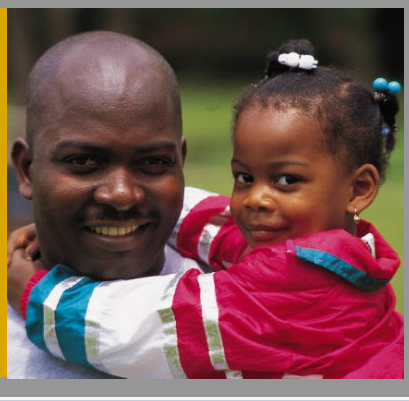
ESLHA

East St. Louis Housing Authority

2016-2017 Benefits Guide



WELCOME TO EAST ST. LOUIS HOUSING AUTHORITY - EMPLOYEE BENEFITS

East St. Louis Housing Authority offers a comprehensive benefit package, which includes Basic Life, Accidental Death & Dismemberment (AD&D), Medical, Voluntary Dental, Vision, Voluntary Short Term Disability and Long Term Disability to all eligible employees.

Two medical plan options are being offered through United Healthcare. In upcoming pages of this benefit guide, we will be referring to them as the Qualified High Deductible Health Plan with a Health Savings Account and the Enriched Plan. Employees are required to make a contribution for single as well as family coverage. You should review these plans carefully as you make your election for the 2016-2017 benefit year. Consider how you use your health benefits to determine which plan is best for you and your family. If you elect to enroll in the Qualified High Deductible Health Plan, you are required to open a Health Savings Account (HSA) because ESLHA will make a per paycheck contribution of $55.98 for employees with single coverage and $120.85 for employees with dependent coverage.

The Standard will remain your carrier for voluntary dental benefits. It is a single plan option which offers a PPO Network, and non-network benefits. If you elect dental coverage for yourself, your spouse, and eligible dependent child(ren), you are responsible for the entire cost.

Vision benefits will continue to be provided by United Healthcare (UHC). UHC offers a network of providers for vision services. If you elect to go outside the network, you will receive a reimbursement to cover some of the vision expenses. You are responsible for submitting a claim to UHC for reimbursement. The vision and medical plans are combined and are provided under one monthly premium

The Basic Life / AD&D, Voluntary Life/AD&D and Long Term Disability coverage will continue to be provided through The Hartford. These benefits are provided at to cost no eligible employees.

Employees are offered voluntary coverage at an additional cost for Supplemental Life/AD&D as well as Short Term Disability coverage through The Hartford. If you are a new employee, you have up to 30 days to elect these voluntary benefits. If you decline coverage you will have to wait until next open enrollment to enroll yourself and/or dependents, complete a medical questionnaire and are subject to approval by The Hartford. You will find more information regarding these benefit offerings later in this benefit guide.

This Benefit Guide includes brief summaries of the ESLHA employee benefit plans. Please review them carefully before making your decision. Questions should be directed to Human Resources. Please pay attention to the enrollment deadline.

UNITED HEALTHCARE - MEDICAL PLAN SUMMARIES

Qualified High Deductible Health Plan with a Health Savings Account - AJJY

Benefit/Service	In Network	Non- Network
Deductible (individual / family)	$1,500 / $3,000	$4,500 / $9,000
Coinsurance	100%	70%
Out-of-Pocket Max. (individual / family)	$6,250 / **$6,850**	$12,500 / $25,000
Office Visit Co-Pay (Primary Care / Specialist)	$35 / $70 After the Deductible	70% After the Deductible
Preventive Care	100% Covered Deductible does not apply	70% After the Deductible
Inpatient Hospital Outpatient Surgery	100% After the Deductible	70% After the Deductible
Lab, X-Ray - Outpatient	100% After the Deductible	70% After the Deductible
Major Diagnostics (CT, PET, MRI, MRA, & Nuclear Medicine)	100% After the Deductible	70% After the Deductible
Emergency Room	$300 Co-Pay After the Deductible	$300 Co-Pay After In Network Ded
Urgent Care	$100 Co-Pay After the Deductible	70% After the Deductible
Prescription Drug *Retail* *Mail Order*	After the Deductible Tier 1 / Tier 2 / Tier 3 $10 / $35 / $60 $25 / $87.50 / $150	After the Deductible Tier 1 / Tier 2 / Tier 3 $10 / $35 / $60 Not Covered

