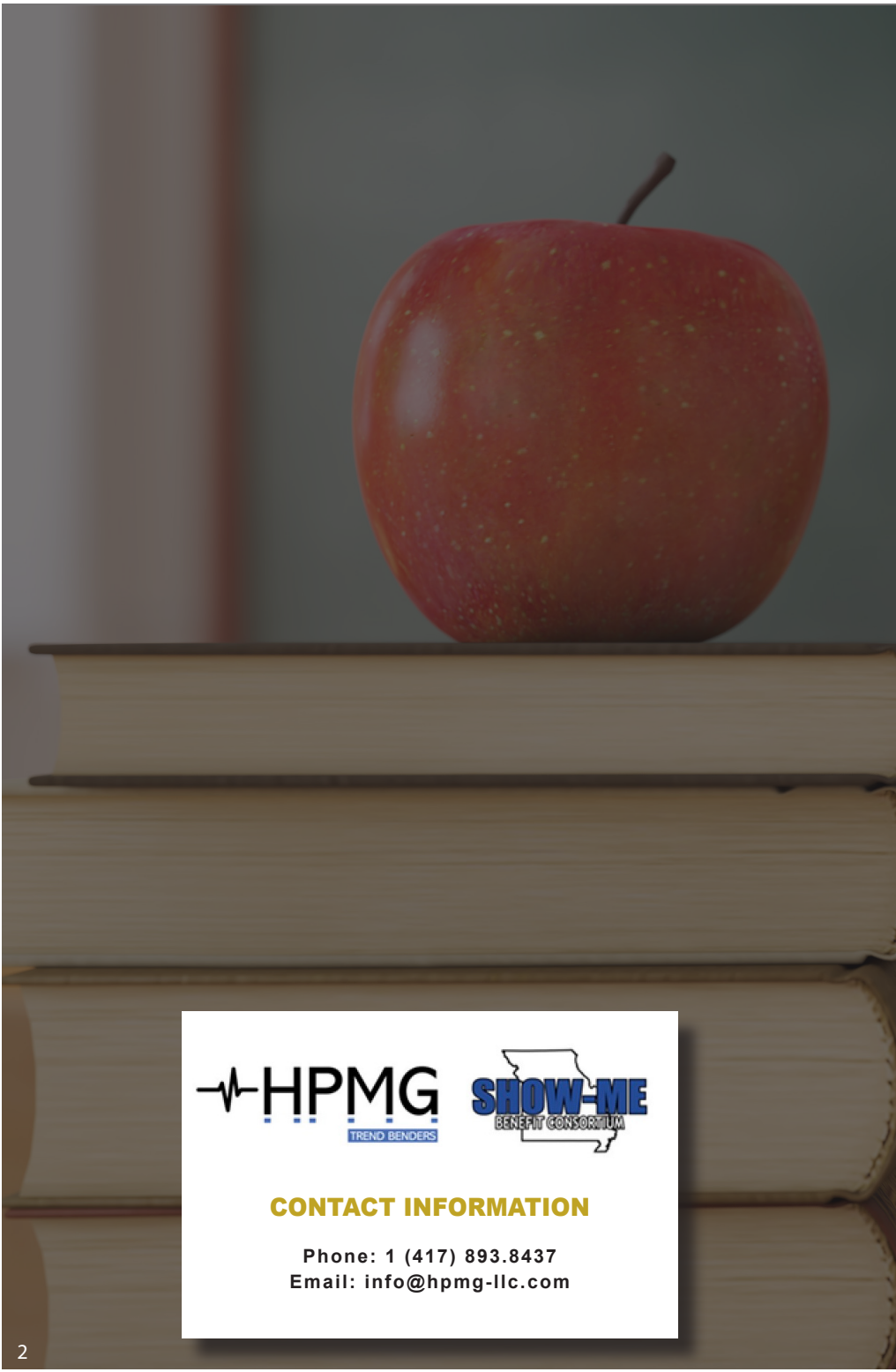
2023

BENEFITS GUIDE LEBANON

Educational BENEFITS
A JTS Financial Company



HPMG TREND BENDERS

SHOW-ME BENEFIT CONSORTIUM

CONTACT INFORMATION

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TABLE OF CONTENTS

WHAT YOU NEED TO KNOW

- Employees under contract who work a minimum of 30 hours per week, unless a bus driver, are eligible to enroll themselves and their qualified dependents in applicable Lebanon School District employee benefits. Employees must be actively at work to enroll in benefits.

