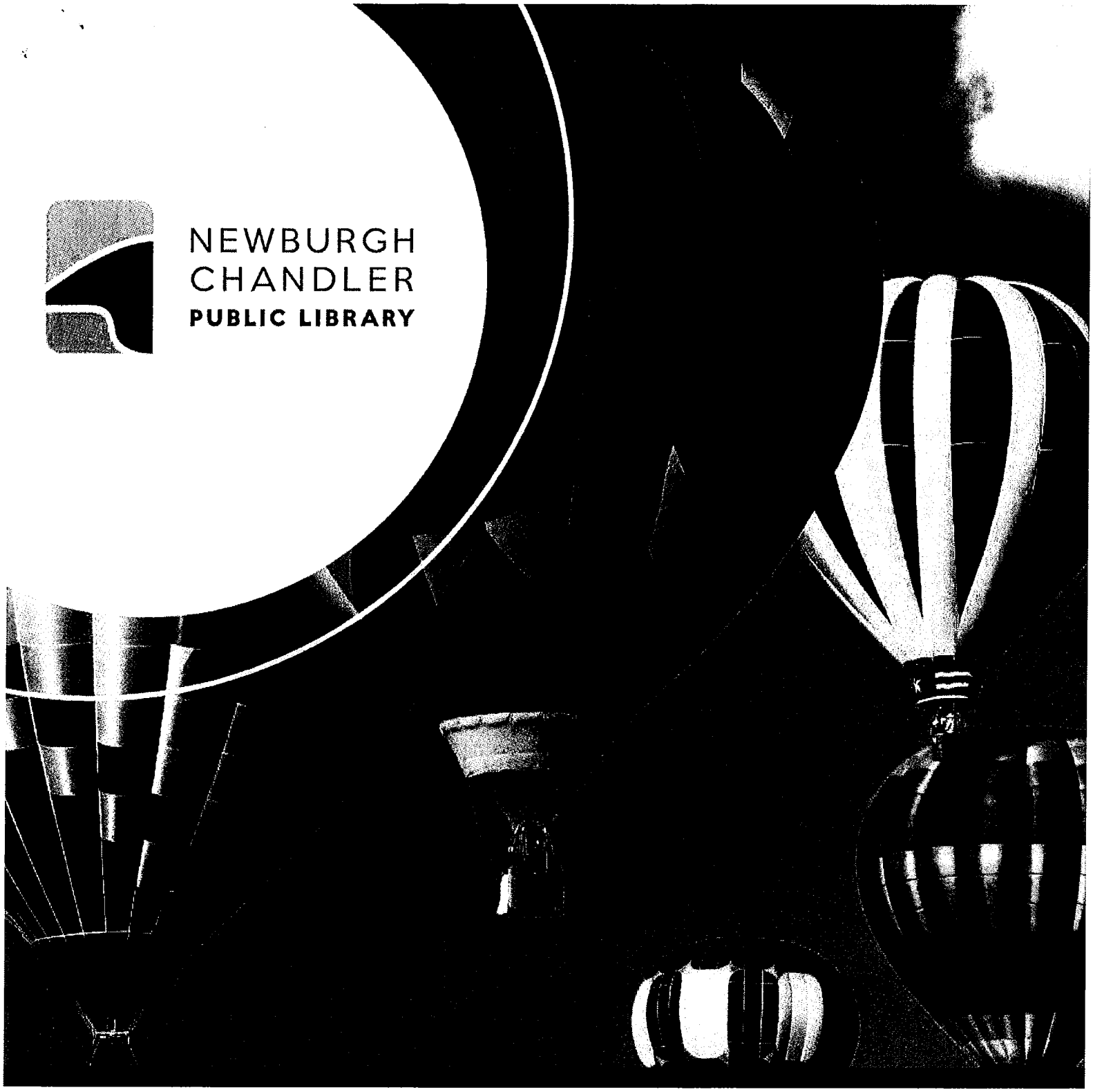
NEWBURGH
CHANDLER
PUBLIC LIBRARY



HELPING YOU UNDERSTAND
Your Benefit Choices

CONTENTS

This is a high-level benefits guide of certain benefits **Newburgh Chandler Public Library** offers. The information in this booklet is intended as a general outline of the benefits offered under **Newburgh Chandler Public Library** benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact the Business Office.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

WELCOME

BENEFITS MENU | ENROLLMENT

BENEFITS OFFERED

MY HEALTH

Medical **Deaconess One Care**
Dental | **Paramount Dental**
Vision | **Met Life**
Life/AD&D | **Mutual of Omaha**
EAP | **Mutual of Omaha**

Open Enrollment Dates

September 13, 2022- September 22, 2022

ENROLLMENT INSTRUCTIONS

1. Review the information in this guide and benefit plan summaries.
2. You must complete select your benefits through the Ease website, even if you are waiving coverage.
    - You should receive instructions to create your Ease account via your work email address.
3. You will not be allowed to make changes after the open enrollment window closes, unless you experience a qualifying life event.