EMPLOYEE BI-WEEKLY CONTRIBUTION (Includes Vision)	
Employee	$73.66
Employee & Family	$329.42

In-Network Plan Highlights

- The Deductible must be satisfied before any benefit is paid by this plan.
- Co-Pays apply towards the out-of-pocket maximum. This includes prescription drug co-pays.
- ESLHA will contribute $1,455.48 for individual and $3,142.10 for family coverage to your Health Savings Account on an annual basis. The contribution is divided and paid on a per pay period basis.
- You are eligible to set up a Health Savings Account if enrolled in this plan.
- You or your spouse cannot participate in a Health Flexible Spending Account if enrolled in the Health Savings Account.
- ***No one in the family is covered 100% until the family deductible has been met.***

Enriched Medical Plan—OX8

Benefit/Service	In Network	Non- Network
Deductible (individual / family)	$500 / $1,000	$1,500 / $3,000
Coinsurance	100%	70%
Out-of-Pocket Max. (individual / family)	$6,250 / $12,500	$12,500 / $25,000
Office Visit Co-Pay (Primary Care / Specialist)	$25 / $70	70% After the Deductible
Preventive Care	100% Covered Deductible does not apply	70% After the Deductible
Inpatient Hospital Outpatient Surgery	100% After the Deductible	70% After the Deductible
Lab, X-Ray - Outpatient	100% Covered Deductible does not apply	70% After the Deductible
Major Diagnostics (CT, PET, MRI, MRA, & Nuclear Medicine)	100% After the Deductible	70% After the Deductible
Emergency Room	$300 Co-Pay	$300 Co-Pay
Urgent Care	$100 Co-Pay	70% After the Deductible
Prescription Drug *Retail* *Mail Order (90-day supply)*	Tier 1 / Tier 2 / Tier 3 $10 / $35 / $60 $25 / $87.50 / $150	Tier 1 / Tier 2 / Tier 3 $10 / $35 / $60 Not Covered

The Qualified High Deductible Health Plan Offers higher deductibles with lower premium. All eligible medical claims are applied to the deductible. Once the deductible is met all in network claims are paid 100% and Co-Pays will apply. You are eligible to open a Health Savings Account with this plan.

The Enriched Plan is offered for those who are looking for higher benefits. This plan has lower deductibles and lower out-of-pocket expenses, however it will cost more in monthly premium than the QHDHP Plan.

EMPLOYEE BI-WEEKLY CONTRIBUTION (Includes Vision)	
Employee	$92.21
Employee & Family	$412.91

No driving. No crowded waiting rooms. See a doctor when you need a doctor.

Virtual Visits

When you work with UnitedHealthcare, you can offer virtual visits to your employees at no additional administrative cost to you. You no longer have to spend time or money assessing, selecting, and implementing an external virtual visit provider. We seamlessly integrate virtual visits into your health plan. The virtual visit provider groups we contract with deliver care using live audio and video technology based on quality standards aligned with American Medical Association (AMA) and Federation of State Medical Boards (FSMB) guidelines.

When employees are sick they often miss work. If they are unable to see their own doctor, they may visit an urgent care or emergency department, which can be costly and time-consuming. With virtual visits, employees can see and speak to a doctor 24 hours a day/7 days a week using a mobile device or computer, all from the convenience of their home or office. If needed, a prescription* can be sent to their local pharmacy. Virtual visits are integrated into their medical benefits.

No administrative costs

Virtual visits are fully integrated with your benefit plan administered by UnitedHealthcare and provided at no additional administrative cost to employers. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefit plan.

What sets UnitedHealthcare's option apart from others?

- Member choice and price transparency
- Contracted virtual visit provider groups are aligned with AMA and FSMB guidelines
- Seamless member experience

*Prescription services may not be available in all states. Go to **myuhc.com** for more information about availability of prescription services.

