CENTER ISD

BENEFIT GUIDE

WWW.MYBENEFITSHUB.COM/CENTERISD

PLAN YEAR: 2022-2023

HOW TO LOG IN

1 VISIT WWW.MYBENEFITSHUB.COM/CENTERISD

2 CLICK **LOGIN**

3 ENTER USERNAME & PASSWORD

All login credentials have been RESET to the default described below:

Username: the first six (6) characters of your last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

Default Password: last name (excluding punctuation) followed by the last four (4) digits of your Social Security Number.

mybenefitsaide

Powered by MGM Benefits Group

Everyone can relate to the stress that comes with a trip to the doctor. And during open enrollment. And trying to find our insurance cards, or remembering our family's allergies... it can be a lot to handle!

That's why we created **MyBenefitsAide** – your solution to all things insurance and employee benefits.

MyBenefitsAide is an all-in-one app that you now have access to as a part of your benefits, giving you an extra hand when you need it. It doesn't matter if it's during open enrollment, in the waiting room at the doctor's office, or when you're just looking to kill a couple of minutes! It's always a great time to call in backup in the form of **MyBenefitsAide:**

When you're at the doctor...

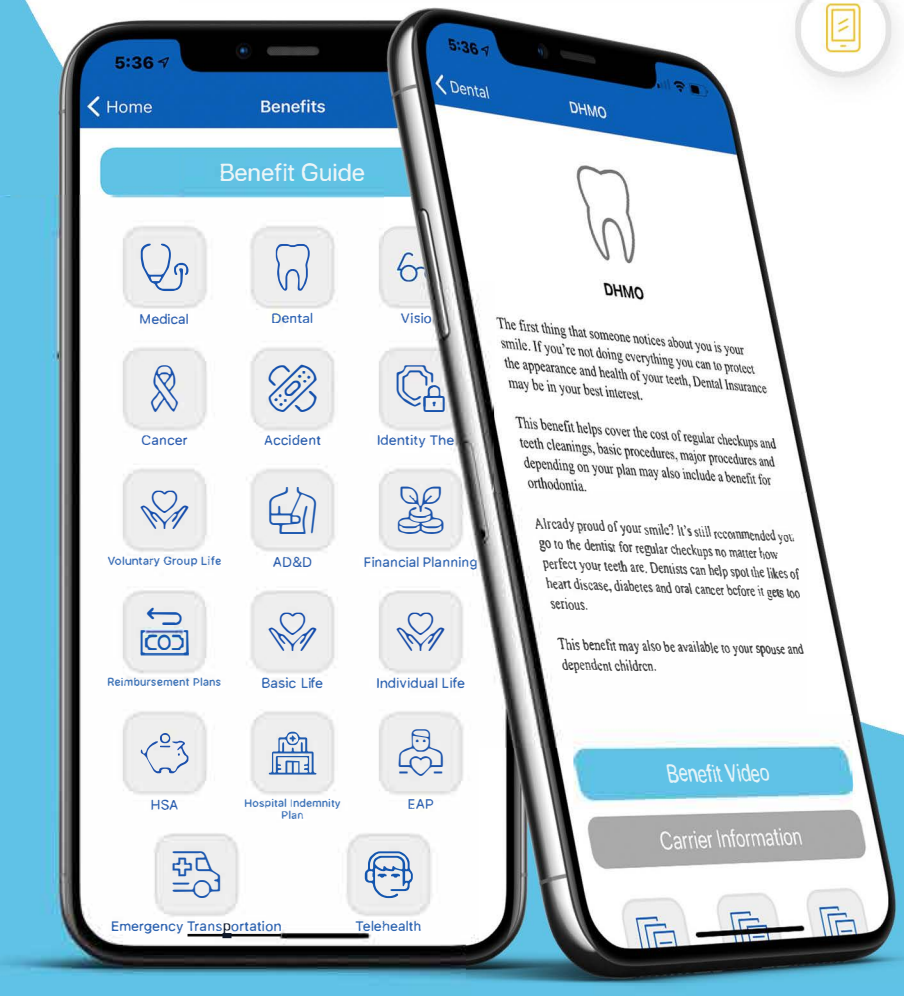
It's easy to get stressed at the doctor's office. Having to pull up your blood type, your family's allergies, or your insurance card at a moment's notice is nerve-racking!

MyBenefitsAide packs features that keep all that information, and more, in one app. This way, you don't have to worry about the stress affecting your blood pressure!

When you have a question...

Have you ever had a question about your benefits or insurance policy but you're not sure who to reach out to?

MyBenefitsAide keeps all your important contact information in one place! Reach out to your broker, plan administrator, carrier, and more! It's like a Contact List inside your app.



When you've got some free time...

Let's face it: Employees don't spend enough time learning about their benefits offering. There's a reason why so many people enroll in the same benefits year after year without thinking twice – it's stressful learning about these benefits!

MyBenefitsAide makes learning about your offering fast and easy with animated videos that you can watch in five minutes or less.

Employees typically spend just 33 minutes on their enrollment[1]. **The thing is, life happens year-round, not just during open enrollment.**

Download from your device's app store and get started today!

Your group number:

TAFG4

Available on the App Store

GET IT ON Google Play

MGM BENEFITS GROUP

GENERAL INFORMATION

Center Independent School District offers a wide range of benefits to eligible employees and their family members. All new or newly eligible employees will go online to enroll in benefits . The district benefit site contains all plan summaries, rate summaries, claim forms and additional product information for employees to access online. Employees are encouraged to browse the plan information provided on the benefit site prior to enrolling. The Advanced Financial Group is the Third-Party Administrator for the district's supplemental benefits and will be assisting on site during the open enrollment period. The annual open enrollment period ends Thursday August 18th. The plan options and coverage levels you select for the plan year will remain in effect from September 1, 2022 through August 31, 2023.

New or newly eligible employees will have 31 days from their hire date to complete their enrollment. Failure to enroll within 31 days could result in exclusion from benefits. Employees will be required to provide the name, date of birth and social security number for any dependents (this includes spouse).

MAKING CHANGES/SPECIAL ENROLLMENT EVENTS

After the initial open enrollment period, you can only add or change coverage during the year if you have a Qualified Family Status Change/Special Enrollment event such as: Marriage, Divorce, Birth or adoption, Death, Court Order (child(ren) coverage only), or if a spouse gains or loses employment. You must submit all the required documentation to the district administrators and make your plan changes within 31 days from the date of the event. If you do not request the appropriate changes during the applicable special enrollment period, the changes cannot be made until the next plan enrollment period or, if applicable, until another special enrollment event occurs.

ALL CURRENT BENEFIT ELECTIONS WILL BE ROLLED FORWARD WITH THE EXCEPTION OF FSA. FLEXIBLE SPENDING ACCOUNT ANNUAL AMOUNTS MUST BE ENTERED EACH YEAR. WE HIGHLY ENCOURAGE EMPLOYEES TO LOGIN AND REVIEW BENEFITS AND BENEFICIARIES.

2022-23 HIGHLIGHTS

MEDICAL/ FSA CHANGES FOR THE 2022-23 PLAN YEAR

-Blue Cross Blue Shield of Texas will continue to be the plan administrator for the health insurance offering for TRS ActiveCare members. Please use the online provider search at TRS ActiveCare Blue Cross to learn more about your network options and plan design. Region 7 ESC schools will see a reduced cost on most plans and tiers.

-The FSA maximum annual limit for 2022 is $2850. The carryover amount for unused funds remains $550. You MUST login to elect/update this benefit.

UPDATES/REMINDERS

-New Dental Carrier- Cigna. Same rates/ plan design/ plan year limits. Full open enrollment this year. Existing employees who do not participate this year but join the plan later will have a late entrant provision starting in 2023-24 (see dental plan summary for details).

-Improved Health Screening Benefit/Accident Prevention Benefit on The Hartford products (Critical Illness/Accident/Hospital Indemnity).

-APL Cancer- added benefits, lower cost.

-CISD provides all full time employees with a $10,000 life insurance policy. Please make sure you have named/updated the beneficiary for this policy inside the benefit system.

-If you have had a qualifying event or plan change during the last year please login and actively enroll in benefits for the 2022-23 plan year. If you have had a change of address, contact information, dependent changes, or need to change beneficiary's please login to make updates.

LOCAL HEALTH CARE. TEXAS-SIZED BENEFITS.

TRS-ActiveCare Plan Highlights 2022-23

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

From the North Texas plains to the Gulf Coast, TRS-ActiveCare is where you live and work. We have more Texas doctors than any other plan and more ways to make your health plan *yours*.

Learn the terms.

- **Premium:** The monthly amount you pay for health care coverage.
- **Deductible:** The annual amount for medical expenses you're responsible to pay before your plan begins to pay its portion.
- **Copay:** The set amount you pay for a covered service at the time you receive it. The amount can vary by the type of service.
- **Coinsurance:** The portion you're required to pay for services after you meet your deductible. It's often a specified percentage of the costs; i.e. you pay 20% while the health care plan pays 80%.
- **Out-of-Pocket Maximum:** The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services.

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The district contributes $300 to all plans. "Your Premium" will be the total premium minus the district contribution.

2022-23 TRS-ActiveCare Plan Highlights Sept. 1, 2022 – Aug. 31, 2023

TRS ActiveCare
Teacher Retirement System of Texas

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your District and State Contributions
= **Your Premium**

Ask your Benefits Administrator for your district's specific premiums.

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia™ pregnancy support
- TRS Virtual Health
- Mental health benefits
- And much more!

**Available for all plans.*
See the benefits guide for more details.

Things to Know

- TRS's Texas-sized purchasing power enables access to broad networks without county boundaries.
- Specialty drug insurance means you're covered, no matter what life throws at you.

All TRS-ActiveCare participants have **three plan options**. Each includes a wide range of wellness benefits.

