,500 / Family $15,000	Single $15,000 / Family $30,000	Single $7,000 / Family $14,000	Single $14,000 / Family $28,000
	Out-of-Pocket Maximums shown include: Deductible(s), Co-insurance, Dr. Office Co-pays and Rx					
Wellness	100%		100%		100%	
Dr. Office Co-Pay						
Primary Care	$45	Ded & Coins	Plan pays 60% - Participant pays 40%		Deductible & Co-insurance	
Specialist						
Non-PPO	$85	Ded & Coins				
PPO						
Urgent Care Center	$85	Ded & Coins				
PT / ST / OT	$85	Ded & Coins				
Rx Card Co-Pay						
Generic						
Preferred	$0		Plan pays 60% - Participant pays 40%		Deductible & Co-insurance	
Non-Preferred	$15					
Brand Name						
Preferred	$45					
Non-Preferred	$85					
Specialty Rx	$250					
	All Rx Coverage includes: ***Step Therapy*** (some scripts start with less expensive scripts before pro					

PPO Network	LOCATION	PPO NETWORK NAME	PPO Website
	Entire United States	Cigna OAP Network	www.cigna.com

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CONNECT TO DOCTORS 24/7

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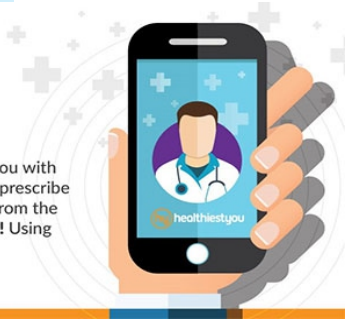
VISIT A DOCTOR 24/7/365 OVER THE PHONE!

Our network of licensed doctors are standing by to help you with the press of a button. They can diagnose, treat, and often prescribe for an array of medical issues right over the phone, even from the comfort of your couch. **The best part is every call is FREE!** Using HealthiestYou can save you tons of time and money!

Download the app and take charge today!



Plans

	Plan - 5		Plan - 6		Plan - 7	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	$5,000 $10,000	$10,000 $20,000	$2,500 $5,000	$5,000 $10,000	$6,500 $13,000	$13,000 $26,000
	70%	50%	50%	30%	50%	30%
	Single $7,000 Family $14,000	$14,000 $28,000	Single $7,500 Family $15,000	$15,000 $30,000	Single $7,050 Family $14,100	$15,000 $30,000
	x Card Co-pays. DOES NOT include amounts in excess of Plan Allowable for Non-Network charges.					
	100%		100%		100%	
	Deductible & Co-insurance		$45 $85 $85 $85	Ded & Coins Ded & Coins Ded & Coins Ded & Coins	Deductible & Co-insurance	
	Deductible & Co-insurance		$0 $15 $45 $85 $250		Deductible & Co-insurance	
	ogression to higher cost scripts) ***Starter Dose*** (10 days for first time scripts) limits on some scripts.					

Wellness Initiative

ONE of the only ways to maintain a "reasonable" outlook for the future of a benefit program is to be able to accurately assess the risks, and to assess those risks annually. The Chambers' Wellness Initiative includes, for participating adults:

- Biometric Full Blood Panel Screening

Through this Initiative, participants will receive an annual overview of their current health and a "score" that goes along with it. The reports and analysis may be used by the participant with their Medical Provider as well as the Care Managers with the Plan.

By participating in the Initiative, the premium rate charged to a participating employer group is reduced.

ALL PLANS INCLUDE:

⇒ Mail Order Pharmacy
⇒ Medically Necessary Ambulance Coverage (Air and Ground)
⇒ Pre-Existing Conditions Covered
⇒ Unlimited Lifetime Maximum
⇒ $150 Co-pay for Non-Emergent use of Emergency Room
⇒ Out-of-Pocket Maximum = Deductible amount + Co-insurance amount + Doctor and Rx Co-pays
⇒ Includes Chiropractic and Physical / Speech Therapy Benefits (when medically appropriate) (There are Plan Limits)
⇒ Credit for the amount of Prior Group Plan Deductible Amount(s) (Transfer Credit for New Employers at Inception of coverage)
⇒ Dr. Office Co-Pay Limits (per visit)
100% for Office Visits - Co-pays included in Out-of-Pocket Maximums
100% for approved Lab & X-ray to $1,000 per year per person
⇒ Routine Wellness ***- 100% - Based on Physician Codes***
Includes Annual Exams, Wellness Mammograms, Pap Tests, Birth Control (Specific List), Wellness Colonoscopy and PSA Tests (other items included as medically appropriate)
⇒ Preferred Provider Organization (PPO) Benefits provided
Non-network paid at a multiple of Medicare (called Maximum Eligible Expense (MEE)) as determined by the claims administrator.
⇒ Automatic Group Life Insurance with Matching AD&D ($15,000 per employee)
⇒ See the Summary Plan Document for complete Plan Details and Limitations/Exclusions