Checklist of what to bring for open enrollment for each dependent that you are enrolling in eligible benefits:

1. Social Security Number
2. Address
3. Date of Birth

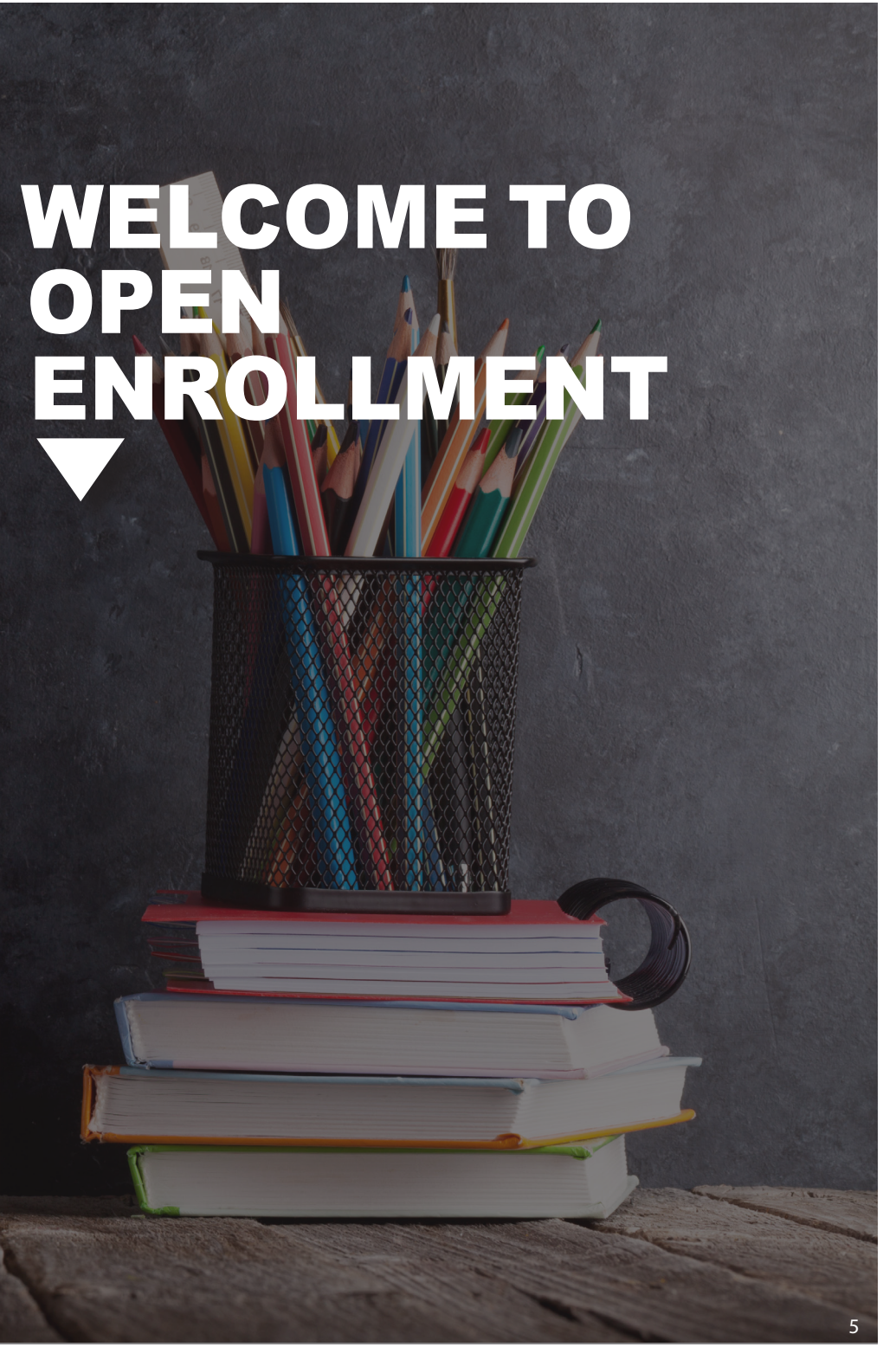
Having these items will expedite the completion of all enrollment forms, beneficiary cards, etc.