UnitedHealthcare®

Integrating virtual visits with medical benefits

Virtual visits are covered under member health plans administered by UnitedHealthcare with some member cost share. Member cost share is based on benefits plan set up as follows:

Your benefit plan	The virtual visit benefit for 2016
High-Deductible Health Plan	• Follows standard medical plan rules • Member pays full cost of virtual visit until deductible is met • Virtual visit cost is approximately $40 • Once deductible is met, member pays their co-insurance or co-pay under their medical plan rules • Once out-of-pocket maximum is met, member pays $0
Co-insurance and Deductible plans	• Follows standard medical plan rules • Member pays same member cost-share percentage, pre- and post-deductible • Once out-of-pocket maximum is met, member pays $0
Co-pay plans	• Can be set to the same co-pay level as an office visit OR • A lesser co-pay than standard office visit

(Subject to operational limits. Virtual visits are not included with UnitedHealthcare's Preventive Plans.)

The cost of virtual visits

- Administrative cost: $0
- Claim cost: Approximately $40 per each virtual visit
- Member cost: Co-pay plans can be at or below in-office visit rate, depending on client preference

The virtual visit provider groups we contract with are aligned with American Medical Association (AMA) and Federation of State Medical Boards (FSMB) guidelines. Contracted provider groups are currently operating in 48 states.*

For more information contact your UnitedHealthcare representative.

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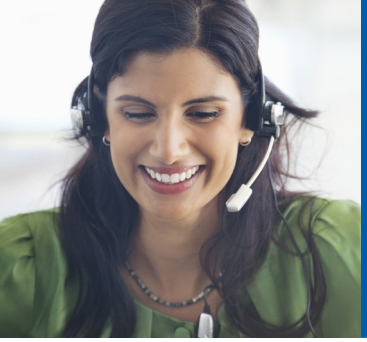
* Contracted virtual visits provider groups may vary by state and are subject to changes dependent on state laws and regulations.

Virtual visits are not an insurance product, health care provider or a health plan. Virtual visits are an internet-based service provided by contracted UnitedHealthcare providers that allow members to select and interact with independent physicians and other health care providers. It is the member's responsibility to select health care professionals. Care decisions are between the consumer and physician. Virtual visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefit plan. Payment for virtual visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. No controlled substances may be prescribed. Other prescriptions may be available where clinically appropriate and permitted by law, and can be transmitted to the pharmacy of the member's choice.

Administrative services provided by United HealthCare Services, Inc. or their affiliates.



Advocate4Me℠ Features

Advocate4Me is designed to help each member find the clear path to the right care – which, in turn, would help lead to increased benefit satisfaction and productivity, fewer calls to HR or small business owners and decreased health care costs.

Getting Members On Board

Robust Data	Advocate4Me works by reviewing data to provide a picture of a member's overall health: • We use data that includes medical claims and costs, screening results, health services utilization and more. • Then we use proprietary models that help give us a picture of what may be in store, health-wise, for the member. • Advocates then proactively engage members who may need health care system and benefits assistance.
Engaging Members	We will use existing member communication vehicles to promote Advocate4Me (e.g., Open enrollment & welcome materials, Benefit Awareness Newsletter).
Connecting Members to Support	We use a variety of technology, data and more to connect members to resources (e.g., natural language routing and proprietary data algorithms).
Single Toll-Free Number and ID Cards	• Single toll-free Advocate4Me number included on Health Plan ID cards the next time your organization is scheduled to have cards re-issued. Until that time, appropriate phone numbers will be routed to Advocate4Me, if a member authenticates. Some exceptions may apply.
Members Can Email, Too	Members can contact the Advocate team by sending an email through the Advocate email box. Advocates use secure email for follow-up with members.

