Mission ...
Western Wisconsin WDB is a collaborative, interactive and coordinated network of training resources and support services that is providing and retaining a well-skilled labor force for employers in western Wisconsin.

Vision ...
To provide a comprehensive and integrated and customer-driven and results-oriented system for workforce development that responds to the needs of the employers, job seekers, incumbent workers and youth.

Western Wisconsin Workforce Development Board, Inc.

Western Wisconsin WDB Executive Committee

Thursday, August 4, 2022
2 to 4 p.m.

Zoom
https://us02web.zoom.us/j/88551873199?pwd=T3BlYlc5Tkov-V2NxdmVOaHZBTTNOUT09

Meeting ID: 885 5187 3199
Password: 982531

Upcoming Meetings

Committee Members

- ☐ Mark Glendenning, Interim Co-Chair, *Inland*
- ☐ Tammy Brown, Interim Co-Chair/Past Chair, *Logistics Health, Inc.*
- ☐ Pat Rodriguez, Interim Vice Chair, *North Central States Regional Council of Carpenters*
- ☐ Pete Eide, Secretary/Treasurer, *Bethel Home and Services, Inc.*
- ☐ Jodi Roesler, *Dairyland Power*
- ☐ Vicki Proudlock, *UI*

A proud partner of the AmericanJobCenter network

This product was created using funding from a grant from the Western Wisconsin Workforce Development Board, Inc., Wisconsin Department of Workforce Development and United States Department of Labor. Equal Opportunity Employer/Program. If you have a disability and need access to this information in an alternative format or translated to another language please contact Melisa Myers by phone (608-789-5499), email (myersm@westernwdb.org), or dial 711 for the Wisconsin Relay service.

Western Wisconsin WDB Executive Committee Agenda
Meeting Agenda
Thursday, August 4, 2022
2 to 4 p.m.

Western Wisconsin Workforce Development Board, Inc.

Agenda Item	Action	Page(s)

I. CONSENT ITEMS
- A. Call to Order
- B. Announcements and Introductions

II. ORDER OF BUSINESS
- A. Benefits/Fringe detail discussion

III. CLOSED SESSION

Pursuant to Wisconsin Statue §19.85(1)(c), the Western Wisconsin Workforce Development Board shall enter into a closed session to consider personnel matters, including compensation and performance.

Motion needed to enter into closed session and a roll call for presence during closed session.

- A. Employee yearly review and compensation

IV. OPEN SESSION

Motion needed to enter into open session and a roll call for presence in open session.

V. CONCLUSION
- A. Unfinished Business
- B. New Business

VI. ADJOURN

Explanation of Benefits

These benefits and procedures are subject to change at the sole discretion of the Western Wisconsin WDB.

An employee's participation in each of these coverages is optional.

Health

The Western Wisconsin WDB pays 80% of employee health insurance monthly premium. Employees are responsible for the remaining 20%. Employee premium portions are deducted pre-tax from each payroll. Employees are eligible for health insurance the first of the month following the date of hire.

Medicare is suggested for employees who reach the age of 65. The Western Wisconsin WDB will reimburse the employee 80% per month toward supplemental Medicare payments.

Should the insurance carrier not medically underwrite an employee, Western Wisconsin WDB will reimburse the employee a portion of the cost to obtain coverage elsewhere. The employee must provide documentation of the cost of the alternate coverage. The reimbursement will equal the amount the organization would pay if the employee were covered under the organization's health insurance plan.

Dental

Western Wisconsin WDB pays 80% of the employee dental insurance monthly premium. Employees are responsible for the remaining 20%. Employee premium portions are deducted pre-tax from each payroll. Employees are eligible for dental insurance the first of the month following 60 from the date of hire.

Life

Western Wisconsin WDB pays 100% of Group Life Insurance premiums up to $50,000. Employee's coverage is two times an employee's gross annual salary or wages updated annually, rounded up to the nearest thousand dollar. Employees are eligible for life insurance coverage the first of the month following 60 days from the date of hire.

Short- and Long-Term Disability

Western Wisconsin WDB provides short- and long-term disability programs to employees. Employees are eligible for short-term and long-term disability benefits the first of the month following 90 days from the date of hire.

Disability leave will be provided with a signed physician's statement attesting to the work disabling condition specifying nature of the disability and work prohibitions including duration of those work prohibitions. Employees may be requested, at Western Wisconsin WDB's expense, to obtain a second opinion at the discretion of the Western Wisconsin WDB Executive Director or Western Wisconsin WDB Chair..