Dental Schedule of Benefits

Dental Benefits	Patient's Liability		General Plan Limits
	Plan 1	Plan 2	
Dental Deductible: (Per calendar year) ◆ Per Individual ◆ Per Family	 $50 $150	 $50 $150	Waived for Preventive Benefits
	PLAN 1 PAYS	**PLAN 2 PAYS**	
Preventative Benefits	100%	100%	Deductible waived. **Includes** fluoride treatment for dependent children under age 14, oral exams, cleaning and x-rays.
Basic Benefits	80%	80%	**Includes** fillings, root canals and periodontic treatment.
*Major Benefits	50%	50%	**Includes** Periodontal and Endodontics Care.
***NOTE**: Participants will be subject to a 6 month waiting period before benefits are covered, unless 12 month prior coverage supplied.			
*Orthodontic Benefits (Under age 19) **Lifetime Orthodontic Benefits** Per Insured Individual	Not Covered Not Covered	50% $1,000	**Excludes** Missed Visit Charges.
***NOTE:** Participants will be subject to a 12 month waiting period before benefits are covered, unless 12 month prior coverage supplied.			
Calendar Year Maximum Benefit Per Insured Individual	$1,000	$1,000	**Excludes** Orthodontic Benefits.

Self-Audit Billing Credit

The Plan offers an incentive credit to all participants to encourage examination and self-auditing of eligible medical bills to accurately reflect the services and supplies received by the participant or covered dependent. The participant is voluntarily asked to review all hospital and doctor bills and verify that he/she has received each itemized service and the bill does not represent either an overcharge or a charge for services never received, regardless of the reason. The Benefit Services Administrator agrees to assist the employee (at his/her request) in determination of errors, and recovery attempts.

In the event a participant's self-audit results in elimination or reduction of charges, twenty-five percent (25%) of the amount eliminated or reduced will be paid directly to the participant (subject to a twenty dollar ($20) minimum savings), provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Benefit Services Administrator (e.g., A copy of the incorrect bill and a copy of the corrected billing.)

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the plan as well as the plan participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the plan member's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Maximum Allowable Fee, regardless of whether the charge is or is not reduced. Maximum benefit of $500 per episode of care.

wch

This is a partial listing of the Benefits and Exclusions provided under the medical plan and is NOT intended to provide complete details of benefits and/or exclusions and limitations. Please refer to the Summary Plan Description (SPD) for details of benefits, limitations and the applicability of these benefits to each situation.

Benefits available...but NOT limited to:

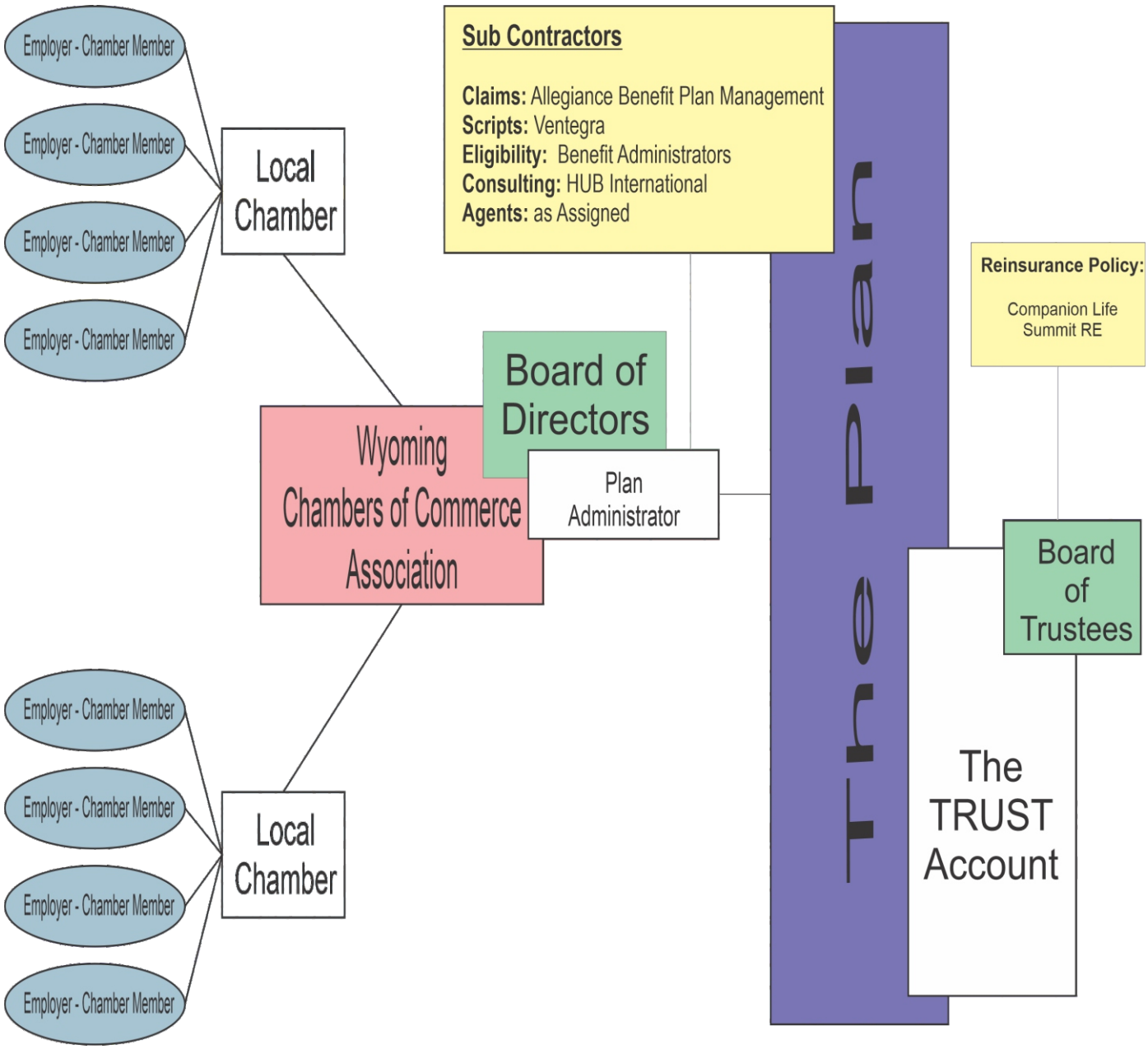
Acupuncture for anesthesia purposes
Allergy tests and allergy injections
Ambulatory/Outpatient Surgery Facility Care
Anesthesia charges
Assistant surgeon charges
(if required due to the surgical aspects)
Birthing Center
Blood and blood related products
Cardiac Rehabilitation
Chemotherapy for treatment of a malignancy
Chiropractic. Manipulation or adjustment of the spinal column
Colonoscopy (Diagnostic)
Diabetes Education. Equipment and
supplies for persons with diabetes
Durable medical equipment,
purchase or rental up to the purchase price
Elective Sterilization
Emergency Room
Hospital inpatient or outpatient services
Laboratory Services
Mastectomy due to diagnosed breast cancer
Mental & Nervous Treatment
Nursing Services
Occupational Therapy
Orthopedic braces
Oxygen & the equipment for its administration
Pathological Services
Physical Therapy
Prescription drugs requiring a prescription under federal law
Professional ambulance service if medically necessary
(Includes air ambulance)
Prosthetic Orthotics
Radiation Therapy
Respiratory/Inhalation Therapy
Services of Physicians
a. Hospital visits
b. Doctor's office calls
c. Doctor's office surgery
Speech Therapy, but only to restore speech
abilities lost due to illness or injury
Surgery charges
Vision Care following covered medical procedure to the eye
Wig up to $300 lifetime (1 wig) due to Administration of cancer treatment
X-Ray Services