If you are a current employee (not a new hire), please keep the following information in mind:

- You cannot make any changes until the annual "open enrollment period", which allows employees who may have previously declined to enroll the opportunity to enroll in new coverage. (Certain restrictions and limitations may apply to employees who initially declined coverage when they first became eligible to enroll.)
  - However, there are certain qualifying events that allow current employees to make benefit changes. These include, but are not limited to:
    - marriage, divorce, adoption or birth of child, death of a spouse or other eligible dependent.

You might see these boxes on certain pages. Here's what they mean:

EC	Employer Contribution - your employer contributes a percentage to your product premiums
ER	Employer Paid - your employer covers 100% of the cost of your product
NH	New Hire Eligible - if you are a new hire for the district, you are eligible for this benefit


WELCOME TO
OPEN
ENROLLMENT

GLOSSARY
OF INSURANCE TERMS

Annual Maximum - the total dollar amount that a plan will pay for care incurred by an individual enrollee or family (under a family plan) in a specified benefit period.

Benefit Year - a period in which covered expenses are accrued and are counted toward the annual maximums, deductibles, and/or out-of-pocket limits.

Benefits - items or services covered under an insurance plan.

Beneficiary - a person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor or on the maturity of the policy.

Broker - an individual agent or agency who represents the buyer, rather than the insurance company, and tries to find the buyer the best policy. The broker can make specific recommendations about which plans best suit you and your family's needs.

COBRA - a federal law that may allow the insured to temporarily keep insurance coverages after employment ends.

Claim - a request for payment under an insurance plan. A claim will list the services rendered, the date of service, and an itemization of cost.

Coinsurance - insurance in which the insured is required to pay a fixed percentage of the cost of expenses after the deductible has been paid.

Copayment (Copay) - a fixed amount that the insured is required to pay before receiving the service.

Deductible - an out-of-pocket amount that an insured must pay prior to an insurance plan paying a claim.

Dependent - a child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Elimination Period - a period of continuous disability which must be satisfied before you are eligible to receive benefits.

Evidence of Insurability (EOI) - part of the application process for an insurance policy during which an applicant provides health information. Coverage does not become effective until approval of the EOI.

Flexible Spending Account (FSA) - a type of account that provides the account holder with specific tax advantages on qualified medical and/or dependent care expenses (ex. Medical Reimbursement, Dependent Care, and/or Limited Purpose FSA).

Guaranteed Issue - a predetermined benefit amount allowed by an insurance plan without requiring Evidence of Insurability (EOI). GI allows you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. This does not, however, preclude the application of the pre-existing condition exclusions.

Limited Purpose FSA - a type of account to be used with an HSA. It is reserved for the payment of dental and vision expenses only.

Long-Term Care - a range of services and supports you may need to meet your personal care needs in the event of a chronic illness or disability.

Medically Necessary - a covered health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.

Network - the facilities, providers, and suppliers your insurance plan has contracted with to provide health care services (i.e. "in-network").

Non-Preferred Provider - a provider who does not have a contract with your insurance carrier or plan to provide services to you. You'll pay more to see a non-preferred provider (i.e. "out-of-network").

Out-of-Pocket Maximum - the maximum amount of money you may pay for services in a benefit year.

Pre-Existing Condition - a medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the insurance company.

Premium/Rate - the amount you pay for your insurance premiums each month.

Qualifying Life Event (QLE) - a change in your situation that can make you eligible for a special enrollment period, allowing you to enroll in an insurance plan outside of the yearly open enrollment period (ex. loss of coverage, getting married or divorced, having a baby/adopting a child, or a death in the family).

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PPO PLAN	
	Valenz Mercy
Individual Deductible	$1,000
Family Deductible	$2,000
Individual Out-of-Pocket Maximum	$3,000
Family Out-of-Pocket Maximum	$6,000
Coinsurance	80%
Lifetime Maximum	Unlimited
COVERED SERVICES	
OV Primary	$10 Copay
OV Specialist	$40 Copay
Preventive Care	$0 Copay
Outpatient Lab Services	$0 Copay
Outpatient RAD*	20% AD*
Urgent Care***	$50 Copay
Emergency Room (waived if AD*)	$200 Copay
Inpatient Hospital Care	20% AD*
Chiropractic	$40 Copay
Physical Therapy Hospital/Outpatient Setting	$40 Copay
Inpatient Injectables	20% AD*
Outpatient Injectables	$0 through SMBC Program
PRESCRIPTIONS	
Generic	$5 Copay
Preferred Brand	$35 Copay
Non-Preferred Brand	$75 Copay
Specialty Drugs	$0 through SMBC Program