Short-term and long-term disability benefits are fully reinstated upon employee's return to work for six consecutive months; meaning the employee has been in continuous work status for six months and has not been receiving disability leave or worker's compensation benefits.

Short-Term Disability (12 week maximum)

- Qualifying Period — 40 working hours (1 week)
- Maximum Benefit Duration — 85 days (11 weeks)
- Benefit
    - ⇨ Weeks 2 through 6 — 100% of earnings (5 weeks)
    - ⇨ Weeks 7 through 9 — 80% of earnings (3 weeks)
    - ⇨ Weeks 10 through 12 — 60% of earnings (3 weeks)

All other forms of paid leave are suspended while an employee is on short-term disability leave. All other Western Wisconsin WDB benefits, including pension and insurance, remain in effect while an employee is on short-term disability.

Long-Term Disability

- Elimination period = 90 days
- Benefit until age 67
- Monthly benefit = 60% of monthly earnings to a maximum of $3,000 per month

Pension

Western Wisconsin WDB contributes 5% of each employee's gross salary or wages to a Simplified Employee Pension - Individual Retirement Account (SEP-IRA) Employees must have completed six months of continuous employment and be at least 21 years of age to receive the benefit.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
This health plan is offered by Quartz Health Benefit Plans Corporation

Quartz

9083062 - QUARTZ ONE PLATINUM P503 HMO-SA6

Coverage Period: 8/1/2022 - 7/31/2023
Coverage for: Single/Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.QuartzBenefits.com/certlookup**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary** or call 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Single: **$1,000** per Benefit Year Family: **$1,000**/individual or **$2,000**/family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Single: **$1,500** per Benefit Year Family: **$1,500**/individual or **$3,000**/family per Benefit Year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.QuartzBenefits.com/FindADoctor or call 1-800-362-3310 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	In-Network providers: No. Out-of-Network providers: Yes, written referral is required.	In-Network: You can see the specialist you choose without a referral. Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	Not covered	Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Specialist visit	$40 copay/visit; deductible does not apply	Not covered	A covered Telehealth visit applies the same cost-sharing as an in-person visit. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Other practitioner office visit	Chiro/Adult Vision: $25 copay/visit; deductible does not apply	Not covered	One routine adult vision exam is covered with no charge. Cost sharing applies to subsequent exams. Benefits are not available for care that is Maintenance and Supportive Care. Glasses/contacts for Adult Routine Vision are not covered. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	Coverage is limited to preventive services as defined by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.QuartzBenefits.com/formulary	Preferred Generics | Tier 1	Value Tier: $5 copay/prescription All others: $10 copay/prescription	Not covered	Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply. Coverage restrictions may apply to some medications. See the Quartz Formulary for details
	Preferred Brands | Tier 2	Value Tier: $5 copay/prescription All others: $40 copay/prescription	Not covered	
	Non-Preferred Brands & Generics | Tier 3	50% coinsurance	Not covered	
	Tier 4	50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Oral Surgery: 10% coinsurance Coverage is limited to procedures listed in your Certificate of Coverage
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Emergency room copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	$40 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	Deductible and/or coinsurance may apply for additional services performed at your visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information.
	Physician/surgeon fees	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Inpatient services	10% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information.
If you are pregnant	Office visits	PCP: $25 copay/visit Specialist: $40 copay/visit; deductible does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for inpatient services. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information.
	Rehabilitation services	10% coinsurance	Not covered	Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy and Pulmonary Rehab per Benefit Year. Cardiac Rehab is limited to 36 visits per event. A covered Telehealth visit applies the same cost-sharing as an in-person visit.
	Habilitation services	10% coinsurance	Not covered	Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy per Benefit Year. Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. A covered Telehealth visit applies the same cost-sharing as an in-person visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Skilled nursing care	10% coinsurance	Not covered	Coverage limited to 30 days per confinement. This benefit is combined with the Swing Bed Care benefit. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information.
	Durable medical equipment	10% coinsurance	Not covered	Purchase of DME with a per unit cost of $500 or more (except for hearing aids) and all DME rentals must be Prior Authorized. Coverage for -- Foot Orthotics: Limited to one pair per Benefit Year. Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto www.QuartzBenefits.com/hearingaids or contact Customer Service.
	Hospice services	10% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	One routine vision exam is covered with no charge. Cost sharing for an office visit applies to subsequent exams.
	Children's glasses	10% coinsurance	Not covered	Limited to one pair of glasses per Benefit Year.
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (Limited)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa, or visit www.HealthCare.gov or call 1-800-318-2596. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health plan the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$40**
■ Hospital (facility) coinsurance	**10%**
■ Other coinsurance	**10%**
This EXAMPLE event includes services like: Specialist office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work*) Specialist visit (*anesthesia*)	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$50
Coinsurance	$450
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,500**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$40**
■ Hospital (facility) coinsurance	**10%**
■ Other coinsurance	**10%**
This EXAMPLE event includes services like: Primary care physician office visits (*including disease education*) Diagnostic tests (*blood work*) Prescription drugs Durable medical equipment (*glucose meter*)	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$40**
■ Hospital (facility) coinsurance	**10%**
■ Other coinsurance	**10%**
This EXAMPLE event includes services like: Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*)	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Quartz