Benefits Exclusions ... NOT a detailed list

Abortion; excepting "risk to mother", rape or incest
Acupuncture or acupressure therapy
Adoption or surrogate expenses
Behavioral Counseling expenses
Biofeedback Therapy
Blood handling and storage charges
Cosmetic surgery
Chelation Therapy, except for heavy metal poisoning
Non-prescribed Corrective footwear
Cosmetic services
Court ordered treatment
Custodial care
(Under Medical) Dental & Dental Implants
Developmental delays
Preferred Provider discount amounts or "cash discounts"
Educational or vocational testing
Excess charges
Exercise
Experimental or investigational
Cosmetic Eyelid and Eyebrow Surgery
Failure to keep appointments
Felonious Acts. Charges resulting from or caused
during the commission of a felony
Food
Cosmetic Foot Care
Foreign medical care or Government provided services
Hair loss
Hearing aids & exams
Hypnotism
Liposuction
Mailing expenses
Marital counseling
Massage therapy
No obligation to pay
No physician recommendation
Nonprescription items
Not appropriate or not medically necessary
Obesity
Occupational
Personal comfort of convenience items
Providing medical information
Relative giving services
Riot
Sales tax
Self-Inflicted
Services before or after coverage
Sex changes
Smoking cessation (except under Preventative Care)
Surgical sterilization reversal
Telephone consultations
Third Party liability
Travel or accommodations (unless Centers of Excellence)
Unwanted hair
Vision care. Visual training or orthoptics
War or Acts of War
Worker's Compensation

Section 125 - Section 125 of the Internal Revenue Code allows for the premiums paid by employees for employer provided group benefits to be withheld from employee pay on a pre-tax basis. **The Wyoming Chamber Health Benefit Plan qualifies as an employer sponsored group benefit plan that could be offered under an employer's Section 125 plan. However, before an employer can offer pre-tax premium payments for his or her employees, the employer must adopt a separate "Section 125 Plan" and allow employees the right to choose whether they wish to participate.** The claims administrator for the Wyoming Chamber Health Benefit Plan has sample documents and/or administration options an employer may need, in order to adopt a pre-tax Section in consultation with the employer's tax counsel. For clarification, please consult with your Agent or the Trust's consultant.

There are several different “vendors” who participate in the Plan and who operate for the benefit of the Plan. All of them are under contract to the Board of Directors and could be replaced should there become a “better” option, or if a vendor were not performing as needed to ensure a quality experience for all concerned.



For additional details regarding the benefits and limitations of these programs, please consult the Summary Plan Description.

Optional Cost Containment Program

This program IS NOT a mandatory plan. It an option designed to provide optimal coverage at a very competitive price for participants, and also protect the additional out-of-pocket costs incurred due to participation in the plan. The location of care, and who the providers are, remains the choice of the participant.

Centers of Excellence

In Health Care, as with all other issues of life, there are Doctors and Hospitals that do what they do better than others in their same profession. Many times, because they do their service so very well, it saves the patient recovery time, complication risks and cost of care. Because these provider's and facilitie's quality of care is exceptional and can offer their services at a competitive price due to location and volume, they qualify as Centers of Excellence.

In typical benefit programs, Centers of Excellence are used particularly for transplant procedures because most facilities and doctors are either not trained or don't have the volume or experience to perform these complicated procedures.

In other diagnoses and treatment of health conditions, there are facilities that excel in treatment quality, low complication/high success rates, low mortality and aggressive pricing. Sometimes, it is better for the patient to even pay a higher price to ensure the higher quality. These Centers of Excellence also excel at the "cutting edge" of technology, diagnosis techniques and effective treatment methods.

FOR JOINT REPLACEMENT AND ORTHOPEDIC SURGERY.

University of Utah Medical Center

"University of Utah Health serves the people of Utah and beyond by continually improving individual and community health and quality of life. This is achieved through excellence in patient care, education, and research; each is vital to our mission and each makes the others stronger."

Orthopedic Center of the Rockies

"Our 35 doctors are specialists in the medicine of motion. They provide orthopaedic, spine, sports medicine, concussion, and podiatry care. The physicians have board certification or advanced training, and have helped thousands of adults and children just like you accelerate their treatment and recovery."

FOR NEUROSURGICAL NECK AND BACK SURGERY.

Front Range Center for Brain & Spine

"Front Range Center for Brain & Spine Surgery is regionally recognized as one of the premier providers of minimally invasive surgery for the brain and spine. The team at Front Range Center for Brain & Spine Surgery is dedicated to providing exceptional care while maintaining an environment of trust and honesty."

FOR SCANS AND LABORATORY SERVICES.

Summit Medical Center

"Summit Medical Center was established to deliver quality care to the Casper community ... The delivery of care was designed with you in mind – to provide an unparalleled healthcare experience, offering multiple specialties with the finest doctors in the region. At the core, our values and fundamentals are based on exemplary patient care – including a nurturing and comfortable home-like environment and around-the-clock patient-focused services and staff."