	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD
Plan Summary	• Lowest premium of all three plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider (PCP) referrals required to see specialists • Not compatible with a Health Savings Account (HSA) • No out-of-network coverage	• Lower deductible than the HD and Primary plans • Copays for many services and drugs • Higher premium • Statewide network • PCP referrals required to see specialists • Not compatible with a Health Savings Account (HSA) • No out-of-network coverage	• Compatible with a Health Savings Account (HSA) • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet your deductible before plan pays for non-preventive care

Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$408	$	$513	$	$423	$
Employee and Spouse	$1,151	$	$1,254	$	$1,189	$
Employee and Children	$734	$	$825	$	$759	$
Employee and Family	$1,378	$	$1,577	$	$1,422	$

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network Coverage Only	In-Network	Out-of-Network
Individual/Family Deductible	$2,500/$5,000	$1,200/$3,600	$3,000/$6,000	$5,500/$11,000
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
Individual/Family Maximum Out of Pocket	$8,150/$16,300	$6,900/$13,800	$7,050/$14,100	$20,250/$40,500
Network	Statewide Network	Statewide Network	Nationwide Network	
PCP Required	Yes	Yes	No	

Doctor Visits				
Primary Care	$30 copay	$30 copay	You pay 30% after deductible	You pay 50% after deductible
Specialist	$70 copay	$70 copay	You pay 30% after deductible	You pay 50% after deductible

Immediate Care				
Urgent Care	$50 copay	$50 copay	You pay 30% after deductible	You pay 50% after deductible
Emergency Care	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	
TRS Virtual Health-RediMD (TM)	$0 per medical consultation	$0 per medical consultation	$30 per medical consultation	
TRS Virtual Health-Teladoc®	$12 per medical consultation	$12 per medical consultation	$42 per medical consultation	

Prescription Drugs			
Drug Deductible	Integrated with medical	$200 brand deductible	Integrated with medical
Generics (30-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics
Preferred Brand	You pay 30% after deductible	You pay 25% after deductible	You pay 25% after deductible
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty	$0 if PrudentRx eligible; You pay 30% after deductible	$0 if PrudentRx eligible; You pay 30% after deductible	You pay 20% after deductible
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61-90 day supply	$25 copay for 31-day supply; $75 for 61-90 day supply	You pay 25% after deductible

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in plan • Lower deductible • Copays for many services and drugs • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals

Total Premium	Your Premium
$1,013	$
$2,402	$
$1,507	$
$2,841	$

In-Network	Out-of-Network
$1,000/$3,000	$2,000/$6,000
You pay 20% after deductible	You pay 40% after deductible
$7,900/$15,800	$23,700/$47,400
Nationwide Network	
No	

$30 copay	You pay 40% after deductible
$70 copay	You pay 40% after deductible

$50 copay	You pay 40% after deductible
You pay a $250 copay plus 20% after deductible	
$0 per medical consultation	
$12 per medical consultation	

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
$0 if PrudentRx eligible; You pay 30% after deductible ($200 min/$900 max)/ No 90-day supply of specialty medications
$25 copay for 31-day supply; $75 for 61-90 day supply

What's New and What's Changing

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

This table shows you the changes between 2021-22 statewide premium price and this year's 2022-23 regional price for your Education Service Center.

		2021-22 Total Premium	New 2022-23 Total Premium	Change in Dollar Amount	Key Plan Changes
TRS-ActiveCare Primary	Employee Only	$417	$408	**($9)**	• Member Rewards was expanded to include more than 100 new procedures • Copay for Teladoc® rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply
	Employee and Spouse	$1,176	$1,151	**($25)**	
	Employee and Children	$751	$734	**($17)**	
	Employee and Family	$1,405	$1,378	**($27)**	
TRS-ActiveCare HD	Employee Only	$429	$423	**($6)**	• In-network maximum rose by $50/individual; $100/families • The Member Rewards program is now available for HD participants - Rewards are paid through a limited-purpose Health Care Account (HCA) and can be used toward dental and vision expenses • Consult fee for Teladoc rose from $30 to $42
	Employee and Spouse	$1,209	$1,189	**($20)**	
	Employee and Children	$772	$759	**($13)**	
	Employee and Family	$1,445	$1,422	**($23)**	
TRS-ActiveCare Primary+	Employee Only	$542	$513	**($29)**	• Member Rewards was expanded to include more than 100 new procedures • Copay for Teladoc rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply
	Employee and Spouse	$1,334	$1,254	**($80)**	
	Employee and Children	$879	$825	**($54)**	
	Employee and Family	$1,675	$1,577	**($98)**	
TRS-ActiveCare 2 (closed to new enrollees)	Employee Only	$1,013	$1,013	**$0**	• Copay for Teladoc rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply • This plan is still closed to new enrollees
	Employee and Spouse	$2,402	$2,402	**$0**	
	Employee and Children	$1,507	$1,507	**$0**	
	Employee and Family	$2,841	$2,841	**$0**	

At a Glance

	Primary	HD	Primary+
Premiums	Lowest	Lower	Higher
Deductible	Mid-range	High	Low
Copays	Yes	No	Yes
Network	Statewide network	Nationwide network	Statewide network
PCP Required?	Yes	No	Yes
HSA-eligible?	No	Yes	No

Effective: Sept. 1, 2022

Compare Prices for Common Medical Services

REMEMBER: Log into Blue Access for Members℠ at **www.bcbstx.com/trsactivecare** to use the cost estimator tool. This will help you find the best prices through different providers.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs*	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient Hospital Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility per day maximum)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$30 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

Pre-certification for genetic and specialty testing may apply. Contact a Personal Health Guide at **1-866-355-5999 with questions.*

www.trs.texas.gov

Revised 05/03/22

ACCIDENT INSURANCE

ABOUT THIS BENEFIT:

Accidents are nearly impossible to predict, but with accident insurance they're easy to prepare for. Accident Insurance allows you to concentrate on your health instead of your finances by issuing a lump-sum benefit when you suffer a covered accident.

LEARN MORE

While prices vary, the average cost of a trip to the emergency room will run you $1,233[1]. You can use this money to help pay toward your emergency room fees, co-pays, and hospital bills.

[1]2013 National Institute of Health

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Nearly 3 million emergency department visits every year are caused by youth sports.[1]

The Advanced Financial Block

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Accident insurance, visit
thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		
Coverage Type		Off-job only
BENEFITS		
EMERGENCY, HOSPITAL & TREATMENT CARE		
Accident Follow-Up	Up to 3 visits per accident	$100
Accident Prevention Benefit	Once per year for each covered person	$100
Acupuncture/Chiropractic Care/PT	Up to 10 visits each per accident	Up to $60
Ambulance – Air	Once per accident	$600
Ambulance – Ground	Once per accident	$200
Blood/Plasma/Platelets	Once per accident	$600
Child Care	Up to 30 days per accident while insured is confined	$25
Daily Hospital Confinement	Up to 365 days per lifetime	$200
Daily ICU Confinement	Up to 30 days per accident	$400
Diagnostic Exam	Once per accident	$100
Emergency Dental	Once per accident	Up to $150
Emergency Room	Once per accident	$200
Hospital Admission	Once per accident	$1,000
Initial Physician Office Visit	Once per accident	$100
Lodging	Up to 30 nights per lifetime	$200
Medical Appliance	Once per accident	$250
Rehabilitation Facility	Up to 15 days per lifetime	$200
Transportation	Up to 3 trips per accident	$400
Urgent Care	Once per accident	$100
X-ray	Once per accident	$200
SPECIFIED INJURY & SURGERY		
Abdominal/Thoracic Surgery	Once per accident	$2,000
Arthroscopic Surgery	Once per accident	$300
Burn	Once per accident	$1,000
Burn – Skin Graft	Once per accident for third degree burn(s)	50% of burn benefit
Concussion	Up to 3 per year	$300
Dislocation	Once per joint per lifetime	Up to $8,000
Eye Injury	Once per accident	Up to $200

Fracture	Once per bone per accident	Up to $8,000
Hernia Repair	Once per accident	$100
Joint Replacement	Once per accident	$1,500
Knee Cartilage	Once per accident	Up to $1,000
Laceration	Once per accident	Up to $200
Ruptured Disc	Once per accident	$1,000
Tendon/Ligament/Rotator Cuff	Once per accident	Up to $1,500
CATASTROPHIC		
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$40,000
Common Carrier Death	Within 90 days	5 times death benefit
Coma	Once per accident	$20,000
Dismemberment	Once per accident	Up to $40,000
Home Health Care	Up to 30 days per accident	$50
Paralysis	Once per accident	Up to $30,000
Prosthesis	Once per accident	Up to $2,000
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included

PREMIUMS

The amounts shown are monthly amounts (12 payments/deductions per year):[4]

COVERAGE TIER	
Employee Only	**$12.59** ($0.41 per day)
Employee & Spouse/Partner	**$19.42** ($0.64 per day)
Employee & Child(ren)	**$24.00** ($0.79 per day)
Employee & Family	**$31.79** ($1.05 per day)

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 15 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to “spouse” in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family’s health. All you have to do is elect the coverage to become insured.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided above. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don’t have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

CRITICAL ILLNESS

ABOUT THIS BENEFIT:

Critical illness insurance is a policy that provides a lump-sum benefit when you are diagnosed with a covered critical illness like a heart-attack, stroke, and other serious conditions – even cancer if it's included in your policy.

This money can be used for anything from minimizing out of pocket costs to other expenses like your mortgage, groceries, or what your medical plan doesn't cover.

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

In the US, an estimated 40 out of 100 men and 39 out of 100 women will develop cancer during their lifetime.[1]

The Advanced Financial Block

Facing a serious illness can be challenging both emotionally and financially. Major medical insurance may pick up most of the tab, but can still leave out-of-pocket expenses that add up quickly. Critical Illness insurance can provide a lump-sum benefit upon diagnosis of a covered illness that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Critical Illness insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

Benefit amounts for covered illnesses are based on the coverage amount in effect for you or an insured dependent at the time of diagnosis.

COVERAGE AMOUNT	
Employee Coverage Amount	$10,000 or $20,000
Spouse Coverage Amount	50% of your coverage amount
Child(ren) Coverage Amount	50% of your coverage amount
COVERED ILLNESSES	**BENEFIT AMOUNTS**
VASCULAR CONDITIONS	
Heart Attack (Myocardial Infarction)*; Heart Failure/Transplant*; Stroke*	100% of coverage amount
Aneurysm; Angioplasty/Stent; Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
Coma*; End Stage Renal Failure; Loss of Hearing; Loss of Speech; Loss of Vision; Major Organ Failure Transplant*; Paralysis	100% of coverage amount
Bone Marrow Transplant; Other Dread Diseases†	25% of coverage amount
NEUROLOGICAL CONDITIONS	
Advanced Multiple Sclerosis; Advanced Parkinson's; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	100% of coverage amount
CHILD CONDITIONS	
Cerebral Palsy; Congenital Heart Disease; Cystic Fibrosis; Muscular Dystrophy; Spina Bifida;	100% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount
Transportation	$100 per trip up to 5 trips
Lodging	$100 per night up to 5 nights
Health Screening Benefit	$75 once per year per covered person
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured & Spouse	500% of coverage amount
Coverage Maximum – Child(ren)	300% of coverage amount
Ability Assist® EAP[3]– 24/7/365 access to help for financial, legal or emotional issues	
HealthChampion[SM4] – Administrative and clinical support following serious illness or injury	

†Other Dread Disease means a covered severe disease that results in a covered person being confined to a Hospital for five (5) or more consecutive days. Covered severe diseases are: Addison's disease (primary adrenal insufficiency/hypocortisolism); bacterial cerebrospinal meningitis; COVID-19, formally SARS-CoV-2/2019-nCoV; diphtheria; encephalitis; Huntington's chorea; Legionnaire's disease; malaria; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus

Premium Worksheet

Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY CRITICAL ILLNESS INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit Amount	Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$10,000	Employee Only	$2.49	$2.49	$4.73	$4.73	$10.87	$10.87	$21.23	$21.23	$39.54	$39.54	$49.92	$49.92
	Employee & Spouse/Partner	$4.33	$4.33	$7.88	$7.88	$17.64	$17.64	$33.93	$33.93	$62.13	$62.13	$77.70	$77.70
	Employee & Child(ren)	$4.68	$4.68	$6.94	$6.94	$13.10	$13.10	$23.46	$23.46	$41.75	$41.75	$52.01	$52.01
	Employee & Family	$6.93	$6.93	$10.51	$10.51	$20.27	$20.27	$36.55	$36.55	$64.71	$64.71	$80.14	$80.14
$20,000	Employee Only	$3.78	$3.78	$8.10	$8.10	$20.08	$20.08	$40.51	$40.51	$76.82	$76.82	$97.67	$97.67
	Employee & Spouse/Partner	$6.33	$6.33	$13.10	$13.10	$31.99	$31.99	$63.97	$63.97	$119.75	$119.75	$151.03	$151.03
	Employee & Child(ren)	$6.24	$6.24	$10.65	$10.65	$22.56	$22.56	$42.87	$42.87	$79.00	$79.00	$99.76	$99.76
	Employee & Family	$9.29	$9.29	$16.18	$16.18	$34.95	$34.95	$66.76	$66.76	$122.28	$122.28	$153.47	$153.47

5962f NS 07/21 Critical Illness Form Series includes GBD-1700, GBD-1701, or state equivalent.