What We Do

Who's on the Line	Front-line staff are called "Advocates" representing Advocate4Me.
A Multi-Disciplinary Team	Advocates are trained on benefits/claims and health care navigation as well as clinical support for some Advocates. Advocates are supported by a team of specialists who can answer questions that extend beyond the Advocate's area of expertise.
Staffing Structure	Benefits, Health and Nurse Advocates are staffed in locations across the country.
Help for the Family	Advocates look for opportunities for positive interventions at the household level and offer support to the entire family.[1]
Help with Pharmacy Benefits	Advocates help members who may be eligible to use mail order to save on their prescriptions, and bring a specialist into the conversation, when appropriate.

What We Do: **Help from Start to Finish**

Single Point of Contact	Advocate4Me serves as a single point of contact for: • Claims/benefits and issue resolution • Provider and facility navigation through UnitedHealthcare's medical network, including appointment scheduling on the member's behalf
First Point of Contact	Advocates serve as the first point of contact for: • Pharmacy claims and benefit questions • General health education and treatment information • Education on myHealthcare Cost Estimator to support health care decisions

For more information about Advocate4Me, please contact your UnitedHealthcare representative.

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What We Do: **Connect Members to Information and Resources**	
Connect to Clinical and Wellness Programs	• UnitedHealthcare Programs – Advocates will proactively identify available programs, provide program education and enroll members, when appropriate. Advocates will connect members to available resources via warm transfer or schedule an appointment. Members responding to proactive outreach will be routed to resources through natural language.
Help with Claims Appeals and Grievances	Advocates will educate members on the claims or benefit appeals process and connect them to resources.
Intelligent Routing	If natural language technology identifies a need and member has access to program, we will route the member to:[2] • UnitedHealthcare Triage Programs – routed to NurseLine or Care24® nurse available 24/7 • UnitedHealthcare Complex Medical Condition Programs – routed to Nurse Advocate who will bring in a Complex Medical Condition specialist for support and enrollment • OptumRx® Mail Order – routed to OptumRx for mail order support • UnitedHealthcare Member Incentives – routed to incentive program specialist • Prior Authorization and Prior Notifications – routed to a prior authorization and notification specialist
Routing to Additional Resources	Advocates educate member on available resources and, if appropriate, warm transfers them to specialist for topics such as: • UnitedHealthcare vision and dental benefits • UnitedHealthcare behavioral benefits support • Optum Employee Assistance Program (EAP) • myuhc.com® technical support
External organizations	Advocates will educate members on available resources and connect them with the resources for external organizations including those providing benefits, behavioral, triage, EAP, clinical or wellness, incentives and Pharmacy.

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[1] *Family* or *household* refers to employees and covered family members. Family-based discussions subject to appropriate authorization.
[2] If a member reaches an Advocate, the Advocate will connect member to appropriate specialist.

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FACTS ABOUT HEALTH SAVINGS ACCOUNTS (HSA)

QUALIFYING FOR A HSA

- You must be enrolled in the Qualified High Deductible Plan.
- You cannot be enrolled in another health plan that is not a Qualified High Deductible Plan.
- You cannot be enrolled in Medicare
- You cannot be claimed as a dependent under someone else's tax return.
- If you or your spouse is enrolled in a Medical Flexible Spending Account (FSA), you cannot open a HSA.
- ESLHA contributes into your HSA $55.98 if you elect individual coverage and $120.85 if you elect family coverage. This is a per paycheck contribution which is deposited into your HSA.

ADVANTAGES OF A HSA

- The funds you place in an HSA are pre-tax from your paycheck.
- Funds in your account rollover year after year.
- Funds grow tax free in an interest-bearing savings account, a money market, mutual funds or all three.
- You can put enough pre-tax dollars into your account to cover the deductible.
- Since the money belongs to you, it is taken with you if you leave ESLHA.
- You can use your HSA for eligible medical expenses for your spouse and/or dependents even if they are not enrolled in your medical plan.

RULES

- There is a maximum amount you can place in a HSA every year.
- The 2016 year maximum: $3,350 Individual and $6,750 Family
- The 2017 year maximum: $3,400 Individual and $6,750 Family
- You must have the funds in your account to pay for qualified medical expenses. It does not work like an FSA.
- If you spend any HSA funds for non-qualified expenses, you will owe taxes and pay a 20% penalty on the withdrawn funds.

