2024 Benefits

Frequently Asked Questions (FAQs)

We offer a full menu of benefits to eligible employees and their families beginning on the first day of employment. You have 30 days from your hire date or the date you transition to a benefits-eligible position to enroll in plans—so be sure to take a close look and make your selections before the deadline. To enroll visit **MyPeoplePlace.com** and click on the Benefit Details tile.

Check out our list of frequently asked questions below. You can scroll through, click on a topic from the table of contents below, or search the entire document. If you still have questions about your benefits after reviewing the website and these FAQs, please contact PeoplePlace at **844-417-5223**.

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ELIGIBILITY QUESTIONS

1. **Am I eligible for benefits?**
   Employees who meet the eligibility requirements below are eligible for coverage:
   - Full-time employees who work 30 or more hours per week
   - Part-time employees who work 20-29 hours per week

2. **Are PRNs eligible for any benefits?**
   PRNs are not eligible for benefits with the exception of a few programs. For a complete list of each benefit program and eligibility by status (full-time, part-time, PRN), view the Benefits Eligibility by Status.

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3. **Are my dependents eligible for benefits?**
   Spouses and children who meet the eligibility requirements below are eligible for coverage:
   - Spouse or common-law spouse
   - Your children or spouse's children up to the age of 26*, including:
     - Natural children
     - Step children
     - Legally adopted children
     - Children in the process of legal adoption
     - Foster children
     - Children covered by a Qualified Medical Child Support Orde
     - Children of whom you have legal guardianship

   Note: If you and a dependent both work for Baylor Scott & White, only one can be covered as a dependent.

   *Subject to approval, the age limit is waived if the child is unmarried, physically and mentally incapacitated and unable to earn an independent living; dependent on you for at least 50% of financial support; claimed by you as a dependent for federal taxes; and disabled and covered under the plan before age 26 (unless you are a new hire or newly benefit-eligible).

4. **Will I need to take any action to verify my dependents eligibility?**
   Yes, when you add new dependents to our benefit plans, you will receive a request from the Dependent Verification Center. This step is important to ensure your dependents remain.

   Documentation such as marriage certificates, birth certificates, legal guardianship paperwork and/or tax forms will be required. It is important to submit all requested documentation in a timely manner to ensure eligible dependents remain covered.

ENROLLMENTQUESTIONS

5. **How do I submit my enrollment?**
   Please follow the steps below to submit your enrollment:
   - Log into **MyPeoplePlace.com**
   - Click **Benefit Details** tile
   - Click **Benefits Enrollment**

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- Click **Start** to access your enrollment event
- Click each benefit tile to review and make your selections
- Click **Submit Enrollment** to finalize your choices

6. **Can I make changes if I've already submitted my enrollment?**
   Yes, you can make changes as long as you are still within 30 days of your hire date or date of benefit eligibility. To make changes, please contact PeoplePlace at **844-417-5223**.

7. **Can I make changes to my benefits later in the year?**
   Once you elect benefits, you are not able to make changes throughout the year unless you experience a qualifying life event—such as marriage, divorce, birth of a child, etc. You will have 30 days to submit a life event event in PeoplePlace > Benefit Details > Life Events.

8. **I already have benefits coverage elsewhere, do I need to take any action?**
   If you do not take any action, all benefits will be waived with the exception of short-term disability (STD). All employees are automatically enrolled in STD. If you wish to opt out, you must do so during your enrollment window by following the steps above.

   Note: If you opt out of STD when you are first eligible, future coverage may be subject to the pre-existing condition provision.

MEDICAL AND PHARMACY PLAN

9. **How do I know which medical plan is right for me?**
   Ask ALEX is a great resource to help decide which benefits are right for you. You can also use the Family Plan Comparison tools to compare your BSW benefits to your spouse's plan. Connect with ALEX by visiting **Start.MyALEX.com/bswh**.

   Alex can also be accessed via your mobile device, via ALEXGo!

10. **When should I expect to receive my new medical ID card?**
    Medical ID cards will be mailed to your home address (or mailing address if one is on file and it's different than yourhome address). The target date to have a medical ID card to you is within ___ of your enrollment. You can also access a temporary copy of your medical ID card by one of the following:

    1. **Log into the BSWHP Member Portal** at **BSWHealthPlan.com/BSWH** to request additional medical ID cards or print and save a temporary copy of your medical ID card. Employees may need to create an account if they are a new hire or have not set up a Member Portal account.