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PPO PLAN / HSA PLAN		
	Valenz Mercy PPO Plan	Valenz Mercy HSA Plan
Individual Deductible	$2,500	$3,000
Family Deductible	$5,000	$6,000
Individual Out-of-Pocket Maximum	$4,500	$6,000
Family Out-of-Pocket Maximum	$9,000	$12,000
Coinsurance	80%	80%
Lifetime Maximum	Unlimited	Unlimited
COVERED SERVICES		
OV Primary	$10 Copay	$10 Copay AD*
OV Specialist	$35 Copay	$35 Copay AD*
Preventive Care	$0 Copay	$0 Copay
Outpatient Lab Services	$0 Copay	20% AD*
Outpatient RAD*	20% AD*	20% AD*
Urgent Care***	$50 Copay	$50 Copay AD*
Emergency Room (waived if AD*)	$100 Copay	20% AD*
Inpatient Hospital Care	20% AD*	20% AD*
Chiropractic	$35 Copay	$35 Copay AD*
Physical Therapy Hospital/Outpatient Setting	$35 Copay	$35 Copay AD*
Inpatient Injectables	20% AD*	20% AD*
Outpatient Injectables	$0 through SMBC Program	$0 through SMBC Program
PRESCRIPTIONS		
Generic	$5 Copay	$5 Copay AD*
Preferred Brand	$35 Copay	$35 Copay AD*
Non-Preferred Brand	$60 Copay	$75 Copay AD*
Specialty Drugs	$0 through SMBC Program	$0 through SMBC Program

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PPO PLAN		
	Dual Network Plan	Dual Network Plan
Individual Deductible	$1,200	$3,000
Family Deductible	$2,400	$6,000
Individual Out-of-Pocket Maximum	$3,600	$5,500
Family Out-of-Pocket Maximum	$7,200	$11,000
Coinsurance	80%	80%
Lifetime Maximum	Unlimited	Unlimited
COVERED SERVICES		
OV Primary	$25 Copay	$25 Copay
OV Specialist	$50 Copay	$35 Copay
Preventive Care	$0 Copay	$0 Copay
Outpatient Lab Services	$0 Copay	$0 Copay
Outpatient RAD*	20% AD*	20% AD*
Urgent Care***	$50 Copay	$50 Copay
Emergency Room (waived if AD*)	$200 Copay	$100 Copay
Inpatient Hospital Care	20% AD*	20% AD*
Chiropractic	$50 Copay	$35 Copay
Physical Therapy Hospital/Outpatient Setting	$50 Copay	$35 Copay
Inpatient Injectables	20% AD*	20% AD*
Outpatient Injectables	$0 through SMBC Program	$0 through SMBC Program
PRESCRIPTIONS		
Generic	$15 Copay	$10 Copay
Preferred Brand	$35 Copay	$35 Copay
Non-Preferred Brand	$75 Copay	$60 Copay
Specialty Drugs	$0 through SMBC Program	$0 through SMBC Program

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

HSA PLAN	
	Dual Network Plan HSA
Individual Deductible	$3,500
Family Deductible	$7,000
Individual Out-of-Pocket Maximum	$7,000
Family Out-of-Pocket Maximum	$14,000
Coinsurance	80%
Lifetime Maximum	Unlimited
COVERED SERVICES	
OV Primary	$25 Copay AD*
OV Specialist	$50 Copay AD*
Preventive Care	$0 Copay
Outpatient Lab Services	20% AD*
Outpatient RAD*	20% AD*
Urgent Care***	$50 Copay AD*
Emergency Room (waived if AD*)	20% AD*
Inpatient Hospital Care	20% AD*
Chiropractic	$50 Coopay AD*
Physical Therapy Hospital/Outpatient Setting	$50 Copay AD*
Inpatient Injectables	20% AD*
Outpatient Injectables	$0 through SMBC Program
PRESCRIPTIONS	
Generic	$15 Copay AD*
Preferred Brand	$35 Copay AD*
Non-Preferred Brand	$75 Copay AD*
Specialty Drugs	$0 through SMBC Program