FACTS ABOUT FLEXIBLE SPENDING ACCOUNTS (FSA)

ADVANTAGE OF A FSA

- You can put pre-tax dollars from your paycheck into an account to pay for eligible medical expenses or dependent care.

DISADVANTAGE OF A FSA

- You should estimate carefully what you expect to spend. If you do not use the funds, they are forfeited at the end of the year.

MEDICAL FSA

- You may elect up to $2,500 for 2015, to pay for eligible medical expenses.
- You or your spouse cannot be enrolled in a HSA.
- The amount you elect is available to you immediately at the beginning of the plan year as payroll deductions are taken throughout the year.

DEPENDENT CARE

- You may elect up to $5,000 for eligible dependent care.
- You must have the funds in this account prior to being reimbursed for dependent care expenses.
- Discuss with your tax advisor if this option or the tax credit on your tax return is best for you.

THE STANDARD - VOLUNTARY DENTAL PLAN SUMMARY

Benefits/Service	PPO Network	Non- Network
Calendar Year Deductible Individual Family	 $0 $0	 $50 $150
Coinsurance Diagnostic/Preventive • Cleanings • X-Rays • Fluoride Basic Services • Fillings • Endodontic & Periodontics • Simple Oral Surgery Major Services • Complex Oral Surgery • Bridges, Dentures & Crowns • Non-Surgical Periodontics Orthodontia (child only)	 100% 100% 50% 50%	 100% Deductible Is Waived 80% Deductible Applies 50% Deductible Applies 50% Deductible Does Not Apply
	Fee Schedule Applies	Balance Billing 90th Percentile
Annual Maximum	$1,000 / person	
Ortho Lifetime Maximum	$1,000 / child	

Plan Highlights

- Selecting a PPO Network dentist offers you the most cost effective coverage.
- If you select a non-participating dentist, Standard will make payment directly to you based upon the lesser of the fee charged or the prevailing fee. You could receive a bill for any non-covered expenses.
- If the cost estimate is more than $200 for non-emergency care, ask your dentist to submit a treatment plan to Standard for a pre-determination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage.

EMPLOYEE BI-WEEKLY CONTRIBUTION	
Employee	$13.24
Employee & Family	$38.29

UNITED HEALTHCARE - VISION PLAN SUMMARY

Plan Highlights

- The period shown under Frequency of Service is based on the last date of service.
- Vision benefits are covered with the medical plan and the employee contribution is included with the medical rates.

Benefit/Service	In Network	Non- Network
Frequency of Service: Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	
Examination Co-pay	$10 Co-pay	Reimbursed up to $40
Lenses Single Bifocal Trifocal Lenticular	$25 Co-Pay 100% 100% 100% 100%	Reimbursed up to: $40 $60 $80 $80
Frames	$25 Co-Pay $130 Allowance	Reimbursed up to: $45 (Less $30 Co-Pay)
Contacts Necessary Cosmetic	 100% $105 Allowance ($25 Co-Pay may apply)	Reimbursed up to: $210 $105

EMPLOYEE BI-WEEKLY CONTRIBUTION	
Employee	Included with Medical
Employee & Family	Included with Medical

THE HARTFORD - BASIC LIFE / AD&D

All eligible employees receive $10,000 of Basic Life and Accidental Death & Dismemberment coverage. This coverage is provided by East St. Louis Housing Authority at no cost. Benefits reduce by 35% at age 60 and an additional 15% at age 70.

THE HARTFORD- VOLUNTARY LIFE / AD&D

During your initial enrollment period you have the opportunity to purchase additional life insurance for yourself, your spouse, and/or dependent child(ren). You cannot cover your spouse or dependent child(ren) unless you elect coverage for yourself. You may elect coverage up to the guaranteed issue amount without completing medical questions. Coverage above the guaranteed issue must be approved by The Hartford, by answering medical questions, before it goes into effect.