WESTERN WISCONSIN WORKFORCE DEVELOPMENT BOARD

HMO Small Group Rate Summary

Effective Date: 8/1/2022

Company County: La Crosse - WI (Rating Area 6)

Age at Member Effective Date	P501: Quartz One Platinum HMO-SA6	P502: Quartz One Platinum HMO-SA6	P503: Quartz One Platinum HMO-SA6	P504: Quartz One Platinum Maintenance HMO-SA6
0 - 14	$ 365.37	$ 360.46	$ 355.85	$ 344.30
15	$ 397.84	$ 392.51	$ 387.48	$ 374.91
16	$ 410.26	$ 404.76	$ 399.57	$ 386.61
17	$ 422.68	$ 417.01	$ 411.67	$ 398.31
18	$ 436.05	$ 430.20	$ 424.69	$ 410.91
19	$ 449.42	$ 443.39	$ 437.71	$ 423.51
20	$ 463.27	$ 457.06	$ 451.20	$ 436.57
21	$ 477.61	$ 471.20	$ 465.16	$ 450.07
22	$ 477.61	$ 471.20	$ 465.16	$ 450.07
23	$ 477.61	$ 471.20	$ 465.16	$ 450.07
24	$ 477.61	$ 471.20	$ 465.16	$ 450.07
25	$ 479.51	$ 473.08	$ 467.02	$ 451.87
26	$ 489.06	$ 482.50	$ 476.32	$ 460.87
27	$ 500.53	$ 493.81	$ 487.49	$ 471.67
28	$ 519.15	$ 512.19	$ 505.63	$ 489.22
29	$ 534.44	$ 527.27	$ 520.51	$ 503.63
30	$ 542.08	$ 534.81	$ 527.96	$ 510.83
31	$ 553.54	$ 546.12	$ 539.12	$ 521.63
32	$ 565.00	$ 557.42	$ 550.28	$ 532.43
33	$ 572.17	$ 564.49	$ 557.26	$ 539.18
34	$ 579.81	$ 572.03	$ 564.70	$ 546.38
35	$ 583.63	$ 575.80	$ 568.42	$ 549.98
36	$ 587.45	$ 579.57	$ 572.15	$ 553.58
37	$ 591.27	$ 583.34	$ 575.87	$ 557.18
38	$ 595.09	$ 587.11	$ 579.59	$ 560.79
39	$ 602.73	$ 594.65	$ 587.03	$ 567.99
40	$ 610.38	$ 602.19	$ 594.47	$ 575.19
41	$ 621.84	$ 613.50	$ 605.64	$ 585.99
42	$ 632.82	$ 624.33	$ 616.34	$ 596.34
43	$ 648.11	$ 639.41	$ 631.22	$ 610.74
44	$ 667.21	$ 658.26	$ 649.83	$ 628.75
45	$ 689.66	$ 680.41	$ 671.69	$ 649.90
46	$ 716.40	$ 706.79	$ 697.74	$ 675.10
47	$ 746.49	$ 736.48	$ 727.04	$ 703.46
48	$ 780.88	$ 770.40	$ 760.53	$ 735.86
49	$ 814.79	$ 803.86	$ 793.56	$ 767.82
50	$ 853.00	$ 841.55	$ 830.77	$ 803.82
51	$ 890.73	$ 878.78	$ 867.52	$ 839.38
52	$ 932.28	$ 919.77	$ 907.99	$ 878.53
53	$ 974.31	$ 961.24	$ 948.92	$ 918.14
54	$ 1,019.68	$ 1,006.00	$ 993.11	$ 960.90
55	$ 1,065.05	$ 1,050.77	$ 1,037.30	$ 1,003.65
56	$ 1,114.25	$ 1,099.30	$ 1,085.22	$ 1,050.01
57	$ 1,163.92	$ 1,148.30	$ 1,133.59	$ 1,096.82
58	$ 1,216.93	$ 1,200.61	$ 1,185.22	$ 1,146.77
59	$ 1,243.20	$ 1,226.52	$ 1,210.81	$ 1,171.53
60	$ 1,296.21	$ 1,278.82	$ 1,262.44	$ 1,221.49
61	$ 1,342.06	$ 1,324.06	$ 1,307.10	$ 1,264.69
62	$ 1,372.15	$ 1,353.74	$ 1,336.40	$ 1,293.05
63	$ 1,409.88	$ 1,390.97	$ 1,373.15	$ 1,328.60
64 and over	$ 1,432.81	$ 1,413.59	$ 1,395.48	$ 1,350.21