The Buck's Got Your Back ®

CANCER INSURANCE

ABOUT THIS BENEFIT:

Cancer Insurance provides financial assistance in the form of a cash benefit upon a cancer diagnosis and treatment, ensuring you can concentrate on your health instead of your finances.

LEARN MORE

Cancer is one of the most debilitating diseases to bounce back from financially. So much so, that 42% of cancer patients drain their life savings within two years of diagnosis[2]. You can use your benefit to help pay toward costly medicine, medical bills, co-pays or even travel and lodging associated with cancer treatment.

[2]The American Journal of Medicine

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Group Cancer Insurance

Limited Benefit Policy

How would cancer impact you and your family?

If you or a family member are diagnosed with cancer, APL's Cancer Insurance may help cover the costs associated with the detection and treatment of cancer and help you be more financially prepared.

How it works

1. **CHOOSE** the benefit options that best protect you and your family.
2. **RECEIVE** treatment for a covered benefit.
3. **FILE** your claim online or mail it in.

Key features

- Radiation Therapy, Chemotherapy, Immunotherapy
- Experimental Treatments
- Surgical and Anesthesia Benefits
- Prescriptions, Transportation Benefits and more
- Plus, multiple plan options to cover you, your spouse or your child(ren) with convenient payroll deduction

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Summary of Benefits for The Advanced Financial Group Block Cancer Plan

	Plan 1 Insured Benefit
Spouse Coverage	Available
Dependent Child(ren) Coverage	Available
Pre-Existing Condition Period/Pre-Existing Condition Exclusion Period	12 months/12 months
Cancer Treatment Benefit	**Level 3**
Radiation Therapy, Chemotherapy, Immunotherapy Maximum per 12-month period	$15,000
Hormone Therapy Maximum of 12 treatments per calendar year	$50 per treatment
Experimental Treatment	paid in same manner and under the same maximums as any other benefit
Benefit Riders	
Cancer Screening Benefit Rider	**Level 1**
Diagnostic Testing 1 test per calendar year	$50 per test
Follow-Up Diagnostic Testing 1 test per calendar year	$100 per test
Medical Imaging	$500 per test; 1 test(s) per calendar year
Surgical Benefit Rider	**Level 1**
Surgical Operation	$30 unit dollar amount; Max $3,000 per operation
Anesthesia	25% of amount paid for covered surgery
Bone Marrow Transplant Maximum per lifetime	$6,000

Group Cancer Insurance

	Plan 1 Insured Benefit
Stem Cell Transplant Maximum per lifetime	$600
Prosthesis Surgical implantation Non-surgical (not hair piece) 1 device per site, per lifetime	 $1,000 per device $100 per device
Miscellaneous Benefit Rider	**Level 4**
Cancer Treatment Center Evaluation or Consultation - 1 per lifetime	$750
Evaluation or Consultation Travel and Lodging - 1 per lifetime	$350
Second / Third Surgical Opinion Per diagnosis of cancer	$300 / $300
Drugs and Medicine	$150 per inpatient confinement; $50 per outpatient prescription, maximum $150 per month
Hair Piece (Wig) - 1 per lifetime	$150
Transportation and Lodging Transportation - maximum 12 trips per calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or $0.75 per mile for travel by bus, plane or train; $0.75 per mile for travel by car; $100 per day for lodging
Family Member Transportation and Lodging Transportation - maximum 12 trips per calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or $0.75 per mile for travel by bus, plane or train; $0.75 per mile for travel by car; $100 per day for lodging
Blood, Plasma and Platelets	$300 per day
Ambulance Maximum of 2 trips per hospital confinement for all modes of transportation combined	Ground: $200 per trip Air: $2,000 per trip
Inpatient Special Nursing Services	$150 per day of hospital confinement
Outpatient Special Nursing Services	$150 per day
Medical Equipment Maximum of 1 benefit per calendar year	$150
Physical, Occupational, Speech, Audio Therapy and Psychotherapy	$25 per visit; maximum of $1,000 per calendar year
Waiver of Premium	Included
Internal Cancer First Occurrence Benefit Rider	**Level 2**
Lump Sum Benefit Maximum 1 per lifetime	Insured or Spouse: $5,000 Eligible Dependent Child(ren): $7,500
Heart Attack/Stroke First Occurrence Benefit Rider	**Level 1**
Lump Sum Benefit Maximum 1 per lifetime	Insured or Spouse: $2,500 Eligible Dependent Child(ren): $3,750
Hospital Intensive Care Unit Benefit Rider	
Intensive Care Unit Maximum of 45 days per confinement for any combination of intensive care unit or step down unit	$600 per day
Step Down Unit Maximum of 45 days per confinement for any combination of intensive care unit or step down unit	$300 per day
Increase in Coverage	Only available at annual renewal. Must be approved by APL and premium rates will be based upon the insured's attained age. Subject to the Time Limit on Certain Defenses and Pre-Existing Condition provisions, as defined in the policy.
Additional Rider(s)	
Portability Amendment Rider	Included

Premiums

Plan 1 - Monthly Premium*				
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
18+	$21.24	$38.10	$26.24	$39.94

*Total premium includes the Plan selected and any applicable rider premium. The premium and amount of benefits vary dependent upon the Plan selected at time of application.

DENTAL INSURANCE

ABOUT THIS BENEFIT:

The first thing that someone notices about you is your smile. If you're not doing everything you can to protect the appearance and health of your teeth, Dental Insurance may be in your best interest.

LEARN MORE

This benefit helps cover the cost of regular checkups and teeth cleanings, basic procedures, major procedures and depending on your plan may also include a benefit for orthodontia.

Already proud of your smile? It's still recommended you go to the dentist for regular checkups no matter how perfect your teeth are. Dentists can help spot the likes of heart disease, diabetes and oral cancer before it gets too serious.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

EE Only	$34.32
EE + Spouse	$79.38
EE + Children	$78.56
EE + Family	$119.32

Cigna Dental Benefit Summary
The Advanced Financial Group School Block High Plan Effective Date: 09/01/2022

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis and other health issues. That's why this dental plan includes **Cigna Dental WellnessPlus^{SM}** features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental Choice Plan				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
WellnessPlus^{SM} Progressive Maximum Benefit: When you or your family members receive any preventive care service during one plan year, the annual dollar maximum will increase in the following plan year; until it reaches the highest level specified below. Please refer to your plan materials for additional information on this plan feature.				
Calendar Year Benefits Maximum Applies to: Class I, II, III & IX expenses	Year 1: $1,250 Year 2: $1,400 Year 3: $1,550 Year 4 & Beyond: $1,700		Year 1: $1,250 Year 2: $1,400 Year 3: $1,550 Year 4 & Beyond: $1,700	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Oral Surgery: minor Repairs: Bridges, Crowns and Inlays	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Oral Surgery: major Anesthesia: general and IV sedation Periodontics: minor and major Endodontics: minor and major Denture Relines, Rebases and Adjustments Repairs: Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $1,500	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class IX: Implants	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in-network and out-of-network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV and IX services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires. ****Note – The Late Entrant Provision is waived for the 09/01/2022 Policy Year, however it WILL apply with the 09/01/2023 Policy Year and going forward.****
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;

- Periodontics: bite registrations; splinting;

- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

EE Only	$23.28
EE + Spouse	$53.86
EE + Children	$48.56
EE + Family	$75.08

Cigna Dental Benefit Summary
The Advanced Financial Group School Block Low Plan Effective Date: 09/01/2022

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis and other health issues. That's why this dental plan includes **Cigna Dental WellnessPlus[SM]** features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental Choice Plan				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
WellnessPlus[SM] Progressive Maximum Benefit: When you or your family members receive any preventive care service during one plan year, the annual dollar maximum will increase in the following plan year; until it reaches the highest level specified below. Please refer to your plan materials for additional information on this plan feature.				
Calendar Year Benefits Maximum Applies to: Class I, II, III & IX expenses	Year 1: $500 Year 2: $600 Year 3: $700 Year 4 & Beyond: $800		Year 1: $500 Year 2: $600 Year 3: $700 Year 4 & Beyond: $800	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Oral Surgery: minor Repairs: Bridges, Crowns and Inlays	70% After Deductible	30% After Deductible	70% After Deductible	30% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Oral Surgery: major Anesthesia: general and IV sedation Periodontics: minor and major Endodontics: minor and major Denture Relines, Rebases and Adjustments Repairs: Dentures	40% After Deductible	60% After Deductible	40% After Deductible	60% After Deductible
Class IX: Implants	40% After Deductible	60% After Deductible	40% After Deductible	60% After Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			

Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in-network and out-of-network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IX services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires. ****Note – The Late Entrant Provision is waived for the 09/01/2022 Policy Year, however it WILL apply with the 09/01/2023 Policy Year and going forward.****
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;

- Athletic mouth guards;

- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge

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EDUCATOR DISABILITY

ABOUT THIS BENEFIT:

Could you imagine going months without a source of income? If you're like 69% of Americans who don't have as much as $1,000 set aside in their savings account, you could run out of funds quickly[3]. Enrolling in Educator LTD helps you protect your paycheck if you were to suffer an injury or illness that left you unable to work.

LEARN MORE

Designed with school employees like you in mind, Educator LTD ensures you get the coverage you need when it matters most. These plans can let you choose the amount of money you'll receive every month, when your benefits begin and how long you'll receive the cash benefit.

Whether you're the primary source of income for your household or your income is supplemental, Educator LTD can help protect your paycheck.

[3]GoBanking

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

unum
Better benefits at work.

Why buy Long Term Disability Insurance?

If you can't work due to an injury or illness, long term disability insurance can replace part of your paycheck for several months or years. The benefits are paid directly to you. Use the payments to pay bills, buy groceries — or however you need.

Leading causes of Unum long term disability claims[1]

- Cancer
- Back disorders (excluding injuries)
- Injuries
- Cardiovascular
- Joint disorders

More than **50%** of U.S. consumers worry they would not be able to support themselves if they became disabled and couldn't work.[2]

The risk of becoming disabled may be greater than you think

1 in 4 of today's 20-year-olds will become disabled before reaching age 67.[3]

48% of current retirees say they retired earlier than they planned, mainly because of health problems or disabilities.[4]

Workers' compensation or Social Security disability may not help

From 2006 to 2015, only **34%** of Social Security Disability Insurance claimants had their applications approved.[5]

Most disabilities are not work-related and therefore are not covered by workers' compensation.[6]

Long Term Disability Insurance can help when you need it most.

Having Unum disability coverage in place can make all the difference when you're unable earn your income.