During the annual enrollment period, you may apply for or increase the amount of coverage. All new and increased coverage requires the completion of medical questions. All requested amounts must be approved by The Hartford before it goes into effect.

Benefit reductions apply when you reach age 65 and 70. Benefits reduce by 35% at age 60 and an additional 15% at age 70.

EMPLOYEE COST PER PAY PERIOD

Age Band	Employee & Spouse Rate per $1,000
Under 30	$.04
30-34	$.04
35-39	$.07
40-44	$.13
45-49	$.21
50-54	$.44
55-59	$.71
60-64	$.81
65-69	$1.43
70-+	$3.57
AD&D	$.02/$1,000
Child/ Family	$.20 Per $1,000

EMPLOYEE COVERAGE
Employees may elect coverage in increments of $10,000 up to to a maximum of $300,000. As a new employee you can elect up to $100,000 without medical underwriting.

SPOUSE COVERAGE
Spousal coverage is available in $5,000 increments not to exceed 100% of the employee amount up to a maximum of $100,000. Spouse rates are based upon the employee's age. As a new employee you can elect up to $30,000 for your spouse without medical underwriting.

CHILDREN
Coverage is available for your child(ren) up to age 26. Coverage is $10,000. The amount you select is for each child you cover. The cost is based upon the family unit as opposed to each child. Guarantee issue does not apply to child coverage. Coverage for a child from 15 days to 6 months is $1,000.

HOW TO CALCULATE VOLUNTARY PREMIUM

$50,000 Elected Coverage ÷ 1,000 = 50 Units X $0.21 Rate * See Note = $10.50 Monthly Cost

*The premium calculation is based upon the life rate for an employee age 45.

REMEMBER: You must use the employee's age to calculate the spouse's premium.

THE HARTFORD - VOLUNTARY SHORT TERM DISABILITY

Short Term Disability coverage is available for you to purchase through The Hartford. It protects your income should you become disabled due to illness or an accident. Benefits begin after a 30-day waiting period. The monthly benefit is 60% of your weekly gross wages to a maximum of $1,500 per week. The maximum benefit period is 9 weeks.

This is a voluntary benefit so you must pay the full cost for this coverage. The cost for this coverage is $.340 per $10 of weekly income. Contact Human Resources for more information.

THE HARTFORD - LONG TERM DISABILITY

Should you remain disabled beyond 90 days due to an illness or accident, are unable to perform the main duties of your own occupation, and if The Hartford determines you are eligible, coverage continues for two years under the ESLHA's long term disability plan. The two years includes the 90 day waiting period. The long term disability benefit is 66 2/3% of your monthly income to a maximum of $7,000 per month.

However, if you are totally disabled and unable to perform the main duties of any occupation, benefits can continue until you reach your normal Social Security retirement age. Remember you must be under a doctors care and partial disability rules may apply, meaning you may have to work part-time if you are able.

If you are a new employee, had a condition within 3 months prior to becoming employed, and that condition causes you to become disabled within the first 12 months of coverage, you are subject to the pre-existing condition limitations of the policy. The pre-existing condition limitation may cause you to be ineligible for long term disability benefits.

Long Term Disability is a benefit provided at no cost to eligible employees.

CALL A DOCTOR PLUS

Employees of ESLHA and their family members have access to a doctor 24 hours a day 7 days a week through the Call A Doctor Plus benefit. When you or a family member need non-emergency medical care and you are unable to reach or make an appointment with your primary care physician, you can contact Call A Doctor Plus for assistance. You will speak with a physician licensed in the State you are calling from and that physician can issue you a prescription if you need one.

This service also provides access to a team of professionals to answer questions about healthcare, find providers, and assistance with medical bill issues. It also provides legal advice on such subjects as child custody, divorce, estate planning, education, mortgages, etc.

HEALTH CARE REFORM REMINDER

Under the Affordable Care Act, the individual mandate is a provision of the Federal Health Law that requires you, your child(ren), and anyone you claim as a dependent on your taxes, to have health insurance in 2016 or pay a tax. That coverage can be supplied through your employer, public programs such as Medicare or Medicaid, or an individual policy you purchase through the Health Insurance Marketplace.