DELTA DENTAL PPO
SUMMARY OF BENEFITS
FOR COVERED EMPLOYEES OF:

Western WI Workforce Development Board, Inc.

(See Dental Benefit Handbook for definitions of capitalized terms.)

GROUP NUMBER: 22804 - 00118

EFFECTIVE DATE OF PROGRAM: August 1, 2022

OPEN ENROLLMENT

Changes in enrollment status will be considered during an Open Enrollment Period 30 days prior to the Contract renewal date, with changes becoming effective on the renewal date.

WAITING PERIOD

Employees and their Dependents who apply for coverage after their initial eligibility period or without a qualifying event (loss of spousal benefits, marriage, divorce, birth or adoption or the loss of employee coverage through another insurer) will:

Wait until the next Open Enrollment Period.

TERMS OF ELIGIBILITY

Eligibility begins:
For eligible new employees, eligibility begins the first day of the month following the waiting period.

For eligible new employees, the waiting period is 60 days.

For employees enrolling their Dependents:
Dependent children are eligible to the date on which they attain age 26, regardless of student status, or if age 26 and beyond, to the date they lose eligibility due to the Dependent's inability to meet all of the requirements contained in the Handbook.

Part-time employees are not covered; minimum hours worked must average at least 40 per week.

DEDUCTIBLE LIMITATIONS

Delta Dental shall not be obligated to pay any Deductible specified below.

The Deductible for Dental Procedures provided by Delta Dental PPO Providers is $25 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $75 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

The Deductible for Dental Procedures provided by Delta Dental Premier Providers is $50 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $150 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

The Deductible for Dental Procedures provided by Noncontracted Providers is $50 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $150 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

MAXIMUM BENEFIT

The maximum total Benefit payable in any Benefit Accumulation Period is limited to the amount specified below.

The maximum total Benefit per Subscriber and per Covered Dependent, per Benefit Accumulation Period for Dental Procedures provided by Delta Dental PPO Providers is $1,000, or $1,000 for Dental Procedures provided by Delta Dental Premier Providers, or $1,000 for Dental Procedures provided by Noncontracted Providers. In no case will the maximum total Benefit exceed $1,000 regardless of the network chosen.

Benefit payments provided for evaluations, x-rays, prophylaxis, fluoride, space maintainers and sealants do not apply to the Maximum Benefit.

ORTHODONTIC MAXIMUM BENEFIT

Delta Dental's obligation for orthodontic Benefits is limited to the maximum specified below.

This plan does not provide an orthodontic Benefit.

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE:

This Contract provides the following Benefits subject to the Coverage percentage listed for each Benefit and subject to any applicable Deductible. The Coverage and Coinsurance percentages may vary based upon the network membership of the treating Provider at the time the Dental Procedure is completed. The application of the Deductible, if any, also may vary based upon the network membership of the treating Provider at the time the Dental Procedure is completed.

For example, if the Coverage percentage shown is "80," that Benefit is 80% of the Maximum Plan Allowance, after satisfaction of any applicable Deductible. In the same example, the Coinsurance (the amount the patient must pay) would be the remaining 20%.

If the Coverage percentage shown is "0", that Benefit is not provided in the Group Contract.

The Benefit Accumulation Period begins on January 1, 2022, ends on December 31, 2022 and thereafter shall be the 12 month period beginning on January 1st.