Unum is the smart solution

We've been the leading provider of group disability benefits in the U.S. for

years.[7]

94% **of long term disability claimants are satisfied** with the overall quality of interaction with their Unum contact.[8]

Unum paid $5.8 billion in benefits in 2016.[9]

We serve 53% of Fortune 100 companies or their subsidiaries and affiliates.[10]

7 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976–1990" (1977–1991); Gen Re, "U.S. Group Disability Market Surveys 1991–2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014–2016 Annual Sales and In Force" (2015–2017)

8 Market Decisions, "2016 Unum STD, FMLA and LTD Claimant Satisfaction Research" (2017)

9 Unum internal claims data (2016)

10 Fortune, "Fortune 500 2016" (2016); Unum customer database (2016)

To learn more about disability insurance, contact your Unum representative.

FOR BROKERS, EMPLOYERS AND EMPLOYEES

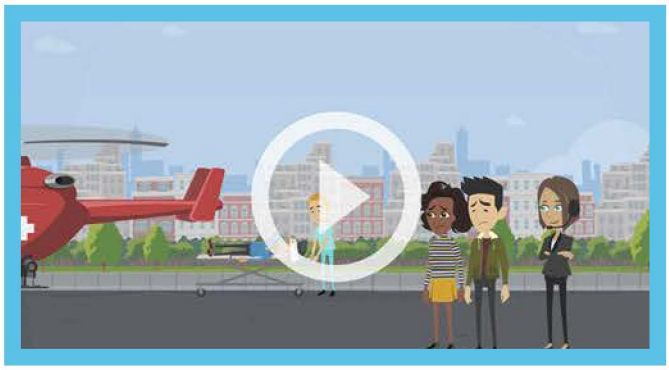
MK-3703 (5-18)

1 Unum internal data, 2017.
2 LIMRA, "2017 Insurance Barometer Study" (2017).
3 Social Security Administration, "Fact Sheet Social Security" (accessed July 5, 2017)
4 EBRI, "The 2017 Retirement Confidence Survey" (2017).
5 Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program" Chart 11 (2016)
6 National Safety Council, "Injury Facts" (2017).

EMERGENCY TRANSPORTATION

ABOUT THIS BENEFIT:

With costs of ground and air emergency transport getting more costly each year, there's a benefit out there that can drastically reduce, if not completely cover, your transport fees! It's called Emergency Transport Service!



LEARN MORE

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EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away from home.

Many American employers and employees believe that their health insurance policies cover most, if not all ambulance expenses. The truth is, they DO NOT!

Even after insurance payments for emergency transportation, you could receive a bill up to $5,000 for ground ambulance and as high as $70,000 for air ambulance. The financial burdens for medical transportation costs are very real.

HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit	Emergent Plus $14/Month
Emergent Ground Transportation	U.S./Canada
Emergent Air Transportation	U.S./Canada
Non-Emergent Air Transportation	U.S./Canada
Repatriation	U.S./Canada

A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

EVERY FAMILY DESERVES A MASA MEMBERSHIP

The Ultimate Peace of Mind for Employees and Their Families

The Harrison's Story

- Jim and his family were at a local festival when his daughter, Sara, suddenly began experiencing horrible abdominal and back pain, after a fall from earlier in the day.
- His wife, Heather, called 911 and Sara was transported to a local hospital, when it was decided that she needed to be flown to another hospital.
- Upon arrival, Sara underwent multiple procedures and her condition was stabilized.
- After further testing, it was discovered that Sara needed additional specialized treatment at another hospital requiring transport on a non-emergent basis.

Based on a true story. Names were changed to protect identities in compliance with HIPAA.

MASA Medical™ Transport Solutions

And then, the Bills came!

	As a MASA Member	If a Non-MASA Member	
	Sara would pay*	If In-Network**	If Out-of-Network**
911 Ground Ambulance Cost: $1,800	$0	$300	$1,600
Emergent Air Ambulance Cost: $45,000	$0	$4,000	$30,000
Non-Emergent Air Transport† Cost: $20,000	$0	$20,000	$20,000
Total Out-of-Pocket Cost	$0	$24,300	$51,600

*Benefit is dependent on Membership Enrolled.
**Out-of-pocket dollars vary dependent on provider, distance, health plan design, current status of deductible and out-of pocket max. These figures are an example of the costs one may incur.
†More and more health plans are not covering interfacility transports on a non-emergent basis.

Any Ground. Any Air. Anywhere.™

No matter how comprehensive your local in-network coverage may be, you still have significant exposure to out-of-network emergency transportation. Moreover, when you and your family travel outside your area, there is an 80% chance of being picked up by an out-of-network provider.

A MASA Membership prepares you for the unexpected. ONLY MASA MTS provides you with:

- **Coverage ANYWHERE** in all 50 states and Canada whether at home or away
- Coverage for BOTH emergent ground ambulance and air ambulance transport **REGARDLESS of the provider**
- **Non-emergent transport services**, which are frequently covered inadequately by your insurance, if at all

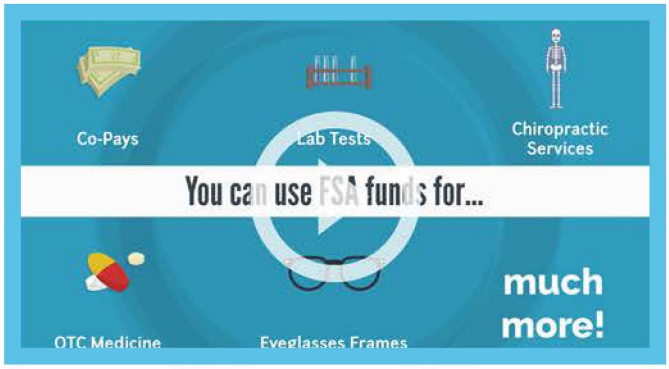
For more information, please contact your local MASA MTS representative or visit www.masamts.com

FLYER_COMP_B2B

FLEXIBLE SPENDING ACCOUNT

ABOUT THIS BENEFIT:

A flexible spending account (FSA) is one of several tax-advantaged financial accounts that can be set up through a cafeteria plan adopted by your employer.



LEARN MORE

A medical FSA is the most common type of flexible spending account allows you to set aside a portion of your earnings to pay for qualified expenses, most commonly for medical costs, such as doctors, dentists, and optometrist copays.

You CANNOT use FSA funds for expenses incurred outside the plan year!

The health FSA limit for 2022 is $2,850.

Employees can "carryover" no more than $550 of unused funds to the 2022-23 plan-year.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Flexible Spending Account (FSA)

Two types of FSAs

For a health FSA, start by choosing an annual election amount. This amount will be available on day one of your plan year for eligible medical expenses.

Then, payroll deductions will be made throughout the plan year to fund your account.

A dependent care FSA works differently than a health FSA. Money is only available as it is contributed and can only be used for dependent care expenses.

Both are pre-tax benefits your employer offers through a cafeteria plan. Choose one or both —whichever is right for you.

What's a cafeteria plan?

A cafeteria plan enables you to save money on group insurance, healthcare expenses, and dependent care expenses. Your contributions are deducted from your paycheck by your employer before taxes are with withheld. These deductions lower your taxable income which can save you up to 35% on income taxes!

Partial List of Eligible Expenses:

- Medical/Dental/Vision Copays and deductibles
- Prescription Drugs
- Physical Therapy
- Chiropractor
- First-Aid Supplies
- Lab Fees
- Psychiatrist/Psychologist
- Vaccinations
- Dental Work/Orthodontia
- Eye Exams
- Laser Eye Surgery
- Eyeglasses, Contact Lenses, Lens Solution
- Prescribed OTC Medications

Enrollment Considerations

After the enrollment period ends, you may increase, decrease, or stop your contribution only when you experience a qualifying "change of status" (e.g. marriage, divorce, employment change, dependent change).

Be conservative in the total amount you elect to avoid forfeiting money at the end of the plan year.

How to Spend

Spending is easy

Our convenient NBS Benefits Card allows you to avoid out-of-pocket expenses, cumbersome claim forms and reimbursement delays. Or you may also utilize the "pay a provider" option on our web portal.

Account access is easy

Get account information from our easy-to-use online portal and mobile app. See your account balance, contributions and account history in real time.

What if I don't use it all?

Because an FSA is a planning tool with great tax benefits, you must use the account balance in its entirety before the end of the plan year or it will be forfeited. This is known as the "use-it-or-lose-it" rule.

Your employer may offer a grace period or a $550 rollover to help if you miss the mark a little bit. *Just make sure to plan carefully when you enroll.*

Healthcare Expense Account

Sample Expenses

Medical Expenses

- Acupuncture
- Addiction programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Brest pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (i.e. bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (i.e. Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Monitoring device (blood pressure, cholesterol)
- Physical exams
- Pregnancy tests
- Prescription drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician
- Wheelchair

Dental Expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crown, etc.

Vision Expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eye glasses
- Laser surgery
- Office fees
- Guide dog and upkeep/other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (deodorant, soap, body powder, sanitary products
- Addiction products
- Allergy relief (oral meds, nasal spray)
- Antacids and heart burn relief
- Anti-itch and hydrocortisone creams
- Athlete's foot treatment
- Arthritis pain relieving creams
- Cold medicines (i.e. syrups, drops, tablets)
- Cosmetic surgery
- Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil
- Counseling (i.e. marriage/family
- Dental care - routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/bleaching)
- Exercise equipment
- Fever & pain reducers (i.e. Aspirin, Tylenol)
- Haircare (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees
- Homeopathic supplement or herbs
- Household or domestic help
- Laser hair removal
- Laxatives
- Massage therapy
- Motion sickness medication
- Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
- Skin care (i.e. sun block, moisturizing lotion, lip balm)
- Sleep aids (i.e. oral meds, snoring strips)
- Smoking cessation relief (i.e. patches, gum)
- Stomach & digestive relief (i.e. Pepto-Bismol, Imodium)
- Tooth and mouth pain relief (Orajel, Anbesol)
- Vitamins
- Wart removal medicine
- Weight reduction aids (i.e. Slimfast, appetite suppressant)

nbs national benefit services

These expenses may be eligible if they are prescribed by a physician (if medically necessary for a specific condition).

Best Practices

Using your NBS Benefits Card

The NBS Benefits Card makes using your FSA easy by allowing you to pay your provider directly with funds from your FSA eliminating cashflow hardships. But even these transactions require substantation. Follow these tips to save time and simplify your experience.

Understanding Claim Substantiation

The rules that govern Flexible Spending Accounts require that all claims be reviewed and adjudicated to ensure they are being used for eligible medical expenses under section 125 of the Internal Revenue Code. NBS uses Merchant Category Codes (MCCs), Inventory Information Approval Systems, and sophisticated matching systems to auto-substantiate 80% of all debit card transactions.

For transactions that cannot be auto-substantiated, you will be asked to submit documentation to support your expense. Documentation may include an itemized receipt and/or a doctor's note of medical necessity. Use the NBS mobile app to take a picture of your receipt and upload it to the portal where it will be reviewed and eligible expenses will be approved. You will be notified if the expense requires any further documentation or if the expense is ineligible. In the case of ineligible expenses, you will be asked to refund your account or offset the expense with other eligible expenses.

1. Use your debit card at your provider.
2. Save your receipt.
3. Upload the receipt to NBS using the NBS Mobile App or my.nbsbenefits.com.
4. NBS will take care of the rest!

Before you leave, ask for a detailed receipt.

Receipt must include:

- The service or product
- The date of the service (Billing/ Statement Date insufficient)
- The amount of the charge

Over-the-counter medications will require a doctor's note of medical necessity.