SUMMARY OF MATERIAL MODIFICATION

ESLHA has amended the Employee Medical Benefit Plan. This contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage that is available to you. f you need a copy of your Summary Plan Description or Certificate of Coverage, please go to www.myuhc.com or contact Marie Sanders in Human Resources.

WHAT DO I NEED TO DO?

Review all benefit information. Ask questions if you do not understand any benefit provision. Complete enrollment forms and return them to Marie Sanders in Human Resources.

HELPFUL INFORMATION

Deductibles - The deductible is the amount of money you pay before services are covered under your medical or dental plan. Normally, it is paid for in-patient and out-patient services under your medical plan. Your deductible is accumulated during each calendar year (January 1 through December 31). It does not apply to any preventive services as required under Health Care Reform.

Coinsurance - After the deductible is satisfied, claims costs are shared with the insurance carrier until the out-of-pocket maximum is reached.

Out-of-Pocket Maximums - This is the maximum amount of money you are required to pay in a calendar year. The deductible, co-pays, and your share of the coinsurance under your chosen plan will equal the most you will pay. Once the out-of-pocket maximum is reached, claims are eligible at 100% of covered services.

Office Visit Copayments - When you visit your primary care physician or a specialist, you are required to pay a copayment for that visit. The office visit co-pay will satisfy part of the out-of-pocket limit associated with the plan. There should be no copayments for services coded as preventive by your physician.

Urgent Care - If you visit an urgent care facility you will be required to pay a copayment for this service. It is higher than a regular office visit and lower than an emergency room copayment. In addition to the co-pay, the deductible and coinsurance may apply when these services are performed: CT, PET, MRI, Nuclear Medicine, Pharmaceutical Products, Scopic Procedures, Surgery, Therapeutic Treatments. Note: Take Care Clinic with Walgreens is considered at the primary care office visit co-pay.

Emergency Room - If you visit a hospital emergency room, you will be required to pay a copayment for this service (unless you are enrolled in the HSA). This is a much higher copayment than a regular office visit or urgent care facility. If you are admitted to the hospital the copayment is waived and the deductible / coinsurance applies.

Preventive Services - All services coded as Preventive are covered 100% and the deductible and copayments will not apply. Situations may arise where the "Preventive" service could be coded as "Diagnostic". In these situations the deductible and copayments could apply. Also, if you receive a preventive service in conjunction with a sick visit, you could still be charged the applicable office visit co-pay, deductible, and/or coinsurance. Communication with your provider of care is important.

Lifetime Benefit Maximum - All plan design options have an unlimited lifetime maximum.

Prescription Drugs - All plan design options will cover Tier 1 drugs after a $10 Co-Pay; Tier 2 drugs require a $35 Co-Pay; and Tier 3 drugs are covered after a $60 Co-Pay for up to a 31-day supply. Mail Order prescription will provide up to a 90-day supply of medication 2.5 times the tier co-pay. Please visit www.myuhc.com to access your prescription drug list as well as the list of prescription drug products that are available through mail order.

Review your Certificate of Coverage. It is a complete summary of your health insurance benefits. You can view the certificate online at www.myuhc.com.

Ask your physician or healthcare provider if they participate in the United Healthcare network. Do not ask if they accept United Healthcare. The providers usually, but not always, accept payments from insurance companies or anyone who wants to give them money; however, not all providers want to accept the contractual discounts required by participation in the network. You can also check the website at www.myuhc.com for the most up-to-date list of participating providers or call customer service at the phone number on the back of your ID card for assistance.

HELPFUL INFORMATION (cont'd…)

This is Important– Understand that all eligible claims for out-of-network providers begins at 110% of what Medicare allows for the procedure. Medicare allowances are extremely low. Claim amounts, which are not eligible, become your responsibility. You could have huge out-of-pocket expenses if you utilize a provider not contracted with United Healthcare.

If you go out-of-network, know that it is your responsibility to pre-certify all procedures. Contact customer service at the phone number on the back of your ID card. There are penalties and more out-of-pocket expenses if you do not pre-certify.