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PPO PLAN		
	Cox Directed	Cox Directed
Individual Deductible	$1,000	$2,500
Family Deductible	$2,000	$5,000
Individual Out-of-Pocket Maximum	$3,000	$4,500
Family Out-of-Pocket Maximum	$6,000	$9,000
Coinsurance	80%	80%
Lifetime Maximum	Unlimited	Unlimited
COVERED SERVICES		
OV Primary	$25 Copay	$25 Copay
OV Specialist	$50 Copay	$35 Copay
Preventive Care	$0 Copay	$0 Copay
Outpatient Lab Services	$0 Copay	$0 Copay
Outpatient RAD*	20% AD*	20% AD*
Urgent Care***	$50 Copay	$50 Copay
Emergency Room (waived if AD*)	$200 Copay	$100 Copay
Inpatient Hospital Care	20% AD*	20% AD*
Chiropractic	$50 Copay	$35 Copay
Physical Therapy Hospital/Outpatient Setting	$50 Copay	$35 Copay
Inpatient Injectables	20% AD*	20% AD*
Outpatient Injectables	$0 through SMBC Program	$0 through SMBC Program
PRESCRIPTIONS		
Generic	$15 Copay	$10 Copay
Preferred Brand	$35 Copay	$35 Copay
Non-Preferred Brand	$75 Copay	$60 Copay
Specialty Drugs	$0 through SMBC Program	$0 through SMBC Program

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

HSA PLAN	
	Cox Directed
Individual Deductible	$3,000
Family Deductible	$6,000
Individual Out-of-Pocket Maximum	$6,000
Family Out-of-Pocket Maximum	$12,000
Coinsurance	80%
Lifetime Maximum	Unlimited
COVERED SERVICES	
OV Primary	$20 Copay AD*
OV Specialist	$40 Copay AD*
Preventive Care	$0 Copay
Outpatient Lab Services	20% AD*
Outpatient RAD*	20% AD*
Urgent Care***	$50 Copay AD*
Emergency Room (waived if AD*)	20% AD*
Inpatient Hospital Care	$40 Copay AD*
Chiropractic	$40 Copay AD*
Physical Therapy Hospital/Outpatient Setting	$50 Copay
Inpatient Injectables	20% AD*
Outpatient Injectables	$0 through SMBC Program
PRESCRIPTIONS	
Generic	$15 Copay AD*
Preferred Brand	$35 Copay AD*
Non-Preferred Brand	$75 Copay AD*
Specialty Drugs	$0 through SMBC Program

$1,000 VALENZ MERCY PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$81.00	$517.00	$598.00
Employee + Spouse	$663.00	$517.00	$1,180.00
Employee + Child(ren)	$535.00	$517.00	$1,052.00
Family	$1,149.00	$517.00	$1,666.00

$2,500 VALENZ MERCY PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$0.00	$517.00	$517.00
Employee + Spouse	$503.00	$517.00	$1,020.00
Employee + Child(ren)	$392.00	$517.00	$909.00
Family	$924.00	$517.00	$1,441.00

$3,000 VALENZ MERCY HSA PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$0.00	$517.00	$431.00
Employee + Spouse	$332.00	$517.00	$849.00
Employee + Child(ren)	$240.00	$517.00	$757.00
Family	$682.00	$517.00	$1,199.00

$1,200 DUAL NETWORK PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$111.00	$517.00	$628.00
Employee + Spouse	$723.00	$517.00	$1,240.00
Employee + Child(ren)	$588.00	$517.00	$1,105.00
Family	$1,233.00	$517.00	$1,750.00

$3,000 DUAL NETWORK PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$26.00	$517.00	$543.00
Employee + Spouse	$555.00	$517.00	$1,072.00
Employee + Child(ren)	$438.00	$517.00	$955.00
Family	$997.00	$517.00	$1,514.00

$3,500 DUAL NETWORK HSA PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$0.00	$517.00	$453.00
Employee + Spouse	$375.00	$517.00	$892.00
Employee + Child(ren)	$278.00	$517.00	$795.00
Family	$743.00	$517.00	$1,260.00