PPO = Delta Dental PPO Provider Premier = Delta Dental Premier Provider NC = Noncontracted Provider

Does Deductible Apply? Yes/No			**Coverage Percentage**			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
N	Y	Y	100	80	80	Evaluations two times per Benefit Accumulation Period.
N	Y	Y	100	80	80	Full mouth series x-rays at sixty month intervals; either individual images, or panoramic image, including bitewings.
N	Y	Y	100	80	80	Bitewing x-rays one time per Benefit Accumulation Period (limited to a set of four images).
						Prophylaxis (teeth cleaning) or periodontal maintenance procedure two times per Benefit Accumulation Period.
N	Y	Y	100	80	80	Prophylaxis.
Y	Y	Y	50	40	40	Periodontal maintenance procedure.
N	Y	Y	100	80	80	Topical fluoride applications two times per Benefit Accumulation Period for Covered Dependent children up to age 19.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
N	Y	Y	100	80	80	Space maintainers for retaining space when a posterior primary tooth is prematurely lost.
Y	Y	Y	80	70	70	Emergency treatment to relieve pain.
N	Y	Y	100	80	80	Topical application of sealants for Covered Dependents up to age 19. Application is limited to the occlusal surface of bicuspids and molars which are free of decay and restorations. Benefits for sealants are limited to one application per tooth per lifetime.
Y	Y	Y	80	70	70	Amalgam (silver) restorations.
Y	Y	Y	80	70	70	Composite (tooth colored) restorations for anterior teeth.
Y	Y	Y	80	70	70	Prefabricated crowns – one per tooth at three year intervals.
Y	Y	Y	50	40	40	Endodontics including root canal treatment.
Y	Y	Y	50	40	40	Surgical endodontic treatment.
Y	Y	Y	50	40	40	Non-surgical periodontics, including procedures necessary for the treatment of diseases of the gums and bone supporting the teeth. Benefit is limited to once per quadrant at 24 month intervals.
Y	Y	Y	50	40	40	Surgical periodontic treatment; benefit is limited to once per quadrant at 36 month intervals.
Y	Y	Y	50	40	40	Non-surgical extractions.
Y	Y	Y	50	40	40	Oral surgery (cutting procedures) and surgical extractions including pre-operative and post-operative care.
Y	Y	Y	50	40	40	Crowns, inlays, or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns are Benefits on the six front teeth, bicuspids, and upper first molars.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
Y	Y	Y	50	40	40	Prosthetics, including fixed bridgework, implants, partial dentures, and complete dentures to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing prosthetic will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns or pontics are Benefits on the six front teeth, bicuspids, and upper first molars. Fixed bridges, implants, partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed bridge or implant and implant related procedures may be a Benefit if no more than two teeth are missing in the dental arch in which the bridge or implant is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch. Coverage for initial replacement of teeth is not limited to those lost while a Subscriber or Covered Dependent.
Y	Y	Y	50	40	40	Repairs and adjustments to prosthetic appliances. Denture reline or rebase is a Benefit at three year intervals.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
N	N	N	0	0	0	Orthodontic appliances, treatment and related services for orthodontic purposes including evaluation, x-rays, extractions, photographs, and study models, subject to the orthodontic maximum benefit. Repair or replacement of orthodontic appliances are not covered. Delta Dental calculates all orthodontic treatment schedules according to the following formula: - 25% of the total Maximum Plan Allowance (subject to the Coverage Percentage stated herein and any applicable Deductible) is considered the initial payment to be paid by Delta Dental, subject to the Coverage Percentage, any applicable Deductible and the orthodontic maximum Benefit stated herein. - The remainder of the Maximum Plan Allowance is divided by the months of treatment and the resulting amount is paid monthly by Delta Dental, subject to the Coverage Percentage, any applicable Deductible and the orthodontic maximum Benefit stated herein. If orthodontic treatment is stopped for any reason before it is complete, Delta Dental will suspend all monthly payments. Coverage includes orthodontic treatment in progress. Treatment is in progress if an appliance or banding has been placed and the patient is receiving treatment by the attending orthodontist according to a current treatment plan. Liability for orthodontic treatment in progress shall extend only to the unearned portion of the treatment in progress (that portion occurring after enrollment) and Delta Dental shall be the sole determinant of this unearned amount eligible for coverage. However, there are no Benefits available for Dental Procedures, including orthodontic treatment in progress, after coverage terminates.

OPTIONAL PROCEDURES

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive Dental Procedure that is adequate to restore the tooth or dental arch to contour and function, but only if the more expensive Dental Procedure is a Benefit of this Contract. The Subscriber or Covered Dependent will be responsible for either the remainder of the Provider's fee if a more expensive covered Dental Procedure is selected or the entire fee if the more expensive Dental Procedure is not a Benefit. The Coinsurance and Deductible will apply regardless of which Dental Procedure is selected.