You can also view your medical ID card on MyBSWHealth app. To log in, use the same username and password you use for the BSWHP Member Portal.

2. Contact BSWHP Care Connect at **844-843-3229** to request additional ID cards.
3. **Access the myBSWHealth app**, scroll down to the Baylor Scott & White Health Plan tile and click on View Card.

UNDERSTANDING MEDICAL PLAN PREMIUMS

11. How is medical premium calculated?

Medical premiums are determined based on your hourly rate as of Sept. 24, 2023

12. Will my medical premiums go up if my salary changes or I receive a bonus?

Your hourly rate as of your hire date or transfer to a benefit-eligible position will be used to determine your medical premiums for 2024. Even if you have changes throughout the year (increases or decreases), your rate for medical coverage will stay the same. The only time your rate will change is if you go from full time to part time, or vice versa.

Note: Hourly rates are locked in as of Sept. 24, 2023 for those that were enrolled in medical in 2023.

FINDING AN IN-NETWORK PROVIDER OR PHARMACY

Depending on the plan you select, we offer medical and prescription coverage through three different Tiers. Watch the **Network Tiers video** for moredetails. You can find in-network providers by using the provider search tool at **BSWHealthPlan.com/BSWH**.

13. Are BSW facilities and affiliated entities covered under Tier 1 BSW Premier HMO network?

It is possible for a new hospital or entity to have BSWH in their name and not be part of Tier 1. Please reference the provider search tool at **BSWHealthPlan.com/BSWH** to confirm provider network status prior to accessing care.

14. Where can I find a list of providers?

A list of providers can be found in the provider search tool at **BSWHealthPlan.com/BSWH**. Search for different types of providers,such as:

- Primary care physicians (PCPs)
- Specialists
- Urgent Care
- Walk-in clinics
- Hospitals and facilities

- Pharmacies

15. **What should I do if my doctors show up in the provider search results but say they are not part of the network?**
    Your provider's office staff may not be aware they are part of the network for Baylor Scott & White medical plans — either through direct contracts with BSWHP or our Tier 2 UnitedHealthcare Options PPO network. If this situation arises with one of your doctors, please ask them to call Provider Services at **800-655-7947** to verify their network participation for Baylor Scott &White employee plan.

16. **What should I do if I am unable to find a specific specialist under the Find a Provider SEQA & EQA search tool?**
    Contact BSWHP Care Connect Center at **844-843-3229** and follow the prompts for Care Navigation for assistance. They can also help you schedule appointments.

17. **What happens if Care Navigation is unable to find an in-network provider for the specific specialist I need?**
    Ask your provider to submit a prior authorization request to BSWHP for their services to be considered at the in-network benefit level. The request will be evaluated, and a decision will be made upon completion of the review. Prior authorization must be obtained before services are covered.

18. **What if I have dependent children that live out of state?**
    Employees and dependents who live out of state or 40 or more miles from the nearest Tier 1 acute care hospital should consider either the PPO plan or HDHP) plan because of theirexpanded provider network. To find out if there are network providers who practice in the location where you or your dependent(s) live, check the provider search tool at **BSWHealthPlan.com/BSWH.**

19. **What is the out-of-area coverage for the PPO and HDHP plans?**
    Out-of-area coverage provides 80% of the coverage after the Tier 2 deductible has been met for employees, and dependents who live out of state or 40 or more miles from the nearest Tier 1 acute care hospital and visit Tier 2 providers for inpatient and outpatient care.
    - Employees and covered dependents that live out of state are automatically flagged for the out-of-area coverage – NO action Required!
    - Employees and dependents that live 40 or more miles from the nearest Tier 1 acute care hospital must contact BSWHP Care Connect Center at **844-843-3229** and request the out-of-area coverage prior to receiving care.

- If you or your dependent had the out-of-area coverage activated but no longer live out of state or 40 or more miles from a Tier 1 acute care hospital, contact BSWHP to deactivate this coverage.

20. Under the SEQA/EQA plans, are out-of-area dependents covered at all?

The only coverage available for out-of-area dependents would be for urgent and emergency care. If you have out-of-state dependents, you should consider the PPO or HDHP plans.