$1,000 COX DIRECTED PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$93.00	$517.00	$610.00
Employee + Spouse	$687.00	$517.00	$1,204.00
Employee + Child(ren)	$556.00	$517.00	$1,073.00
Family	$1,182.00	$517.00	$1,699.00

$2,500 COX DIRECTED PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$10.00	$517.00	$527.00
Employee + Spouse	$523.00	$517.00	$1,040.00
Employee + Child(ren)	$410.00	$517.00	$927.00
Family	$953.00	$517.00	$1,470.00

$3,000 COX DIRECTED PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$0.00	$517.00	$440.00
Employee + Spouse	$349.00	$517.00	$866.00
Employee + Child(ren)	$255.00	$517.00	$772.00
Family	$706.00	$517.00	$1,223.00

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES PLAN 1	
PREVENTATIVE SERVICES (No Deductible) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 80%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 0%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
ANNUAL MAXIMUM	In Network: $1,250 per person Out-of-Network: $1,250 per person
DEDUCTIBLE	In Network: $50 per person / $150 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$24.49
Employee + Spouse	$48.21
Employee + Child(ren)	$62.71
Family	$94.58

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES PLAN 2	
PREVENTATIVE SERVICES (No Deductible) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 80%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 50%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
CHILD ORTHODONTIA RIDER (DEDUCTIBLE APPLIES) 50%	$1,000 Lifetime Maximum
ANNUAL MAXIMUM	In Network: $1,250 per person Out-of-Network: $1,250 per person
DEDUCTIBLE	In Network: $50 per person / $150 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$29.44
Employee + Spouse	$58.12
Employee + Child(ren)	$74.92
Family	$111.63

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES PLAN 3	
PREVENTATIVE SERVICES (No Deductible) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 100%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 80%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
CHILD ORTHODONTIA RIDER (DEDUCTIBLE APPLIES) 50%	$1,000 Lifetime Maximum
ANNUAL MAXIMUM	In Network: $1,250 per person Out-of-Network: $1,250 per person
DEDUCTIBLE	In Network: $50 per person / $150 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$33.99
Employee + Spouse	$67.24
Employee + Child(ren)	$84.58
Family	$126.73

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES PLAN 4	
PREVENTATIVE SERVICES (No Deductible) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 80%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 50%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
CHILD ORTHODONTIA RIDER (DEDUCTIBLE APPLIES) 50%	$1,000 Lifetime Maximum
ANNUAL MAXIMUM	In Network: $1,750 per person Out-of-Network: $1,750 per person
DEDUCTIBLE	In Network: $50 per person / $150 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$35.97
Employee + Spouse	$71.16
Employee + Child(ren)	$86.15
Family	$131.79

Vision insurance is offered to help people see by providing affordable access to high-quality eye care and eyewear. An individual or family vision insurance plan saves you money on frames, lenses, contacts, eye exams and more.

VISION SERVICES PLAN 1	
Exam Copay	$20
Materials Copay	$20
CONTACTS	
Elective Allowance	$110 allowance
Contact Lens Evaluation, Fitting, & Follow-Up Care Copay	$60 maximum
LENSES	
Single Vision Allowance	Covered in full after $20 Copay
Bifocal Allowance	Covered in full after $20 Copay
Trifocal Allowance	Covered in full after $20 Copay
Lenticular	Covered in full after $20 Copay

SERVICES	FREQUENCY
Exam	12 months
Frames	24 months
Spectacle Lenses	12 months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months

COVERAGE TIER	MONTHLY RATES
Employee	$4.00
Employee + Spouse	$8.02
Employee + Child(ren)	$8.50
Family	$13.38

Vision insurance is offered to help people see by providing affordable access to high-quality eye care and eyewear. An individual or family vision insurance plan saves you money on frames, lenses, contacts, eye exams and more.

VISION SERVICES PLAN 2	
Exam Copay	$10
Materials Copay	$10
CONTACTS	
Elective Allowance	$150 allowance
Contact Lens Evaluation, Fitting, & Follow-Up Care Copay	$60 maximum
LENSES	
Single Vision Allowance	Covered in full after $10 Copay
Bifocal Allowance	Covered in full after $10 Copay
Trifocal Allowance	Covered in full after $10 Copay
Lenticular	Covered in full after $10 Copay

SERVICES	FREQUENCY
Exam	12 months
Frames	24 months
Spectacle Lenses	12 months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months

COVERAGE TIER	MONTHLY RATES
Employee	$5.77
Employee + Spouse	$11.53
Employee + Child(ren)	$12.87
Family	$19.56

Your needs vary greatly upon age, number of dependents, dependents' ages and your financial situation. Term Life is designed to provide benefits to your designated beneficiary for loss of life. AD&D insurance covers you and your beneficiaries in the event of an accidental loss of life. Lebanon pays 50% of $50,000 towards all eligible employee's group term life insurance.