HEALTH SAVINGS ACCOUNT

ABOUT THIS BENEFIT:

More people are signing up for health savings accounts (HSA) than ever before due to the increase in participation in high deductible health plans.

LEARN MORE

The concept of an HSA is simple: It's a debit card you can only use for approved medical transactions like a prescription, over the counter medicines, or your co-pay at the doctor or dentist office.

The benefit of an HSA account is that it can be taken out of your paycheck pre-tax, which means it's not included in your gross income and therefore, not subject to federal income tax. The best part about this policy is that funds roll over from year to year, so you can save for future healthcare expenses.

YOU HAVE TO BE ENROLLED IN THE TRS HD PLAN IN ORDER TO ELECT THE HSA!!!

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

HEALTH SAVINGS ACCOUNTS

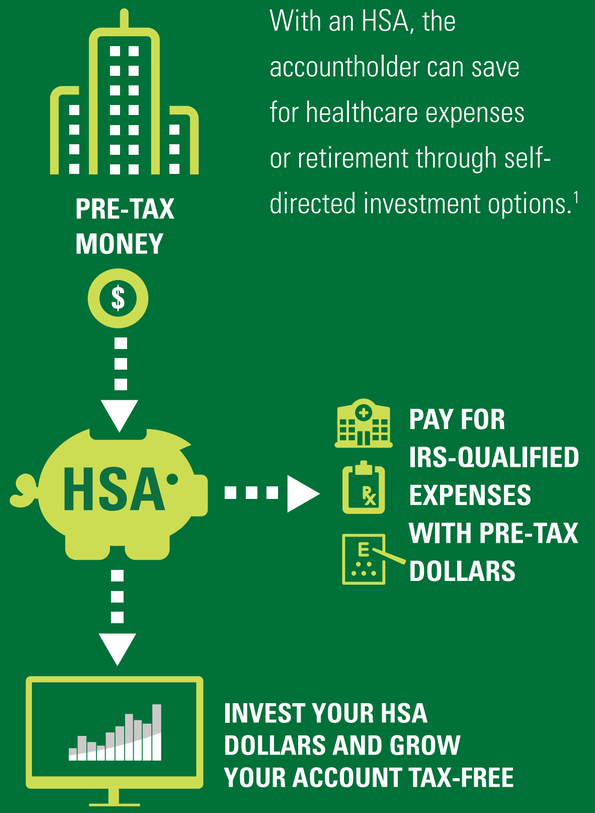
Save for Healthcare. Save for Retirement.

BUSINESS RELATIONS
844-650-8944
businessrelations@hsabank.com

What is an HSA?

A Health Savings Account (HSA) is an individually owned, tax-advantaged account that individuals can use to pay for current or future IRS-qualified medical expenses.

With an HSA, the accountholder can save for healthcare expenses or retirement through self-directed investment options.[1]



How an HSA Works

The accountholder contributes to the HSA through payroll deduction, online banking transfer, or a personal check to HSA Bank. Employers or third parties, such as a spouse or parent, may contribute to the account as well.

Individuals can then pay medical providers directly with the HSA Bank Health Benefits Debit Card or out of pocket. Accountholders have the option to reimburse themselves or keep the funds in their HSAs to allow them to grow further.

Unused funds roll over year to year. After age 65, funds can be withdrawn for any purpose without penalty (subject to ordinary income taxes).

HSA Eligibility

An individual with a high-deductible health plan (HDHP) – either through an employer or spouse or acquired independently – is typically eligible to open an HSA.

Additionally, these stipulations apply to all applicants:

- Cannot be covered by any other non-HSA-compatible health plan, including Medicare Parts A and B
- Cannot be covered by TriCare
- Must not have accessed his/her VA medical benefits in the past 90 days
- Cannot be claimed as a dependent on another person's tax return (excluding spouses)
- Must have coverage on a qualified HDHP on the first day of the month

Potential HSA Tax Savings

An HSA provides triple tax savings[2].

1. Contributions to an HSA can be made with pre-tax dollars and any after-tax contributions that the accountholder makes to his/her HSA are tax deductible.
2. HSA funds earn interest, and investment earnings are tax-free.
3. When used for IRS-qualified medical expenses, distributions aren't taxed.

Annual IRS Contribution Limits

Contributions made by all parties to an HSA cannot exceed the annual limit set by the Internal Revenue Service (IRS). Anyone can contribute to an individual's HSA, but only the accountholder and employer can receive tax deductions on those contributions. Combined annual contributions made by the accountholder, employer, and third parties (such as a parent or spouse) must not exceed these limits.[3]

According to IRS guidelines, each year the accountholder has until the tax filing deadline to contribute to the HSA.

Catch-up Contributions

Accountholders who meet these qualifications are eligible to make an HSA catch-up contribution of $1,000:

- Health Savings accountholder; age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated)
- Authorized signers who are 55 or older must have their own HSA in order to make the catch-up contribution

IRS-Qualified Medical Expenses

An HSA can be used to pay for a wide range of IRS-qualified medical expenses for the accountholder, spouse, or tax dependents. These expenses are generally defined as an expense for healthcare services, equipment, or medications. Please also see IRS Publication 502 for further information. Funds used to pay for IRS-qualified medical expenses are always tax-free.

HSA funds can also be used to get reimbursed for past medical expenses if the expense was incurred after the HSA was established. While the accountholder isn't required to submit any receipts to HSA Bank, it is recommended that the accountholder hold onto bills and receipts for tax purposes.

Examples of IRS-Qualified Medical Expenses[4]:

Acupuncture
Alcoholism treatment
Ambulance services
Annual physical examination
Artificial limb or prosthesis
Birth control products
Chiropractor
Childbirth/delivery
Convalescent home
(for medical treatment only)
Crutches
Doctor's fees
Dental treatments
(including X-rays, braces, dentures, fillings, oral surgery)
Dermatologist
Diagnostic services
Disabled dependent care
Drug addiction therapy
Fertility enhancement
(including in-vitro fertilization)
Guide dog
(or other service animal)
Gynecologist
Hearing aids and batteries
Hospital bills
Insurance premiums[5]
Laboratory fees
Lactation expenses
Lodging
(away from home for outpatient care)
Menstrual care products
Nursing home
Nursing services
Obstetrician
Osteopath
Over-the-counter medicines (visit hsabank.com/QME for details)
Oxygen
Pregnancy test kit
Podiatrist
Prescription drugs and medicines
Prenatal care and postnatal treatments
Psychologist
Smoking cessation programs
Special education tutoring
Surgery
(excluding unnecessary cosmetic surgery)
Telephone or TV equipment to assist those with hearing or vision impairments
Therapy or counseling
Medical transportation expenses
Transplants
Vaccines
Vasectomy
Vision care
(including eyeglasses, contact lenses, laser eye surgery)
Weight loss programs
(for a specific physician-diagnosed disease – such as obesity, hypertension, or heart disease)
Wheelchairs
X-rays

HSA Frequently Asked Questions

What is a Health Savings Account (HSA)?

An HSA is a tax favored account used in conjunction with an HSA-compatible health plan. The funds in the account are used to pay for IRS-qualified medical expenses such as services applied to the deductible, dental, vision, and more.

Who can get an HSA?

Any eligible individual that:

- Is covered by an HSA-compatible health plan
- Is not covered by other health insurance (except certain types of limited coverage)
- Is not enrolled in Medicare
- Is not claimed as a dependent on someone else's tax return
  - Children cannot establish an HSA
  - Eligible spouses can establish their own HSA

How much can I contribute annually to an HSA?

Visit hsabank.com/irs-guidelines to view the annual HSA contribution limits.

Catch-Up Contributions

Accountholders who meet the qualifications noted below are eligible to make an HSA catch-up contribution of $1,000.

- Health Savings accountholder
- Age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated)

Spouses who are 55 or older and covered under the accountholder's medical insurance can also make a catch-up contribution into a separate HSA in their own name.

Can any high-deductible health insurance policy qualify for an HSA?

It can be a health maintenance organization (HMO), preferred provider option (PPO), or indemnity plan as long as it meets the IRS requirements. Your insurance company will determine if the policy is an HSA-compatible health plan.

Who can make contributions?

Contributions can come from employers, the accountholder, or third parties. The combined contribution amount is subject to the IRS contribution limits.

HSA Frequently Asked Questions

Are there income restrictions?

There are no income restrictions for opening or contributing to an HSA.

What are the advantages of an HSA?

HSA funds roll over year-to-year; there are tax benefits on contributions, earnings and distributions; and long-term investment opportunities are available.

Is an HSA compatible with an HRA/FSA?

Yes, this is permitted if the combination is:

- "Limited purpose" flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) that restrict reimbursements to certain permitted benefits such as vision, dental, or preventive care benefits.

- "Post-deductible" FSA or HRAs that only provide reimbursement after the minimum annual deductible has been satisfied under the HDHP.

If I set up an HSA through my employer, what happens if I switch jobs?

The funds are portable and go with you.

Can I withdraw the money for non-medical expenses?

Yes, though the withdrawal may be subject to income tax and penalties. After the age of 65, you can use the funds for non-qualified expenses without penalty, though the funds may be subject to income tax.

Please call the number on the back of your HSA Bank debit card or visit us at www.hsabank.com

hsabank own your health®

HOSPITAL INDEMNITY

ABOUT THIS BENEFIT:

Hospital Indemnity insurance provides a cash benefit for every day, week or month you are hospitalized. Most policies have additional features that help with out of pocket costs related to medical care.

Benefits are paid to you directly and it works in addition to your health insurance coverage.

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY HOSPITAL INDEMNITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

The average cost for a hospital stay is $2,607 per day[1]

The Advanced Financial Block

Hospital indemnity (HI) insurance pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. It also provides additional daily benefits for related services. Even with the best primary health insurance plan, out-of-pocket costs from a hospital stay can add up.

The benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or co-pays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.).

To learn more about Hospital Indemnity insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

Benefit amounts are based on the plan in effect for you or an insured dependent at the time the covered event occurs. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		
Coverage Type	On and off-job (24 hour)	
Covered Events	Illness and injury	
HSA Compatible	Yes	
BENEFITS		
HOSPITAL CARE[2]		
First Day Hospital Confinement	Up to 1 day per year	$1,500
Daily Hospital Confinement (Day 2+)	Up to 30 days per year	$100
Daily ICU Confinement (Day 2+)	Up to 30 days per year	$200
FAMILY CARE		
Health Screening	Up to 1 day per year	$100
RIDERS		
Continuous Care Rider		Included
Daily Confinement/Bed Reservation		$100/180 Days/Lifetime
VALUE ADDED SERVICES		
Ability Assist® EAP[4] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM5] – Administrative & clinical support following serious illness or injury		Included

PREMIUMS

The amounts shown are monthly amounts (12 payments/deductions per year):[3]

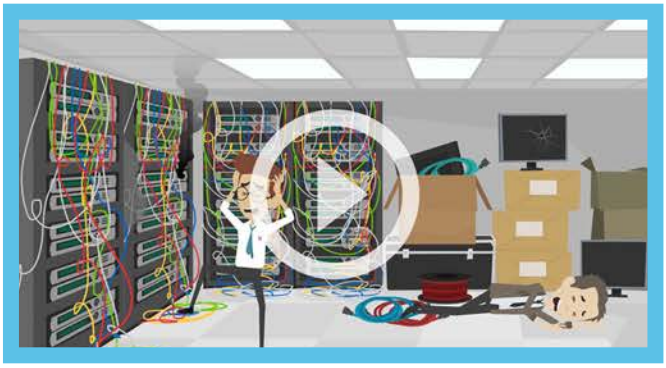
COVERAGE TIER	
Employee Only	**$17.77** ($0.58 per day)
Employee & Spouse/Partner	**$36.87** ($1.21 per day)
Employee & Child(ren)	**$33.46** ($1.10 per day)
Employee & Family	**$54.89** ($1.80 per day)

IDENTITY THEFT PROTECTION

ABOUT THIS BENEFIT:

Identity theft claims millions of victims each year and is the fastest growing crime in the United States. Identity Theft Protection is an affordable service that can protect everything from your social security number to your social media profiles.