If you travel and need medical services, other than emergency services, check online at www.myuhc.com for a participating provider at a location near you.

This is just a summary of benefits and is intended as a highlight only. If this description conflicts in any way with the Certificate of Coverage or Outpatient Prescription Drug Rider, the Certificate of Coverage and Outpatient Prescription Drug Rider shall prevail.

WHERE SHOULD I RECEIVE CARE?

Primary Care - For routine, primary/preventive care, or non-urgent treatment, it is recommended you go to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You will also pay the least out of pocket amount when you receive care in your doctor's office.

Convenience Care - Sometimes, you may not be able to get to your doctor's office and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center which can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located in some Walgreens and offer services without the need to schedule an appointment. Services are subject to the primary care physician office visit co-pays.

It is recommended that you seek routine medical care from your primary care physician whenever possible.

Urgent Care - Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours, you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an Urgent Care Center. At an Urgent Care Center, you can generally be treated for many minor medical problems faster than at an Emergency Room. It is recommended, however, that you seek routine medical care from your primary care physician whenever possible.

Services available for Urgent Care may vary per center. If you choose to use an Urgent Care Center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the website at www.myuhc.com.

Emergency Room - If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest Emergency Room or call 911. Emergency services are always considered at the in-network benefit level.

If you obtain care at an Emergency Room, you will likely pay more out of pocket than if you were treated at your doctor's office, a Convenience Care Center, or Urgent Care Facility.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Offer free or Low-Cost Health Coverage to Children and Families

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Please contact Human Resources for the list of states offering assistance.
You can also contact the following:
U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/ebsa **www.cms.hhs.gov**

1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565

PRE-TAX CONTRIBUTIONS

All contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to section 125 of the IRS code. This means premiums will be deducted from your gross income and tax will be applied to the remaining payroll amount.

ENROLLMENT

The annual enrollment period for ESLHA will start September 7, 2016, and end September 14, 2016. During the annual enrollment period, you may enroll your eligible family members, terminate coverage, or make a change to any of your benefit elections. If you wish to enroll, add or make changes to your current coverage, add or terminate dependents on any plan, you must complete an enrollment change form and submit it to Human Resources.

If you are a new employee, you must complete your benefit elections and submit the enrollment forms to Human Resources within 30 days of your eligibility date.

Remember, the elections you make cannot be changed during the benefit year unless you experience a life change event such as marriage, divorce, death of a family member, or the birth/adoption of a child.

Employee Benefits - Key Contact Sheet

EAST ST. LOUIS HOUSING AUTHORITY Human Resources Rhonda Lockett or Marie Sanders	**CBIZ BENEFITS & INSURANCE SERVICES** Nicol Schmidt 314-692-5847
UnitedHealthcare Healing health care. Together.	**MEDICAL & VISION** Member Services: 1-800-357-0978 (This phone number is a general member service number. If your ID card is available, please use the phone number on the back of your card) www.myuhc.com
TheStandard Positively different.	**BASIC LIFE , VOLUNTARY LIFE, LONG TERM DISABILITY, SHORT TERM DISABILITY AND DENTAL** Customer Contact Center: 1-888-937-4783 www.standard.com
Call A Doctor Plus	Member Services: 1-888-571-5562 www.cadrplus.com
FLEXIBLE SPENDING ACCOUNT CBIZ FLEX	Send Claims to: CBIZ Flex, 2797 Frontage Rd. Suite 2000, Roanoke, VA, 24017 Fax Claims to: 1-800-584-4185 Submit Claims Online: www.myplans.cbiz.com

REASONS TO CALL	**WHO TO CALL**
Claims Questions	Carrier / CBIZ
Identification Cards / Numbers	Carrier
Pre-Certification	Carrier
Provider Directory	Carrier Websites
Payroll Issues /Status Changes/ Miscellaneous Issues	ESLHA
How to use this resource for claims resolution:	First contact Member Services If issue is still unresolved, contact CBIZ.