IMPORTANT

You must notify the Business Office and change elections within 30 days of the event.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

EASE

ENROLLMENT INSTRUCTIONS

ease

Enrollment Guide at a Glance

1. Log in to Ease per the instructions you have received from your HR administrator or Broker. For optimal performance it is recommended that you use Chrome or Firefox as your browser.

2. Click Start Enrollment to begin your enrollment.

3. Follow the prompts on each page to complete your benefit enrollment. Click Continue to proceed to the next section.

4. Verify your personal information is correct and enter in any of your dependent information.

5. If requested during the enrollment process, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6. Please Select ✓ ✗ your benefit by selecting Enrolled ✓ ✗ or Waived ✓ ✗ for each plan.

   Click Continue to proceed to the next benefit.

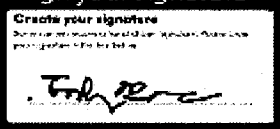
7. You will then be prompted to provide any missing data. Once you have done this, you will be able to review and sign your forms using your mouse or mobile device. Sign Forms

8. Before you review your forms

type your name.

THEN

Sign your signature



and follow the prompts to finish.

9. If you have questions, reach out to your HR administrator or Broker.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective the 1st of the month following 30 days from your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse, domestic partner, party to a civil union** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner/party to a civil union; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Medical, Dental, Vision	The **last day of the calendar year** the child turns **age 26.**

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify **the Business Office** and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to the Business Office within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

PPO

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

HDHP

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

In Network Benefits

Include the lowest deductible, out of pocket maximum and cost sharing amounts. This includes but is not limited to: Deaconess Health System. Any services rendered by a provider in the Deaconess OneCare network will not result in balance billing.

Out of Network Benefit

Providers who are not contracted with OneCare will fall into this category. Benefits will be subject to the highest deductible, out of pocket maximum, and cost sharing.

(Out-of-Area Emergent true emergency) urgent care services will be covered as in-network. If services are provided by a PHCS (MultiPlan) participating provider, members will not be subject to balance billing. All other services provided by non-contracted providers maybe subject to balance billing.

Did You Know?

- ✓ **Preventive Services** are **covered at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (http://deaconessonecare.com) under "Find a Doctor or Hospital". Select "Search as Guest" and search for in-network providers through your employer, choosing the network based on the plan type you are choosing.

MEDICAL
HEALTH | PLAN COMPARISON

Monthly Employee Cost:

PPO Plan 1	
Employee Only	$130.86
Employee & Spouse	$1,003.29
Employee & Child(ren)	$872.42
Employee & Family	$1,744.85

HDHP Plan 2	
Employee Only	$105.22
Employee & Spouse	$806.69
Employee & Child(ren)	$701.47
Employee & Family	$1,402.94

Your Care Options and When to Use Them.

Primary Care Physician (PCP)
- Routine, primary/preventive care
- Non-urgent treatment

Urgent Care Centers vs. Freestanding Emergency Rooms
- Consider an urgent care center as an extension of your PCP, though the cost can be a little more.
- Freestanding emergency rooms should be used for health conditions that require a high level of care.

Deaconess OneCare HEALTH PLAN

BENEFITS	Plan 1	Plan 2
DEDUCTIBLE	PPO	HDHP
	Tier 1/ 2/ 3	Tier 1/ 2/ 3
Single Deductible	$1,500 / $3,000/ $6,000	$5,000 / $6,500/ $13,800
Family Deductible	$3,000 / $6,000/ $12,000	$10,000 / $13,000/ $27,600
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	10%/ 20%/ 50%	10%/ 20%/ 50%
Health Savings Account		
Eligible Plan for HSA		X
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$30 copay	Deductible & Coinsurance
Specialist - Office Visit	$60 copay	Deductible & Coinsurance
Urgent Care Facility	$100 copay	Deductible & Coinsurance
Emergency Room Visit	$500 copay	Deductible & Coinsurance
OUT-OF-POCKET (OOP) MAXIMUM		
Single Maximum	$5,000/ $7,500/ $26,100	$6,500/ $7,500/ $21,150
Family Maximum	$10,000/ $15,000/ $52,200	$13,000/ $15,000/ $42,300

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON

TRADITIONAL DRUGS

TIERS 1 & 2 (GENERIC) | Lowest copays: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 3 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are non-preferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay.