It actively monitors and flags any suspicious activity via identity and credit monitoring. If fraud does occur, experts will help you recover your identity and restore your credit.



LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

LifeLock™ with Norton™ | Benefit Plans

Your Employee Benefit Can Help Protect Your Identity and Devices.

Everyday we put our information at risk on the internet.

Everyday activities like online shopping, banking, and even browsing can expose your personal information, making you more vulnerable to cybercrime.

LifeLock with Norton Benefit Plans combine leading identity theft protection and device security against online threats, viruses, ransomware and malware, at home and on-the-go. Let us help protect your identity, your devices and your online privacy, in an always connected world.

Get more value for your money! Enroll through your employer today!

No one can prevent all identity theft or all cybercrime.

Benefit Pricing - Monthly Rates

	LifeLock with Norton | Benefit Essential	LifeLock with Norton | Benefit Premier
Employee Only (18+ Years Old)	$7.99	$13.49
Employee + Family[Δ]	$15.98	$26.98

[Δ] The LifeLock Benefit Junior plan is for minors under the age of 18. LifeLock enrollment is limited to employees and their eligible dependents. Eligible dependents must live within the employee's household, or be financially dependent on employee. LifeLock services will only be provided after receipt and applicable verification of certain information about you and each family member. Please refer to employer group for the required information under your plan. In the event you do not complete the enrollment process for any family member, those individuals will not receive LifeLock services, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete enrollment. If you do not complete the enrollment process for each family member, you may continue to pay more for LifeLock services than you otherwise would if you had selected a lower tier plan.

		LifeLock with Norton | Benefit Essential	LifeLock with Norton | Benefit Premier
LIFELOCK IDENTITY THEFT PROTECTION	LifeLock Identity Alert™ System[†]	●	●
	• Payday - Online Lending Alerts[†]	●	●
	• Credit Alerts & Social Security Alerts[†]	●	●
	LifeLock Mobile App (Android™ & iOS)[**] Downloading the app does not provide protection.	●	●
	Dark Web Monitoring[**]	●	●
	LifeLock Privacy Monitor™	●	●
	USPS Address Change Verification	●	●
	Lost Wallet Protection	●	●
	Reduced Pre-Approved Credit Card Offers	●	●
	Fictitious Identity Monitoring	●	●
	Data Breach Notifications	●	●
	Credit, Checking & Savings Account Activity Alerts[†**]	●	●
	Checking & Savings Account Application Alerts[†**]		●
	Bank Account Takeover Alerts[†**]		●
	401K & Investment Account Activity Alerts[†**]	●	●
	File Sharing Network Searches	●	●
	Sex Offender Registry Reports	●	●
	Online Account Monitoring[**] Expected availability 2020, subject to change.	●	●
	Prior Identity Theft Remediation[9] This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.	●	●
	U.S.-based Identity Restoration Specialists	●	●
	24/7 Live Member Support[Δ]	●	●
	Million Dollar Protection™ Package[†††] • Stolen Funds Reimbursement • Personal Expense Compensation • Coverage for Lawyers and Experts	Up to $1 Million each	Up to $1 Million each
	Credit Application Alerts[2**]	One-Bureau	One-Bureau
	Credit Monitoring[1**]	One-Bureau	Three-Bureau
	Annual Credit Report & Credit Score[1**] The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		Three-Bureau
	Monthly Credit Score Tracking[1**] The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		One-Bureau
NORTON DEVICE SECURITY	Secures PCs, Macs, Smartphones/Tablets[**]	Up to 3 devices (Family gets 6 devices)	Up to 5 devices (Family gets 10 devices)
	Online Threat Protection[**]	●	●
	Password Manager[**]	●	●
	Parental Controls[3**]	●	●
	Smart Firewall[**]	●	●
	Cloud Backup[3**]	10 GB	50 GB
ONLINE PRIVACY	SafeCam[3**]	●	●

844-698-8640

Norton LifeLock

[1] If your plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax; and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU. If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful plan enrollment. Please note that in order to enjoy all features in your chosen plan, such as bank account alerts, credit monitoring, and credit reports, it may require additional action from you and may not be available until completion.

[2] If your plan includes One Bureau Credit Application Alerts, two requirements must be met to receive said features: (i) your identity must be successfully verified with TransUnion; and (ii) TransUnion must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE ONE BUREAU CREDIT APPLICATION ALERTS. One Bureau Credit Application Alerts will take several days to begin after your successful LifeLock plan enrollment.

[3] Not all features are available on all platforms. Norton Family Parental Controls, Norton Cloud Backup, and PC SafeCam are presently not supported on Mac OS.

[†] LifeLock does not monitor all transactions at all businesses

[†††] Reimbursement and Expense Compensation, each with limits of up to $1 million for LifeLock with Norton Benefit Essential and LifeLock with Norton Benefit Premier and up to $25,000 for Benefit Junior, and up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: LifeLock.com/legal.

[**] These features are not enabled upon enrollment. Member must take action to activate this protection.

[9] Subject to eligibility requirements defined in Terms & Conditions at https://www.lifelock.com/legal/prior-id-theft-remediation. Symantec reserves the right to change and/or cease services at any time.

[Δ] English only.

No one can prevent all identity theft or cybercrime.

LifeLock and Norton by Symantec are now Norton LifeLock.

GPPM8782

INDIVIDUAL LIFE

ABOUT THIS BENEFIT:

Life insurance becomes necessary the moment someone else depends on you. It can be your spouse, children, or even your parents. If your death would affect the lifestyle of someone you love, it's time to enroll.

Individual life provides a specified lump-sum benefit to your beneficiary at the time of your death. These policies do not expire, and the price of your premiums typically won't change from the date you enroll. And, even if you leave your employer the policy stays with you.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

Life insurance can be an ideal way to provide money for your family when they need it most. PURELIFE-PLUS offers permanent insurance with a high death benefit and long guarantees[1] that can provide financial peace of mind for you and your loved ones. PURELIFE-PLUS is an ideal complement to any group term and optional term life insurance your employer might provide and has the following features:

- YOU OWN IT
- YOU CAN TAKE IT WITH YOU WHEN YOU CHANGE JOBS OR RETIRE
- YOU PAY FOR IT THROUGH CONVENIENT PAYROLL DEDUCTIONS
- YOU CAN COVER YOUR SPOUSE, CHILDREN AND GRANDCHILDREN, TOO[2]
- YOU CAN GET A LIVING BENEFIT IF YOU BECOME TERMINALLY ILL[3]
- IT'S AFFORDABLE

3 QUICK QUESTIONS

You can qualify by answering just 3 questions – no exams or needles.

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

1. Been actively at work on a full time basis, performing usual duties?
2. Been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days?
3. Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation, dialysis treatment, or treatment for alcohol or drug abuse?

1. After the guarantee period, premiums may go down, stay the same or go up.
2. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
3. Conditions apply.

Flexible Premium Adjustable Life Insurance to age 121. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18. Some limitations apply. See the PureLife-plus brochure for details. Texas Life is licensed to do business in the District of Columbia and every state but New York.

19M016-C 1092 (exp0321)

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

TEXASLIFE INSURANCE COMPANY **CASE OVERVIEW**

Overview for CENTER ISD

February 26, 2022

EMPLOYEE AND SPOUSE EXPRESS ISSUE

Lifetime Maximum Amounts for Issue Ages Shown[1][2]			
Proposed Insured	Ages	Minimum	**Express**[2] Maximum
Employee	17 to 34	$25,000	$150,000
	35 to 39	15,000	150,000
	40 to 49	10,000	150,000
	50 to 65	10,000	75,000
	66 to 70[5]	10,000	10,000
Spouse	17 to 34	25,000	50,000
	35 to 39	15,000	50,000
	40 to 49	10,000	50,000
	50 to 60	10,000	25,000
	61 to 70[5]	N/A	N/A
Child Policy	15 days - 26[4]	25,000	25,000
Grandchild(ren)	15 days - 18[4]	25,000	25,000

1. One policy and one risk classification available per insured at each enrollment.
2. At the insured's current issue age, Maximum shown is the cumulative maximum available, inclusive of all in-force plus currently applied for face amounts.
3. Minimum Employee participation for Express Issue is the greater of five lives or 10% of eligible Employees.
4. The Dependent's signature is required for 19 and older in some states. Coverage is not available on children in Washington or on grandchildren in Washington or Maryland. In Maryland, child must reside with the applicant to be eligible for coverage.
5. In the state of Washington, no coverage available for employees & spouses over age of 65.

RIDERS

Proposed Insured	Accidental Death (Ages 17-59)	Disability Waiver Prem (Ages 17-59)
Employee	No	No
Spouse	No	No
Child(ren)	No	No
Grandchild(ren)	No	No

IMPLEMENTATION AND ENROLLMENT TARGET DATES

Enrollment Start Date: July 1, 2022 End of Enrollment Date: August 31, 2022

First Deduction Date: September 20, 2022 Policy Issue Date: October 1, 2022

Payroll Frequency: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☒ Monthly ☐ Other