21. What access to coverage do we have for travel outside of Texas or outside of the country?

If you are traveling out of state and need emergency care, your member cost share will be based on the plan you decide to enroll in. For the SEQA, your copay is $250 + 10% coinsurance, EQA is $300 copay + 10% coinsurance, PPO is $350 + 10% coinsurance and HDHP is 10% coinsurance after deductible is met. If you are admitted, the copay + coinsurance under the SEQA, EQA and PPO will be waived, and if you are enrolled in the PPO the applicable inpatient benefit will apply based on the facility network status.

For example, under the PPO and HDHP plans, if the facility is Tier 2, the Tier 2 inpatient benefit will apply. If the facility isTier 3, inpatient services will be paid at the Tier 2 benefit level. Coverage for out of the country is only available for emergency services and the benefit is the same as in-country services based on the plan you elect for 2024.

22. Are any resources available to help me decide if an appointment with my PCP, urgent care, or an emergency room visit is best for my symptoms?

Check out **Where to go for care** or the 24/7 Nurse Line is available to help patients make informed health care decisions. To talk to a nurse, call Care Connect at **844-843-3229** and follow the prompts to the Nurse Line.

23. When I need urgent care, which facilities are covered by our plan?

Under the SEQA/EQA plans urgent care is covered at the applicable copay no matter what urgent care center you go to. For our PPO and HDHP plans, our provider networks include many urgent care locations in the Tier 1 BSW Premier HMO Network and Tier 2 UnitedHealthcare Options PPO Network. Tier 1 Network urgent care locations include Concentra, City Doc, Cook Children's Urgent Care, Legacy Urgent Care, NextCare Urgent Care, etc. We are continuing to review and expand our urgent care network as needed.

Please use the provider search tool at **BSWHealthPlan.com/BSWH** for a complete list.

24. What is the coverage if I use of a non-contracted urgent care provider?

If you elect the SEQA or EQA plan, you are only responsible for paying the applicable Tier 1 copay. If you elect the PPO or HDHP plan, the benefit is the same as the plan's Tier 2 cost.

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Please visit the benefits website at **BSWHealth.com/Benefits** for complete details about your coverage and cost under each plan.

25. Where can I find a list of contracted pharmacies?

Please visit the provider search tool at **BSWHealthPlan.com/BSWH** for a list of contracted pharmacies under each plan. Your member cost share for prescriptions filled at non-BSW pharmacies is higher and will depend on the type of medication you are prescribed (e.g., preferred generic, preferred brand, etc.) and the plan you elect for 2024.

Please visit **BSWHealth.com/Benefits** for complete details about your prescription coverage under each plan option.

UNDERSTANDING MEDICAL COVERAGE AND PROCEDURE COSTS

26. What is a deductible?

A deductible is the amount you pay for covered services before the plan starts to pay.

27. What is coinsurance?

After the deductible is met, you and the plan share the cost of a covered service. This is called coinsurance. Percentages may vary by service and network tier.

28. What is a copay?

A copayment — or "copay" — is a flat fee per visit that you pay for a medical or pharmacy service. The plan pays the rest of the cost.

29. What is an out-of-pocket maximum?

The out-of-pocket maximum is the most you will pay for eligible Tier 1 or Tier 2 healthcare and pharmacy expenses, including your deductible and coinsurance, in a plan year.

30. What is prior authorization?

The prior authorization process requires your physician, or any other health care provider, to secure pre-approval for certain procedures, services, or mediations to determine medical necessity and ensure the request is appropriate.

31. How can I find out what costs count toward my deductible and out-of-pocket expenses?

This information is available in the Summary Plan Description and can be found at **BSWHealth.com/Benefits**.

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32. **What number should I contact with questions about medical claims, prior authorization, and coverage?**
    Please call BSWHP Care Connect Center at **844-843-3229** between 7 a.m. and 7 p.m. CT, Monday - Friday. The customer advocates can answer a wide range of questions and check with a subject matter expert on questions they can't resolve.

33. **Where can I find a list of what services are subject to prior authorization? Is this my responsibility or my provider's responsibility?**
    The prior authorization list can be found at **BSWHealthPlan.com/BSWH** under Tools and Resources. It is the provider's responsibility to handle the prior authorization process, but you should confirm your provider has approval on file before you receive care for services that require prior authorization.

34. **On the Medical Plan Coverage and Costs, it only provides Employee Only and Employee + Family options. Is there an annual deductible specific to Employee + Spouse or Children?**
    No, the deductible is the same as Employee + Family. The SEQA, EQA and PPO plans have embedded deductibles, which means the plan provides after-deductible coverage once an individual with family coverage meets the individual deductible, even if the family deductible has not been met. Note: This does not apply to the HDHP plan.