Make sure to check for mail order discounts that may be available.

SPECIALTY DRUGS

TIER 5 | Lowest specialty drug copay: Tier 5 specialty drugs are generally more effective and less expensive than non-preferred specialty drugs in tier 6.

TIER 6 | Highest specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

Rx Retail Copays*	PPO Plan 1
Generic	$15
Brand Name Formulary	$45
Brand Name Non-Formulary	Deductible, $100
Specialty Drugs**	Deductible,30%

Rx Retail Copays*	HDHP Plan 2
Generic	Deductible then, $15
Brand Name Formulary	Deductible then, $45
Brand Name Non-Formulary	Deductible then, $100
Specialty Drugs**	Deductible, 30%

*Specialty Drug Benefit does not apply to orally administered cancer chemotherapy drugs, which are covered at the same level as chemotherapy administered intravenously or by injection

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90 day supply, rather than the 30 day retail supply. Typically, you will pay less if you choose to get a mail order 90 day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being www.GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times there are generic or different manufacturers that will save you money at the pharmacy.

DENTAL
COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

dental health OPTIONS by Health Resources, Inc.

PPO Network

PLAN FEATURES	
Network Details	PPO Dentists **Paramount Dental**
Benefit Period	**Calendar Year**
DEDUCTIBLE	
Single	**$0** In-network
Family	**$0** In-network
When does it apply?	n/a
COVERED SERVICES	
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments*	**Covered at 100%**
CLASS II: Basic Services *Periodontics (surgical & non-surgical), endodontics (root canals), oral surgery, fillings, prosthetic maintenance & x-rays (full mouth)*	**Covered at 50%**
CLASS III: Major Services *Prosthodontics, crowns, inlays/onlays, dentures, implants & bridges*	**Covered at 50%**
ANNUAL MAXIMUM	
Maximum Benefit *Allowed per Benefit Period*	**$1,000 per covered individual**

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

Monthly Employee Cost	
Employee Only	$29.90
Employee + One	$64.30
Employee + Family	$109.90

How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on www.insuringsmiles.com/FindADentist.

VISION
COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

MetLife

PLAN FEATURES	IN-NETWORK *Choice Network* PROVIDER	OUT-OF-NETWORK PROVIDER
Vision Exam	**$10** copay	Reimbursed up to **$45**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$25** copay	Reimbursed up to **$30**
Bifocals	**Covered**	Reimbursed up to **$50**
Trifocals	**Covered**	Reimbursed up to **$65**
Frames	**$150** retail allowance	Reimbursed up to **$70**
COVERED SERVICES		
Contact Lenses	Amount over **$150**	Up to **$105**
Contact Lens Evaluation Fitting	**Up to $60 copay**	Included in Exam Reimbursement
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months

Need to locate a participating In-Network provider?

Visit www.vsp.com/eye-doctor

Search by location, office or doctor name.

Monthly Employee Cost	
Employee Only	$8.25
Employee & Spouse	$19.70
Employee & Child(ren)	$17.83
Employee & Family	$34.75

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

Mutual of Omaha

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	Flat **$10,000** Benefit
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit
Benefit Reduction Schedule	Your insurance will reduce to: – 65% of the original amount at age 65 – 50% of the original amount at age 70

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

EMPLOYEE ASSISTANCE PROGRAMS

AVAILABLE SERVICES

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

Mutual of Omaha

EAP CONTINUED

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney • 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

IMPORTANT CONTACT INFORMATION

Plan	Provider	Contact Information
Medical	Deaconess OneCare HEALTH PLAN	(812) 378-7103
Dental	dental health OPTIONS by Health Resources, Inc.	(800) 727 -1444
Vision	MetLife	1 (800) 428-4833
Basic Life	Mutual of Omaha	(402) 342-7600
EAP	Mutual of Omaha	1 (800) 316-2796

Have Questions?

Please see the chart above for provider customer service phone numbers and website addresses.

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive a request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.