AMENDMENT
TO
SUMMARY OF BENEFITS
FOR

Western WI Workforce Development Board, Inc.
22804 00118

This Amendment modifies the group dental Benefits afforded by the Policy with Delta Dental of Wisconsin, Inc., and must be read in conjunction with the Handbook and Summary of Benefits. All terms and conditions of the Policy remain in effect, except as modified by this Amendment. Please read this Amendment carefully.

Please be advised that on August 1, 2022, the following Evidence-Based Integrated Care Plan ("EBICP") Benefits are provided under your Policy. To participate in EBICP, eligible dental Policy enrollees or their Providers are required to set the appropriate health condition indicator online at deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin. This Amendment supersedes any previous amendment provided to you regarding EBICP.

The EBICP Benefits are as follows:

Periodontal Disease

1. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

Diabetes

1. With an indicator of a **Diabetes** diagnosis, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

Pregnancy

1. With an indicator of **Pregnancy**, a participant is eligible for one additional dental visit for adult prophylaxis or periodontal maintenance during the pregnancy.

High Risk Cardiac Conditions

1. With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:

    - History of infective endocarditis
    - Certain congenital heart defects (such as having one ventricle instead of the normal two)
    - Individuals with artificial heart valves
    - Heart valve defects caused by acquired conditions like rheumatic heart disease
    - Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
    - Individuals with pulmonary shunts or conduits
    - Mitral valve prolapse with regurgitation (blood leakage)

Suppressed Immune System Conditions

1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

Kidney Failure or Dialysis Conditions

1. With an indicator for **Kidney Failure or Dialysis Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

Cancer Related Chemotherapy and/or Radiation

1. With an indicator for **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

THIS AMENDMENT IS PART OF THE SUMMARY OF BENEFITS AND HANDBOOK REFERENCED HEREIN AND SHOULD BE KEPT WITH THOSE DOCUMENTS.

EBICPIIAmend 04.2016

Delta Dental of Wisconsin
www.deltadentalwi.com

Jessie Foss
Western Wi Workforce Dev Board
2615 East Ave South Ste 101
La Crosse WI 54601-0000

Thank you for choosing Delta Dental of Wisconsin as your dental benefits company. A summary of your benefit plan renewal is below.

The new premium will automatically go into effect on the renewal date listed below. However, if you would like to explore plan design or premium options, or if we can be of further assistance, please contact your agent Steven Fleis or call us at 800-236-3713 or email sales@deltadentalwi.com.

Group Number: 22804-118 Renewal Date: August 1, 2022

Current Plan Design	**PPO**	**Premier or Non-Network**
Deductible – Individual/Family	$25 $75	$50 $150
Individual Annual Maximum	$1,000	$1,000
Diagnostic & Preventive	100%	80% *
Basic Restorative	80% *	70% *
Major Restorative	50% *	40% *
Orthodontic Services	0%	0%
Lifetime Orthodontic Maximum		

=Deductible Applies (wp)=Waiting Period may apply – please reference your group contract

		Monthly Premium	
Coverage Type	**Enrollment**	**Current**	**Renewal**
Employee		$42.06	$42.06
Family	2	$111.45	$111.45
Totals	**2**	**$222.90**	**$222.90**

Thank you for allowing Delta Dental to serve your dental benefits needs.

Joe Kottke
Account Representative

cc: FLEIS INSURANCE AGENCY INC
Steven Fleis
PO Box 537
Onalaska WI 54650-2701

POLICY ENDORSEMENT NO. 22804 - 118 - 05032022

Attached to and forming a part of the Contract to Provide Dental Care Benefits between Western Wi Workforce Dev Board and Delta Dental of Wisconsin, Inc.

It is agreed and understood that Declarations, Section 7, Monthly Premium will be replaced with the following, effective August 1, 2022 and ending on July 31, 2023:

Single Coverage (employee, 1 Party)	$42.06
Family Coverage (employee and spouse, 2 Party)	$111.45
Family Coverage (employee and child(ren))	$111.45
Family Coverage (full family, 3+ Party)	$111.45

DELTA DENTAL®

Employees Need DeltaVision

Add vision insurance to your benefits package today.

Regular eye checkups can assist in the early detection of diabetes and high blood pressure.

25% of school age children may have visions problems, and when undiagnosed, can lead to disadvantages in the classroom.