35. **I am a remote employee working out of state. Can I use virtual appointments through the BSWH app?**
    You may be able to use the MyBSWHealth virtual care option, but due to clinical licensing requirements, clinicians may not be able to send a prescription out-of-state, if needed.

36. **How are emergency transportation services covered?**
    Emergency transportation services are covered at 100% after the applicable member cost sharing for the SEQA, EQA and PPO plans. Under the HDHP plan, emergency transportation services are covered at 90% after the deductible is met. Refer to the coverage and cost chart for details.

37. **Are lab costs covered at 100% under preventive care?**
    If the labs are deemed preventive, billed as preventive and sent to an in-network lab, they will be covered at 100%.

38. **What is the maternity coverage under each plan?**
    The SEQA/EQA and PPO plans offer a bundled maternity copay* which provides the following coverage:

- **SEQA/EQA Plan:** $400 copay for all expenses related to maternity/delivery care, including pre-natal and well-baby charges, if newborn is added to the plan for coverage within 30 days of birth.
- **PPO Plan:** $1,200 copay (Tier 1 only) for all expenses related to maternity/delivery care, including pre-natal and well-baby charges, if newborn is added to the plan for coverage.
  - **HDHP plan:** Does not offer the bundled maternity copay. Maternity coverage for Tier 1 providers is at 10% after the deductible is met.

**Copay applies to the facility claim. All other services billed with a maternity/delivery diagnosis code will be paid at 100%, including pre-natal services and well-baby charges. Newborns must be added to the medical plan within 30 days of birth for well-baby charges to be covered.*

39. What happens to my spouse's medical insurance coverage when he or she turns 65 and is eligible for Medicare?

We do not have a requirement that states your spouse must be removed from the plan. You may continue to cover them on your plan even though they are eligible and may be enrolled in Medicare.

UNDERSTANDING PHARMACY COVERAGE

40. Is there an additional cost to use non-BSW pharmacies?

Yes. Your member cost share for prescriptions filled at non-BSW pharmacies is higher and will depend on the type of medication you are prescribed (e.g., preferred generic, preferred brand, etc.) and the plan you elect for 2024. Please visit **BSWHealth.com/Benefits** for complete details about your prescription coverage and cost under each plan option.

41. What is the Member Choice Program?

The Member Choice program encourages members and providers to make more cost-effective medication choices. With this program, if you or your provider request a brand name drug when a generic equivalent is available, you become responsible for the non-preferred co-pay plus the difference in cost between the brand name and the generic equivalent. Please note the difference in cost does not apply to any deductible or out-of-pocket maximum for the Plan.

42. Are prescriptions applied to the deductible on all plans?

Prescriptions are not subject to the deductible for the SEQA, EQA and PPO plans, except for the EQA and PPO non-preferred brand and generic at contracted pharmacies, which have $100 individual deductible. Under the HDHP plans, all prescriptions apply to the deductible and coinsurance.

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SPENDING / SAVINGS ACCOUNT QUESTIONS

43. If I enroll in a 2024 Flexible Spending Account (FSA), what is the timeframe to use my funds?
FSA funds can be used to pay for eligible expenses incurred between Jan 1, 2024 – Mar. 15, 2025.

44. When can I use my FSA funds?
Healthcare FSA funds are available to use at the start of the plan year and you can use the entire amount right away.However, you must incur eligible expenses through Mar. 15, 2025.

45. What happens if I have remaining funds after Mar. 15, 2025, in my account?
You can continue to submit eligible expenses incurred by Mar. 15 through Apr. 30, 2025.

46. Do I have to be enrolled in a BSW medical plan to enroll in the healthcare Flexible Spending Account (FSA)?
You can still participate in the healthcare or dependent care FSA even if you are not enrolled in a BSW medical plan.

47. How do I pay for items from my FSA/HSA account (i.e., card, reimbursement, etc.)?
Under the HDHP and Health care FSA, you have the following reimbursement and payment options:

- Use your Optum debit card, an electronic payment card, to pay some expenses
- Pay out of pocket for an expense and request a reimbursement online or through the Optum mobile app

48. Will I receive a new Optum Bank debit card if I already have one from last year?
New enrollees and those who have a card that is expiring will receive a debit card.