EMPLOYEE BENEFIT	
Employer Paid Amount: $2.25 Employee Paid Amount: $2.25	$50,000
AD&D Benefit	$50,000

EMPLOYEE PAID	BASIC DEPENDENT LIFE
Amount	SPOUSE: $2,000 CHILD: $1,000
Premium Cost	$0.54

VOLUNTARY GROUP TERM LIFE INSURANCE

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Your needs vary greatly upon age, number of dependents, dependents' ages and your financial situation. Term Life is designed to provide benefits to your designated beneficiary for loss of life. AD&D insurance covers you and your beneficiaries in the event of an accidental loss of life.

	EMPLOYEE	SPOUSE	DEPENDENT
Minimum Amount	$10,000	$5,000	$2,000
Maximum Amount	$500,000	$250,000	$10,000
Amount	$500,000 in increments of $10,000, not to exceed 5x annual earnings	$250,000 in increments of $5,000, not to exceed 100% of employee amount	Child(ren): Birth through 26: $10,000 in increments of $2,000
Guaranteed Issue	$200,000: Through Age 69 $0.00: Age 70+	$50,000: Through Age 69 $0.00: Age 70+	-
Group Term Life Benefit Reduction	Benefits reduce to 65% upon the person's attainment of age 65-69, and 50% at age 70+ (Spouse Reduction is based on Employee Age)		-
Benefit Features	Portability Conversion Privilege Waiver of Premium	-	-

The hospital indemnity policy helps offer you financial protection in the event that you or your dependents are admitted to the hospital. Benefits provide you with assistance in paying your deductible and co-payments associated with inpatient expenses.

BENEFITS	
Hospital Room & Board Benefits (180 Daily Benefits per Coverage Year)	$100
Hospital Admission Benefit (One Daily Benefit per Coverage Year)	$500
Nursery Admission Benefit (One Daily Benefit per Coverage Year)	$500
Nursery Confinement Benefit (Ten Daily Benefit per Coverage Year)	$100
Portability	Unlimited or when employee retires or reaches age 70
Pre-Existing Limitation	None
Non-Insurance Services	
On-Call Travel Assistance	Included

COVERAGE TIER	MONTHLY PREMIUM
Employee	$16.80
Employee + Spouse	$28.08
Employee + Child(ren)	$23.48
Family	$33.84

NOTE: THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

MEDICAL TRANSPORT SOLUTIONS (MASA)

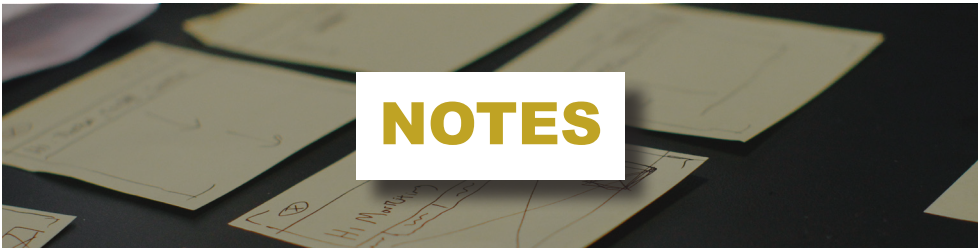
The high cost of emergent and non-emergent transportation results in unexpected out of pocket expenses. MASA protects members from these expenses related to emergency air transportation and ground ambulance charges.