Form: 18M065 PureLifePlus2018-C4AAB5ND9DM R06/21

TEXASLIFE INSURANCE COMPANY

MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
Issue	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-1			9.25							81
2-4			9.50							80
5-8			9.75							79
9-10			10.00							79
11-16			10.25							77
17-20			10.25	15.05	18.25	26.25	34.25	42.25	50.25	75
21-22			10.50	15.45	18.75	27.00	35.25	43.50	51.75	74
23			10.75	15.85	19.25	27.75	36.25	44.75	53.25	75
24-25			11.00	16.25	19.75	28.50	37.25	46.00	54.75	74
26			11.50	17.05	20.75	30.00	39.25	48.50	57.75	75
27-28			11.75	17.45	21.25	30.75	40.25	49.75	59.25	74
29			12.00	17.85	21.75	31.50	41.25	51.00	60.75	74
30-31			12.25	18.25	22.25	32.25	42.25	52.25	62.25	73
32			13.00	19.45	23.75	34.50	45.25	56.00	66.75	74
33			13.50	20.25	24.75	36.00	47.25	58.50	69.75	74
34			14.25	21.45	26.25	38.25	50.25	62.25	74.25	75
35		10.05	15.25	23.05	28.25	41.25	54.25	67.25	80.25	76
36		10.35	15.75	23.85	29.25	42.75	56.25	69.75	83.25	76
37		10.80	16.50	25.05	30.75	45.00	59.25	73.50	87.75	77
38		11.25	17.25	26.25	32.25	47.25	62.25	77.25	92.25	77
39		12.00	18.50	28.25	34.75	51.00	67.25	83.50	99.75	78
40	9.25	12.75	19.75	30.25	37.25	54.75	72.25	89.75	107.25	79
41	9.95	13.80	21.50	33.05	40.75	60.00	79.25	98.50	117.75	80
42	10.75	15.00	23.50	36.25	44.75	66.00	87.25	108.50	129.75	81
43	11.45	16.05	25.25	39.05	48.25	71.25	94.25	117.25	140.25	82
44	12.15	17.10	27.00	41.85	51.75	76.50	101.25	126.00	150.75	83
45	12.85	18.15	28.75	44.65	55.25	81.75	108.25	134.75	161.25	83
46	13.65	19.35	30.75	47.85	59.25	87.75	116.25	144.75	173.25	84
47	14.35	20.40	32.50	50.65	62.75	93.00	123.25	153.50	183.75	84
48	15.05	21.45	34.25	53.45	66.25	98.25	130.25	162.25	194.25	85
49	15.95	22.80	36.50	57.05	70.75	105.00	139.25	173.50	207.75	85
50	16.95	24.30	39.00	61.05	75.75	112.50				86
51	18.15	26.10	42.00	65.85	81.75	121.50				87
52	19.45	28.05	45.25	71.05	88.25	131.25				88
53	20.45	29.55	47.75	75.05	93.25	138.75				88
54	21.45	31.05	50.25	79.05	98.25	146.25				88
55	22.55	32.70	53.00	83.45	103.75	154.50				89
56	23.55	34.20	55.50	87.45	108.75	162.00				89
57	24.75	36.00	58.50	92.25	114.75	171.00				89
58	25.85	37.65	61.25	96.65	120.25	179.25				89
59	27.05	39.45	64.25	101.45	126.25	188.25				89
60	28.55	41.70	68.00	107.45	133.75	199.50				90
61	29.85	43.65	71.25	112.65	140.25	209.25				90
62	31.45	46.05	75.25	119.05	148.25	221.25				90
63	33.05	48.45	79.25	125.45	156.25	233.25				90
64	34.75	51.00	83.50	132.25	164.75	246.00				90
65	36.65	53.85	88.25	139.85	174.25	260.25				90
66	38.75									90
67	41.05									91
68	43.55									91
69	46.05									91
70	48.65									91

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY

MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age Issue	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-1										81
2-4										80
5-8										79
9-10										79
11-16										77
17-20			15.25	23.05	28.25	41.25	54.25	67.25	80.25	71
21-22			16.00	24.25	29.75	43.50	57.25	71.00	84.75	71
23			16.75	25.45	31.25	45.75	60.25	74.75	89.25	72
24-25			17.25	26.25	32.25	47.25	62.25	77.25	92.25	71
26			17.75	27.05	33.25	48.75	64.25	79.75	95.25	72
27-28			18.25	27.85	34.25	50.25	66.25	82.25	98.25	71
29			18.50	28.25	34.75	51.00	67.25	83.50	99.75	71
30-31			21.00	32.25	39.75	58.50	77.25	96.00	114.75	72
32			21.75	33.45	41.25	60.75	80.25	99.75	119.25	72
33			22.00	33.85	41.75	61.50	81.25	101.00	120.75	72
34			22.25	34.25	42.25	62.25	82.25	102.25	122.25	71
35		15.30	24.00	37.05	45.75	67.50	89.25	111.00	132.75	72
36		15.75	24.75	38.25	47.25	69.75	92.25	114.75	137.25	72
37		16.80	26.50	41.05	50.75	75.00	99.25	123.50	147.75	73
38		17.25	27.25	42.25	52.25	77.25	102.25	127.25	152.25	73
39		18.45	29.25	45.45	56.25	83.25	110.25	137.25	164.25	74
40	14.15	20.10	32.00	49.85	61.75	91.50	121.25	151.00	180.75	76
41	15.05	21.45	34.25	53.45	66.25	98.25	130.25	162.25	194.25	77
42	16.15	23.10	37.00	57.85	71.75	106.50	141.25	176.00	210.75	78
43	17.55	25.20	40.50	63.45	78.75	117.00	155.25	193.50	231.75	80
44	18.25	26.25	42.25	66.25	82.25	122.25	162.25	202.25	242.25	80
45	19.25	27.75	44.75	70.25	87.25	129.75	172.25	214.75	257.25	81
46	20.05	28.95	46.75	73.45	91.25	135.75	180.25	224.75	269.25	81
47	21.05	30.45	49.25	77.45	96.25	143.25	190.25	237.25	284.25	82
48	21.95	31.80	51.50	81.05	100.75	150.00	199.25	248.50	297.75	82
49	23.25	33.75	54.75	86.25	107.25	159.75	212.25	264.75	317.25	83
50	24.35	35.40	57.50	90.65	112.75	168.00				83
51	25.45	37.05	60.25	95.05	118.25	176.25				83
52	27.05	39.45	64.25	101.45	126.25	188.25				84
53	28.45	41.55	67.75	107.05	133.25	198.75				85
54	29.75	43.50	71.00	112.25	139.75	208.50				85
55	31.15	45.60	74.50	117.85	146.75	219.00				85
56	32.75	48.00	78.50	124.25	154.75	231.00				85
57	34.35	50.40	82.50	130.65	162.75	243.00				86
58	36.05	52.95	86.75	137.45	171.25	255.75				86
59	37.75	55.50	91.00	144.25	179.75	268.50				86
60	39.55	58.20	95.50	151.45	188.75	282.00				86
61	41.85	61.65	101.25	160.65	200.25	299.25				86
62	44.05	64.95	106.75	169.45	211.25	315.75				87
63	46.25	68.25	112.25	178.25	222.25	332.25				87
64	48.45	71.55	117.75	187.05	233.25	348.75				87
65	50.85	75.15	123.75	196.65	245.25	366.75				87
66	53.45									88
67	56.25									88
68	59.15									88
69	62.25									88
70	65.55									89

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TELEHEALTH

ABOUT THIS BENEFIT:

With telehealth, you can get the treatment you need for minor sicknesses without having to visit your doctor's office.

By enrolling in this benefit, you'll gain access to medical consultations through phone call, email, and video chat. Telehealth will typically have you talking to a doctor within 30 minutes of setting up the appointment.

You'll speak to a doctor who can diagnose your minor aches and illnesses, and they can even prescribe medication for the likes of the common cold, flu, pink eye, and many other medical conditions.

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

CENTER ISD GROUP #- 1800MD225 Member #- is the employees social

OVERVIEW

CONVENIENT CARE ANYWHERE™

1.800MD™

America's Most Reliable Telemedicine Network™

QUALITY CARE WHEN YOU NEED IT MOST

Looking for care that fits your schedule? 1.800MD offers reliable, quality health care at your fingertips with a remarkable reputation.

1.800MD is a fast, convenient alternative to waiting days for an appointment or spending hours sitting in the doctor's office, urgent care or ER. Whether it is 2 a.m. from your toddler's room or 7 p.m. from your business trip destination, our telehealth solutions save you time and money while providing peace of mind.

WHY CHOOSE 1.800MD?

SAVES MONEY

Visits to the emergency room or urgent care are costly prices to pay when many visits can be handled by calling 1.800MD. As a low-cost alternative 1.800MD physicians treat many common conditions via phone or video consultations, reducing un-necessary doctor's visits and saving you money.

CONVENIENCE AND QUALITY CARE

With more than a decade of experience, 1.800MD provides individuals, families, employers and groups with best of class medical care 24/7/365. Available any time day or night, our board-certified physicians are equipped to diagnose, recommend treatment and prescribe medications while in the comfort of your home, office or business trip destination.

SUPPORT

Independently owned, 1.800MD focuses on customer satisfaction. Our member service representatives are available any time to assist you or answer any questions you may have.

CUTTING EDGE TECHNOLOGY

1.800MD's website and mobile app are extensions of our customer service commitment. They provide consumers with access to fast, convenient access to health care. Individual secure member portals contain information and tools to help make informed health care decisions.

HOW DOES IT WORK?

1. ACTIVATE ACCOUNT

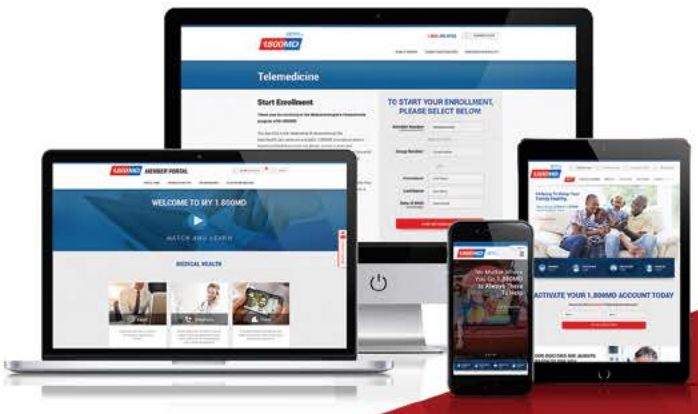
Activate your account online at **www.1800md.com** or by calling **1.800.530.8666**. Once activated, you will need to setup your member profile and complete your electronic health record.

2. REQUEST A CONSULT

Login to your account online or call member services at **1.800.530.8666** to request a consult anytime 24/7.

3. RECEIVE CARE

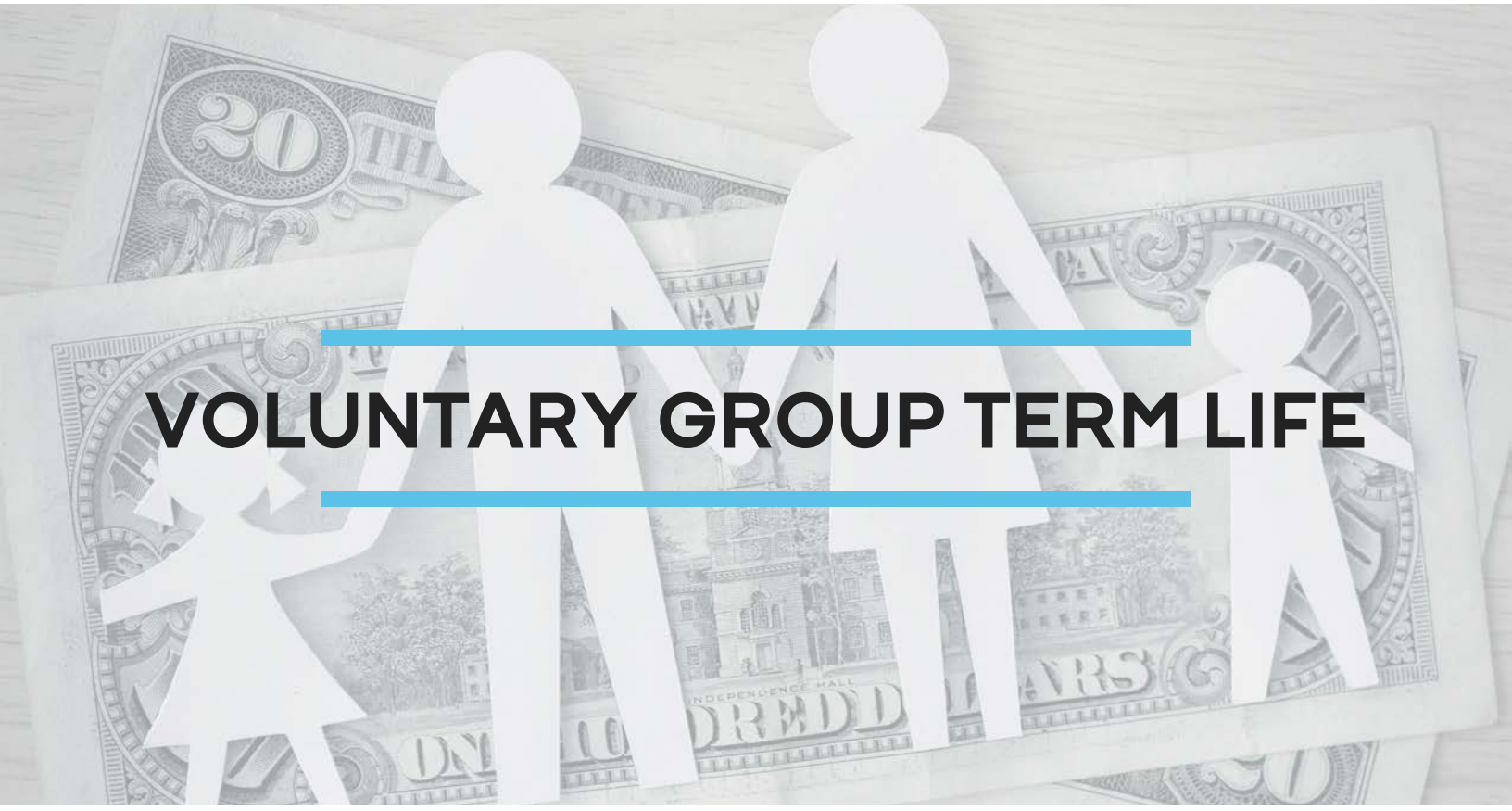
Receive diagnosis and treatment, giving you quality care and peace of mind where ever you are.