49. What are the maximum contributions for the FSA and HDHP for 2024? The maximum contributions for 2024 are:

- Healthcare FSA – $3,050
- Dependent care FSA – $5,000
- HSA individual coverage – $4,150
- HSA family coverage – $8,300

50. When can I use my funds if I elect the dependent care FSA?
Your funds are available after your contribution has been applied to your account. For daycares that accept credit cards, you can use your Optum card to pay for eligible expenses.

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51. Are my Health Savings Account (HSA) funds available to use immediately?
Your funds are available to you after your contribution has been applied to your account.

52. Am I able to update my HSA contribution amount throughout the year?
Yes, you can update your HSA contribution anytime throughout the year by going to **Request Help**.

53. Am I able to contribute to an HSA if I am enrolled in Medicare?
No, you cannot contribute to an HSA if you are enrolled in Medicare.

54. Am I able to update my FSA contribution amount throughout the year?
Employees can change their elected amount only within 30 days of a qualifying life event.

DENTAL AND VISION PLAN QUESTIONS

UNDERSTANDING YOUR DENTAL COVERAGE

55. Will I receive dental ID cards?
You can access your dental card by visiting MyCigna.com or downloading the myCigna app. Note: First-time users will need to select “Register Now” and enter the requested information, confirm identify and create security information. However, an ID card is not necessary to access your dental benefits. Your dental office can verify your eligibility and benefits by contacting Cigna at **877-505-5872** and providing your name, date of birth, and employee ID number or social security number.

Your employee ID number can be found on your paycheck in PeoplePlace.

56. How can I find a dental provider in my area?
To locate dental providers in the Cigna network, click on the applicable plan below. Enter your ZIP code and search by Type, Name or Health Facility.

- **Search DHMO/Access Plus Network**
- **Search Choice/Cigna DPPO Network**

57. What are the benefits maximums for each of the dental plans with Cigna?
The annual maximum benefit is:

- DHMO Plan – There is no maximum benefit
- Choice Plan – $1,250 per person
- Choice Plus Plan – $2,500 per person

58. Is there a maximum age for orthodontia on the DHMO or Choice Plus plan?
Orthodontia is offered to both children and adults on the DHMO and Choice Plus plan.

59. Is there a maximum benefit orthodontia on the DHMO or Choice Plus plan?
The maximum benefit is:
- DHMO Plan – $1,608 (child) and $2,592 (adult) up to 24 months
- Choice Plus Plan – $2,000 lifetime maximum benefit

60. How are dental implants covered?
Implants are covered as a major service.
- DHMO Plan – Cost can range, please reference the Fee Schedule for cost.
- Choice Plus Plan – Your deductible would apply first, then the plan would pay 50%. The cost would apply to the annual maximum

UNDERSTANDING YOUR VISION COVERAGE

61. Will I receive a new ID card for vision?
New enrollees will receive an ID card from EyeMed. The goal is to have this to you no later than Jan. 1. If you werepreviously enrolled in the vision plan, you will not receive a new ID card. You can also print an ID card through the EyeMed app or by visiting **EyeMed.com**, logging in and selecting Help and Resources.

62. What is covered with EyeMed?
Visit **BSWHealth.com/Benefits** for more details on what is covered by the vision plan, and a list of providers thataccept EyeMed.

63. What local optometrists can we access with EyeMed?
Visit **EyeMed.com** to locate a provider in your area.

SUPPLEMENTAL BENEFITS

UNDERSTANDING CRITICAL ILLNESS, ACCIDENTAL INJURY AND HOSPITAL CARE PLANS

64. What is the accidental injury plan?
Accidental Injury insurance pays a fixed cash benefit directly to you when you have a covered accident like a fracture or dislocation. A schedule of benefits is used to determine how much you

receive and items covered include doctor and emergency room visits, x-rays and hospital stays. These payments can be used to cover things like co-pays and deductibles, groceries and childcare.

65. What is the critical illness plan?

If you're diagnosed with a covered critical illness, like cancer or a heart attack, your lump sum benefit can be used as you wish, to cover expenses like rent or transportation while you focus on getting well. This plan is a guarantee issue and no medical questions are required.

66. What is the hospital care plan?

If you are hospitalized after your coverage effective date, you will receive a fixed benefit admission and daily benefit after a qualified hospitalization, including childbirth on day 1. Use it for medical copays and deductibles, travel to see a specialist, childcare, help around the house, alternative treatments and more.