FOR CARDIOVASCULAR / HEART PROCEDURES.

Mayo Clinic in Rochester, MN

"Thousands of patients come to Mayo Clinic in Rochester, Minnesota every day for diagnosis or treatment of a medical problem. Patients can make their own appointments or be referred by a physician. Most patients are treated on an outpatient basis, meaning their evaluation, tests and treatments are done in the Clinic and they return to their home or lodging at the end of the day. Patients who require hospitalization are admitted to one of the three Mayo hospitals in Rochester."

Centers of Excellence

The process of getting benefits through the Centers of Excellence (COE) program has been complicated in the past. Too many “hands” involved and not enough understanding of the Program.

The COE Coordinator eliminates the issues of getting access and keeping the insured Patient involved. The Coordinator will work with:

- The Insured
- The Insurance Plan
- The Providers of Care
- Lodging and Transportation Vendors

This process ensures (1) that the appointments are set at the correct location, (2) that the claims processor is properly notified as to the billing arrangement, (3) the transportation and lodging costs, where applicable, are paid by the Plan, (4) that the claims are paid according to the Plan Document, and (5) most importantly, that the patient’s experience is the best that it can be.

The goals of this process are to increase utilization of the COE program by increasing the ease of which it is utilized. By having a center point of contact where the Plan Participant can become and stay involved, the Claims Processor can get clear information and direction thereby eliminating re-processing of claims and plan frustration, and making sure the provider is correctly and timely paid, everyone “wins”.

Quality care provided by high quality providers at a very equitable price.

Centers of Excellence

When considering a Center of Excellence, there are items to be aware of during the decision making process. Those items should include issues such as pre-authorizing the procedure, travel expenses including return travel issues such as discomfort, companion costs, follow-up care for the procedure as well as complication cost and care, should there be complications.

It is important to know that simply having a procedure done in a Center of Excellence does not guarantee a better out-come for the procedure, although statistically these Centers are at the very cutting edge of quality and have some of the best out-come statistics in the nation, if not the entire world. It is still imperative that the patient make an informed decision of where and with whom to receive the necessary medical care.

There are additional expenses involved with getting to a Center of Excellence, hence the plan agrees to:

~ Waive Deductible and any Co-pays associated with a covered treatment at Center of Excellence (**no Deductible waiver for HSA Plans**)
~ Pay100% after Deductible
~ Reimbursement of eligible expenses up to:
$2,500 per course of treatment for Travel related to Surgery for the patient and companion

Neither the employer nor the claim administrator will require that a patient seek care at a particular facility or a physician. It is the patient's responsibility to make a diligent effort in securing the physician and facility of choice. Contact information and Provider information may be received from the Care Coordinator shown below.

Centers of Excellence Coordinator

Kae Jones

(307) 473-3000
direct (307) 233-8586

HUB

University of Utah Orthopedics
http://healthcare.utah.edu/orthopaedics/

Orthopedic Center of the Rockies
http://www.orthohealth.com

Summit Medical Center, Casper
https://summitmedicalcasper.com

Front Range Center for Brain & Spine
http://www.brain-spine.com/

Mayo Clinic at Rochester
http://www.mayoclinic.org/rochester/

Additional Life & AD&D Insurance

	Employee	Spouse	Child
Benefit Schedule	Increments of $10,000	Increments of $10,000	Increments of $1,000
Maximum Benefit	$300,000	$150,000	$10,000
Minimum Benefit	$10,000	$10,000	$1,000
Guarantee Issue	$200,000	$25,000	Full Benefit
AD&D Benefit	Matches Life Benefit	Matches Life Benefit	Matches Life Benefit
Age Reduction Schedule	To 65% at age 65 To 50% at age 70	To 65% at age 65 To 50% at age 70	None
Conversion	Included	Included	Included
Portability	Included	Included	Included
Waiver of Premium	Eligible to age 60 Waived to age 65	Not Included	Not Included