ANY GROUND. ANY AIR. ANYWHERE. ™

BENEFITS	PLATINUM	EMERGENT PLUS
Cost	$39/month	$14/month
Family Included	Yes	Yes
Emergent Ground Transportation (U.S. & Canada)	Yes	Yes
Emergent Air Transportation (U.S. & Canada)	Yes	Yes
Repatriation (Worldwide)	Yes	Yes
Non-Emergent Interfacility Transportation (Worldwide)	Yes	Yes
Return Transportation (Worldwide)	Yes	No
Vehicle Return (Basic Coverage Area)	Yes	No
Organ Transplant Transportation (U.S. & Canada)	Yes	No
Pet Return (Basic Coverage Area)	Yes	No
Minor Children/Grandchildren Return (Basic Coverage Area)	Yes	No
Mortal Remains Transportation (Worldwide)	Yes	No

MASA Medical™ Transport Solutions

- Global Reach Emergent Plus (US 50/ Canada), Platinum (up to worldwide)
- Leading company in the Industry
- The only plans that cover at home and away
- MASA steps in where insurance falls short by helping protect families against uncovered costs
- MASA also provides many benefits not covered by insurance
- Any Ground. Any Air. Anywhere TM Simply contact 911 for Emergency Transport
- Covers any of the 1,500+ Air Ambulances in US with 300 different Provider Companies
- Covers any of the 21,000 Ground Ambulance Providers in the US
- US Based Support, Local Reps, Simple Enrollment, Easy Claims, and Online access



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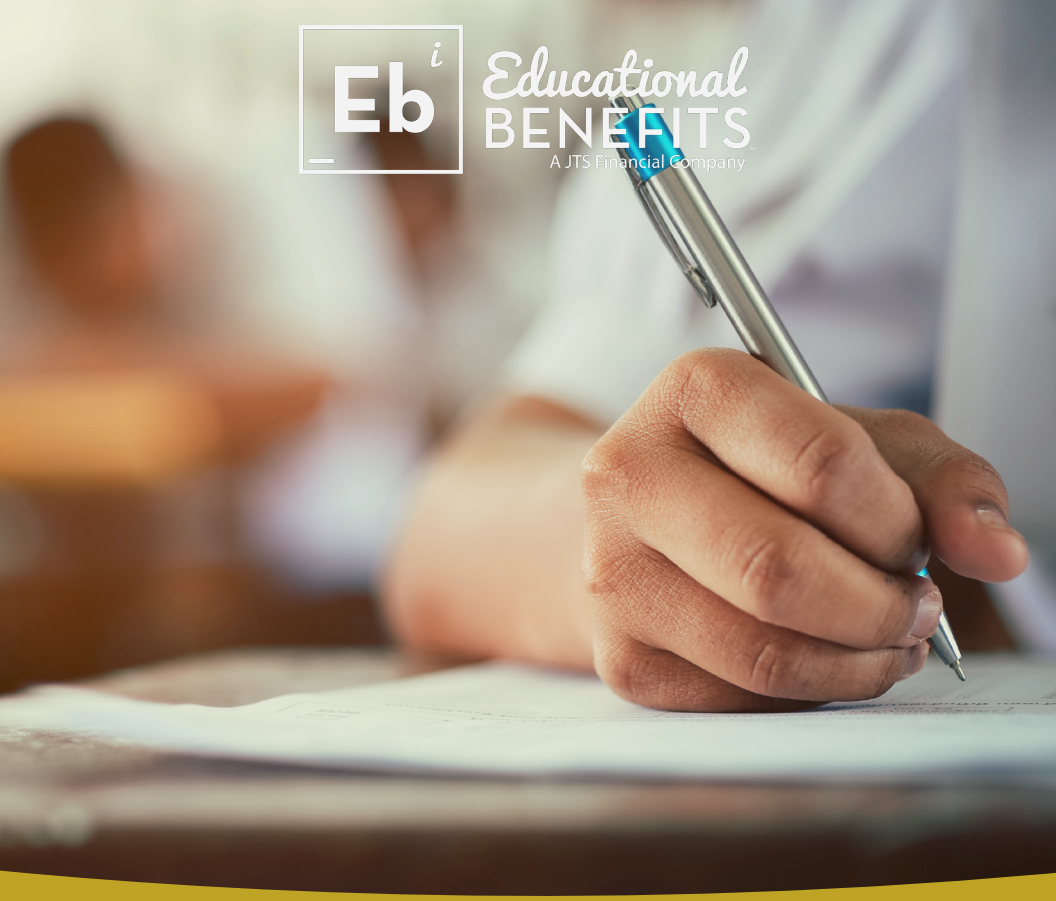

HPMG TREND BENDERS

SHOW-ME BENEFIT CONSORTIUM

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