67. What accidents or injuries are covered on the accidental injury insurance?

Visit the Summary of Benefits on **BSWHealth.com/Benefits** for a complete list of covered accidents/injuries.

68. What illnesses are covered on the critical illness insurance?

Visit the Summary of Benefits on **BSWHealth.com/Benefits** for a complete list of covered illnesses.

69. What is covered with the hospital care insurance?

Visit the Summary of Benefits on **BSWHealth.com/Benefits** for a complete list of covered illnesses.

70. Are there pre-existing condition limitations?

Benefits would not be payable for any condition that was diagnosed or treated prior to the coverage effective date. For the hospital care plan, hospitalization associated with childbirth that occurs after the effective date will be covered.

71. Is there a benefit waiting period?

No, there is no benefit waiting period.

72. What is the wellness benefit?

A $50 wellness benefit is available for each covered person on the accidental injury and critical illness plan if a covered health screening is performed (i.e. annual check-up, colonoscopy, mammogram, vaccinations, etc.).

73. How often can a covered person be paid a benefit for the Health Screening Benefit or Wellness Benefit under these plans?
The benefit is payable one time per covered person per calendar year. **Note:** If you are enrolled in the accidental injury and critical illness plans, you can receive this benefit under both plans.

74. Can I waive coverage and still enroll dependents into these plans?
No, employee coverage must be issued for dependent spouse and/or child coverage to become effective.

75. Do I need to be enrolled in the medical plan to elect accidental injury, critical illness or hospital care plan?
No, these plans do not replace medical insurance, they are supplements to your existing medical coverage, however you do not have to elect a medical plan through BSWH to enroll in these benefits.

UNDERSTANDING SHORT- AND LONG-TERM DISABILITY, LIFE AND AD&D COVERAGE

76. What is short-term disability (STD)?
STD coverage provides income replacement if you suffer a non-work-related injury, illness or pregnancy that prevents you from working. STD benefits are payable for up to 180 calendar days as long as you continue to be disabled.

77. Do I need to be enrolled in STD coverage to receive parental leave benefits?
Yes, you must be enrolled in STD to receive maternity, non-birthing parent or adoption leave benefits.

78. How much coverage does STD provide?
STD provides a base coverage of 60% with the option to buy-up coverage to 70%. Note: Depending on your role, additional plan options may be available.

79. Are preexisting conditions covered on the short-term disability (STD) plan?
If you waive coverage during your initial eligibility and elect it later either during annual enrollment of if you experience a life event, you will be subject to the pre-existing condition exclusion which states: If you've been diagnosed, treated or received medical advice for a condition (including pregnancy) within three months of your effective date on the plan, that condition will be excluded for a period of 12 months.

80. If I waive short-term disability coverage now and opt to enroll later, such as during annual enrollment, will the preexisting condition provision apply?

Yes, if you waive short-term disability during your initial eligibility and elect to enroll later, the preexisting condition provision would apply.

81. What is long-term disability (LTD)?

LTD coverage provides income replacement benefits if you are still disabled from an occupational or non-occupational illness or injury after the later of 180 days or the end of the STD benefit. Basic LTD coverage is provided to you at no cost with the option to buy-up coverage.

82. Does the long-term disability (LTD) plan have a limit for how long the benefit is paid?

LTD will continue to make payments up until Social Security retirement age if someone continues to meet the definitionof disabled under the plan.

83. Will my premiums for STD, LTD, Life and AD&D change throughout the year if my salary changes?

Yes, your premiums for STD, LTD, Life and AD&D may adjust throughout the year if your salary changes.

84. While submitting my enrollment, I received a warning message about evidence of insurability for life insurance. Am I required to do anything?

Yes, you are required to submit a completed evidence of insurability (EOI). Shortly after your enrollment, you will receive an email from New York Life with instructions. For questions about the EOI form, contact New York Life at **800-362-4462**.

85. What is evidence of insurability (EOI)?

Evidence of insurability (EOI) is an application process in which you provide information on the condition of your health or your dependent's health to be considered for certain types of insurance coverage.

86. When am I required to submit EOI?

Employees and spouses may elect coverage up to the guarantee issue amount without any medical underwriting, or evidence of insurability. The guarantee issue amounts are:

- Three times salary (up to $1 million) for employees
- $75,000 for spouses

For questions about the EOI form, contact New York Life at **800-362-4462**.