Additional Plan Design Details

- On the policy effective date, all members (enrolled or eligible) may increase their benefit amount up to the guarantee issue amount without providing evidence of insurability.
- On the policy effective date, all members (enrolled or eligible) may increase their spouse's benefit amount up to the guarantee issue amount without providing evidence of insurability.
- On the policy effective date, all members (enrolled or eligible) may increase their child's benefit amount up to the guarantee issue amount without providing evidence of insurability.
- An Accelerated Benefit is included. Terminally ill members may withdraw up to 75% of their Life benefit to a maximum of $500,000 (when Basic Life and any Additional Life are combined).
- An Accelerated Benefit is not available for dependents.
- Life insurance for dependents continues automatically, without premium payment, for five months after the death of the insured member.
- During a Family Status Change, members who are currently enrolled, as well as those eligible but not currently enrolled, may increase their benefit amount, as well as their spouse's and child's benefit amounts (if included in the proposal), up to the guarantee issue amount without providing evidence of insurability. Evidence of insurability is required for those whose evidence of insurability was not approved by us during any prior period of eligibility.
- Dependents coverage includes child(ren) from live birth through age 25.

Employee and Spouse

Rate: Per $1,000	Lives	Age	Rate
	TBD	0-29	.060
		30-34	.067
		35-39	.104
		40-44	.155
		45-49	.250
		50-54	.405
		55-59	.647
		60-64	.955
		65-69	1.511
		70-74	2.641
		75-999	4.937

Child

Life	
Rate: Per $1,000	.233
AD&D	
Rate: Per $1,000	.020
Rate Guarantee	3 years

Conditions

- Additional Life can only be purchased in conjunction with Basic Life.
- Member's Basic Life benefits plus Additional Life benefits may not exceed 8 times annual earnings.
- Until coverage has been in force for two years (one year in Colorado, Missouri and North Dakota), death that results from suicide or other intentionally self-inflicted injury is not covered. This exclusion does not apply to plans written in Washington.
- Except as provided in the Additional Plan Design Details, we require evidence of insurability for:
  - Increases in elected benefit amounts from the current plan to this plan.
  - Members who are eligible under the current plan but are not enrolled.
  - Spouses who are eligible under the current plan but are not enrolled.
  - Children who are eligible under the current plan but are not enrolled.
  - Individuals who enroll more than 31 days after they are first eligible for coverage.
  - Increases in elected benefit amounts after initial enrollment.
- Member must be enrolled in Additional Life to enroll in the Spouse Life plan.
- Member must be enrolled in Additional Life to enroll in the Child Life plan.
- Dependents must be insured under Dependents Life in order to be eligible for AD&D.
- The elected benefit amount for Child AD&D must match the benefit amount for Child Life
- Member must be insured under Additional Life in order to be eligible for Additional AD&D
- The elected benefit amount for Spouse AD&D must match the benefit amount for Spouse Life
- The elected benefit amount for Additional AD&D must match the benefit amount for Additional Life
- Spouse Life can't exceed 50% of member's enrolled benefit for Additional Life.
- Child Life can't exceed 100% of member's enrolled benefit for Additional Life.

	Plan 1: Balanced Care Vision I	
	VSP Choice Network + Affiliates	**Out of Network**
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Frame Allowance	$120**	Up to $70
Frequencies		
Exam/Lens/Frames	12/12/24 Based on date of service	12/12/24 Based on date of service

***The Costco and Walmart allowance will be the wholesale equivalent.*

Deductible, Maximum

Deductibles		
	$10 Exam $25 Eye Glass Lenses or Frames*	$10 Exam $25 Eye Glass Lenses or Frames
Maximum		
per benefit period	None	None

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

Contact Lenses

Fit & Follow Up Exams	Participant cost up to $60	No benefit
Contacts		
Elective	Up to $120	Up to $105
Medically Necessary	Covered in full	Up to $210

Monthly Rates

Member	$6.58
Member + Spouse	$13.16
Member + Children	$14.08
Member + Spouse & Children	$22.50

Rates are guaranteed for 24 months following the effective date listed above. This quote also assumes enrollment in our electronic ID Card delivery (eCard) program.
This benefit and cost summary expires on 1/1/2021 unless replaced, withdrawn or amended by The Standard.

Any member residing in Colorado may not be solicited until The Standard completes the required state filing and approval is received.

Lens Options (participant cost)*

	Plan 1: Balanced Care Vision I	
	VSP Choice Network + Affiliates (Other than Costco)	**Out of Network**
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

*Lens Option participant costs vary by prescription, option chosen and retail locations.

Additional Balanced Care Vision I Choice Network Features (In Network)

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Lens Options (Participant Cost)*	$15 - Solid Plastic Dye (Except Pink I & II) $17 - Plastic Gradient Dye $31-$82 - Photochromatic Lenses (Glass & Plastic) Lens Option member cost vary by prescription and option chosen.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare℠	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.