20% of employee productivity can be lost due to incorrect vision prescriptions. Adding vision insurance to your benefits package can mean improved productivity and less absenteeism.

The answer is clear: DeltaVision

Significant advantages to combining Delta Dental and DeltaVision:

- Discounted vision rates apply when combined with an existing dental plan
- Available on a voluntary or employer contributory basis
- Eligibility only requires a minimum of two enrolled employees
- Joint enrollment and billing
- Combined, local account management

DeltaVision offers participants a comprehensive vision plan with innovative add-ons and online services:

- Freedom to choose from frames, lenses, and contact options
- 71% average member savings versus retail cost at provider locations
- Diabetic eyecare benefit
- Retinal imaging
- Additional discounts even after the benefit is used

Through our partnership with EyeMed Vision Care®, DeltaVision is able to offer:

- The nation's largest vision network
- Top optical retailers and thousands of independent providers, and online providers like Glasses.com and ContactsDirect.com
- Industry-leading customer service
- Online provider directory available 24/7

Connect With Us

www.deltadentalwi.com

SS306-1706

Please contact your Account Representative for purchase or more information.
Additional plan options are available.

DELTA DENTAL®

DeltaVision Plan

Quote Number 00092302
Valid through 09/30/2022

DeltaVision® FULL PLAN	
Network	Insight
Benefit Plan	A
Frame/Contact Allowance	$150/$150
Copay (exams/standard plastic lenses)	$20/$20
Frequency (exams/lenses or contacts/frames); *Based on calendar year*	12/12/12
Dependent Age Limit	To age 26

BENEFIT DETAILS	Network Benefit	Non-Network Reimbursement
Comprehensive Spectacle Exam	Member pays copay, plan pays balance	$35
Retinal Imaging	Member pays up to $39	None
Standard Contact Lens* Fit and Follow-Up	Paid in full	$40
Premium Contact Lens** Fit and Follow-Up	10% off retail price plus $55 allowance	$40
Frames *(any available frame at provider location)*	Plan pays frame allowance, then 20% off balance	50% of the selected in-network allowance
Laser Vision Correction - Lasik or PRK	15% off retail price or 5% off promotional price	None
Diabetic Eye Care Benefits included that provide an additional office visit and diagnostic testing for those who have diabetes.		
Standard Plastic Lenses		
Single Vision	Member pays copay, plan pays balance	$25
Bifocal	Member pays copay, plan pays balance	$40
Trifocal	Member pays copay, plan pays balance	$55
Standard Progressive	Member pays $85	$40
Premium Progressive	See next page for benefit information	$60
Lens Options		
UV Coating	Member Pays $15	None
Tint *(solid & gradient)*	Member Pays $15	None
Standard Scratch Resistance	Member Pays $15	None
Standard Polycarbonate	Member Pays $40	None
Standard Anti-Reflective Coating	Member Pays $45	None
Premium Anti-Reflective Coating	See next page for benefit information	None
Other Add-Ons and Services	20% off Retail Price	None
Contact Lenses - In lieu of spectacles *(Contact lens allowance covers materials only)*		
Conventional	Plan pays contact allowance, then 15% off balance	80% of the selected allowance amount for contacts
Disposable	Plan pays contact allowance	80% of the selected allowance amount for contacts
Medically Necessary***	Paid in full	$200

**Lenses that are spherical power only, soft lens materials, including planned replacement and conventional lenses. Lenses are to be used in a daily wear (removed prior to sleep) mode only.*
***Includes all lens powers and designs other than spherical powers (i.e. toric, multifocal, etc.), modes of wear that are extended or overnight schedules and rigid or gas-permeable materials.*
****Medically necessary contacts require authorization from a vision doctor when some conditions are present. Please contact the plan for more information.*

Please contact your Account Representative for purchase or more information.
Additional plan options are available.

DELTA DENTAL®

DeltaVision Plan

Quote Number 00092302
Valid through 09/30/2022

BENEFIT DETAILS - continued

	Member Cost In-Network	Non-Network Reimbursement
Progressive Lens		
Standard Progressive	$85 copay	$40
Premium Progressive as follows:		
Tier 1	$105 copay	$60
Tier 2	$115 copay	$60
Tier 3	$130 copay	$60
Tier 4	$85 copay, 80% of charge less $120 allowance	$60
Anti-Reflective Coating		
Standard Anti-Reflective Coating	$45	None
Premium Anti-Reflective Coating as follows:		
Tier 1	$57	None
Tier 2	$68	None
Tier 3	80% of charge	None

Please contact your Account Representative for purchase or more information.
Additional plan options are available.

DELTA DENTAL®

DeltaVision Plan

Quote Number 00092302
Valid through 09/30/2022

Additional In-Network Discounts

- 20% discount on items not covered by the plan at network providers. This discount may not be combined with any other discounts or promotional offers. This discount does not apply to an EyeMed® provider's professional services (i.e. exams) or contact lenses. Retail prices may vary by location.
- 40% discount on complete eyeglass purchases after your plan benefits have been fully used (includes prescription sunglasses).
- 15% discount on conventional contact lenses after your plan benefits have been fully used.
- Members can purchase eyeglasses online and apply their in-network eyeglass benefits at www.glasses.com.
- Members can purchase contact lenses online and apply their in-network contact benefits at www.contactsdirect.com.
- Discounts do not apply for benefits provided by other group benefit plans.

How to Maximize Your DeltaVision Plan

- Use providers participating in your vision plan network; your benefit dollars will go farther at participating providers.
- Use your full benefit allowance. Frames and lenses (plastic or contact) each have an annual benefit allowance; the benefit allowance must be used on a single purchase day.
- Frequency of benefits: your benefit frequency is based on a calendar year benefit accumulation period.
- Participating providers may offer promotional pricing on vision materials. You can partake in either the DeltaVision Network Benefit or the promotional price available, but not both. Your provider can help you to determine which is best for you. If you select the promotional pricing you can submit your expenses for Non-Network Reimbursement.
- Prescription sunglasses can be purchased with your benefit allowance for frames and plastic lenses.
- A 20% discount may be available on selected brands of non-prescription sunglasses from participating providers - ask your vision provider.
- Your vision benefits include both a frame allowance and a lens allowance. The lens allowance will cover either eye glass lenses or contact lenses. If you purchase both glasses and contacts, you will be responsible for the cost of either the eye glass lens or the contacts, depending upon which was purchased first. Your provider can assist you on making the best choice to maximize your vision benefit.

Plan Limitations/Exclusions

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Services provided as a result of any worker's compensation law.
- Plano nonprescription lenses and nonprescription sunglasses (except for 20% discount).
- Aniseikonic lenses.
- Services or materials provided by any other group benefit providing vision care.
- Two pairs of glasses in lieu of bifocals.
- Allowances are one-time use benefits; there is no remaining balance if entire allowance is not used after initial purchase.
- Lost or broken materials are not covered.

Please contact your Account Representative for purchase or more information.
Additional plan options are available.

DELTA DENTAL®

DeltaVision Plan

Prepared by
Your Account Representative
Quote Number 00092302
Valid through 09/30/2022

Quote Number 00092302

RATING ASSUMPTIONS	
Employer Contribution (Single/Family)	0-25%/0-25%
Broker Commission	8%

MONTHLY PREMIUMS	Without Delta Dental Plan	With Delta Dental Plan
TWO-TIER		
Employee	$5.96	$5.79
Family	$14.84	$14.42
THREE-TIER		
Employee	$5.96	$5.79
Employee + One Dependent	$11.35	$11.03
Employee + Two or More Dependents	$17.81	$17.30
FOUR-TIER		
Employee	$5.96	$5.79
Employee + Spouse	$11.92	$11.58
Employee + Child(ren)	$12.17	$11.82
Employee + Spouse + Child(ren)	$18.13	$17.61

This is not a complete description of benefits, exclusions, or limitations. This proposal is not a guarantee of coverage.
A group application is required. Rates subject to change based on actual employer contribution, participation, plan selection and approval by Delta Dental of Wisconsin Underwriting. Final rates are guaranteed for 48 months from the effective date of coverage unless otherwise specified.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: July 1, 2014

POLICY NUMBER: 417612 012

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2014: None

For employees entering an eligible group after July 1, 2014: 90 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

Your Employer includes the cost of your Employer-paid coverage in your taxable income.

ELIMINATION PERIOD:

90 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $3,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months

Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Minimum Benefit

Pre-Existing: 12/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: July 1, 2014

POLICY NUMBER: 417612 011

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2014: None

For employees entering an eligible group after July 1, 2014: 60 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

2 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$50,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

Pre-Existing: 12/12/24

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: July 1, 2014

POLICY NUMBER: 417612 011

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2014: None

For employees entering an eligible group after July 1, 2014: 60 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

2 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 70; or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of AD&D insurance.

If you have reached age 75 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of AD&D insurance.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$50,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.