Call 1.800.530.8666 or visit www.1800MD.com to secure convenient care anywhere.

1.800.**530.8666**

www.**1800MD**.com

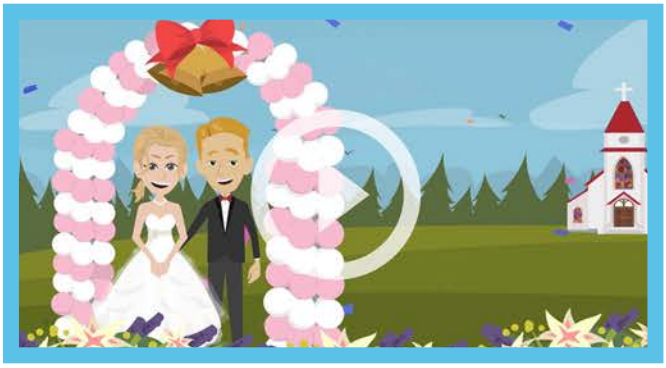


VOLUNTARY GROUP TERM LIFE

ABOUT THIS BENEFIT:

Basic life insurance provided by your employer is a good employee benefit, but the amount of coverage may not cover your obligations if you were to suddenly pass away.

Voluntary Group Term Life insurance policy issues a cash benefit to your designated beneficiary in the event of your passing. This money can be used toward anything from final costs to paying off any remaining debts; like your mortgage, car loans, or student loans.



LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

The Advanced Financial Group School Block Voluntary Life and AD&D Insurance Plan Highlights

Who is eligible for this coverage?	All actively employed employees working at least 15 hours each week for your employer in the U.S. and their eligible spouses and children to age 26.
What are the coverage amounts?	Employee: up to 5 times salary in increments of $10,000; not to exceed $500,000. Spouse: up to 100% of employee amount in increments of $5,000; not to exceed $500,000. Child: up to 100% of employee coverage amount in increments of $5,000; not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $5,000.
What are the AD&D coverage amounts?	Employee: up to 5 times salary in increments of $10,000; not to exceed $500,000. Spouse: up to 100% of employee amount in increments of $5,000; not to exceed $500,000. Child: up to 100% of employee coverage amount in increments of $5,000; not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $5,000. Note: You may purchase AD&D coverage for yourself regardless of whether you purchase term life coverage. In order to purchase life and AD&D coverage for your dependents, you must buy coverage for yourself.
Can I be denied coverage?	**Current employees:** If you and your eligible dependents are enrolled in the plan and wish to increase your life insurance coverage, you may apply on or before the enrollment deadline for any amount of additional coverage up to $250,000 for yourself and any amount of additional coverage up to $50,000 for your spouse. Any life insurance coverage over the guaranteed amount(s) will be subject to answers to health questions. If you and your eligible dependents are not currently enrolled in the plan, you may apply for coverage on or before the enrollment deadline and will be required to answer health questions for any amount of coverage. **New employees:** To apply for coverage, complete your enrollment within 31 days of your eligibility period. If you apply for coverage after 31 days, or if you choose coverage over the amount you are guaranteed, you will need to complete a medical questionnaire which you can get from your plan administrator. You may also be required to take certain medical tests at Unum's expense.
How do I apply?	Please see your plan administrator.
When is coverage effective?	Please see your plan administrator for your effective date. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. For your dependent spouse and children, insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Totally disabled means that as a result of an injury, sickness, or disorder, your dependent spouse and children: are confined in a hospital or similar institution; or are confined at

	home under the care of a physician for a sickness or injury. Exception: Infants are insured from live birth.
Is the coverage portable (can I keep it if I leave my employer)?	If you retire, reduce your hours or leave your employer, you can continue coverage for yourself your spouse and your dependent children at the group rate. Portability is not available for people who have a medical condition that could shorten their life expectancy — but they may be able to convert their term life policy to an individual life insurance policy.
Are there any life insurance exclusions or limitations?	Life insurance benefits will not be paid for deaths caused by suicide within the first 24 months after the date your coverage becomes effective. If you increase or add coverage, these enhancements will not be paid for deaths caused by suicide within the first 24 months after you make these changes.
Will my premiums be waived if I'm disabled?	If you become disabled (as defined by your plan) and are no longer able to work, your life premium payments will be waived until your disability period ends.
What does my AD&D insurance pay for?	The full benefit amount is paid for loss of: • life; • both hands or both feet or sight of both eyes; • one hand and one foot; • one hand or one foot and the sight of one eye; • speech and hearing. Other losses may be covered as well. Please contact your plan administrator.
Are there any AD&D exclusions or limitations?	Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from: • disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM); • suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane; • war, declared or undeclared, or any act of war; • active participation in a riot; • committing or attempting to commit a crime under state or federal law; • the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol; • intoxication – "being intoxicated" means you or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.
When does my coverage end?	You and your dependents' coverage under the Summary of Benefits ends on the earliest of: • the date the policy or plan is cancelled; • the date you no longer are in an eligible group; • the date your eligible group is no longer covered; • the last day of the period for which you made any required contributions; • the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage.

	In addition, coverage for any one dependent will end on the earliest of: • the date your coverage under a plan ends; • the date your dependent ceases to be an eligible dependent; • for a spouse, the date of a divorce or annulment; • for dependent coverage, the date of your death. Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Underwritten by Unum Life Insurance Company of America, Portland, Maine

EN-1773 (8-17) FOR EMPLOYEES

UNUM CORPORATION LIFESTYLE LIFE/AD&D RATES
The Advanced Financial Group School Block

Monthly Payroll Deduction

EMPLOYEE*

Life/AD&D

Age Band	$10,000	$20,000	$30,000	$40,000	$50,000	$70,000	$100,000	$130,000	$150,000
0-24	$0.80	$1.60	$2.40	$3.20	$4.00	$5.60	$8.00	$10.40	$12.00
25-29	$0.80	$1.60	$2.40	$3.20	$4.00	$5.60	$8.00	$10.40	$12.00
30-34	$0.90	$1.80	$2.70	$3.60	$4.50	$6.30	$9.00	$11.70	$13.50
35-39	$1.00	$2.00	$3.00	$4.00	$5.00	$7.00	$10.00	$13.00	$15.00
40-44	$1.50	$3.00	$4.50	$6.00	$7.50	$10.50	$15.00	$19.50	$22.50
45-49	$2.00	$4.00	$6.00	$8.00	$10.00	$14.00	$20.00	$26.00	$30.00
50-54	$3.30	$6.60	$9.90	$13.20	$16.50	$23.10	$33.00	$42.90	$49.50
55-59	$5.40	$10.80	$16.20	$21.60	$27.00	$37.80	$54.00	$70.20	$81.00
60-64	$8.20	$16.40	$24.60	$32.80	$41.00	$57.40	$82.00	$106.60	$123.00
65-69	$13.60	$27.20	$40.80	$54.40	$68.00	$95.20	$136.00	$176.80	$204.00
70-74	$21.49	$42.98	$64.47	$85.96	$107.45	$150.43	$214.90	$279.37	$322.35
75+	$21.49	$42.98	$64.47	$85.96	$107.45	$150.43	$214.90	$279.37	$322.35

$250,000 IS THE MAXIMUM THAT MAY BE ISSUED WITHOUT ANSWERING HEALTH QUESTIONS

SPOUSE**

Life/AD&D

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$50,000	$55,000	$60,000
0-24	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$4.00	$4.40	$4.80
25-29	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$4.00	$4.40	$4.80
30-34	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$4.50	$4.95	$5.40
35-39	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$5.00	$5.50	$6.00
40-44	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$7.50	$8.25	$9.00
45-49	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$10.00	$11.00	$12.00
50-54	$1.65	$3.30	$4.95	$6.60	$8.25	$9.90	$16.50	$18.15	$19.80
55-59	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$27.00	$29.70	$32.40
60-64	$4.10	$8.20	$12.30	$16.40	$20.50	$24.60	$41.00	$45.10	$49.20
65-69	$6.80	$13.60	$20.40	$27.20	$34.00	$40.80	$68.00	$74.80	$81.60
70-74	$10.75	$21.49	$32.24	$42.98	$53.73	$64.47	$107.45	$118.20	$128.94
75+	$10.75	$21.49	$32.24	$42.98	$53.73	$64.47	$107.45	$118.20	$128.94

SPOUSE AMOUNT CANNOT EXCEED 100% OF EMPLOYEES AMOUNT
and $50,000 is the most that can be issued without answering health questions

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CHILD(REN)

	$5,000	$10,000
LIFE/AD&D	$0.91	$1.82

NOTE: FINAL RATES MAY VARY SLIGHTLY DUE TO ROUNDING.

THESE GRIDS ARE PRICES OF FREQUENTLY SELECTED AMOUNTS. YOU MAY CHOOSE ANY INCREMENT OF $10,000 UP T0 $500,000 FOR EMPLOYEES (EE) AND $5,000 UP TO $500,000 FOR YOUR SPOUSE (SP). TO PURCHASE AN AMOUNT OTHER THAN LEVELS INDICATED ABOVE, SIMPLY COMPLETE THE FOLLOWING:

EMPLOYEE	_____	X	_____	=	_____
CALCULATION	# OF 10,000(EE) UNITS		YOUR AGE COST PER 10,000 UNIT		EMPLOYEE MONTHLY COST
SPOUSE	_____	X	_____	=	_____
CALCULATION	# OF 5,000(SP) UNITS		YOUR AGE COST PER 5,000 UNIT		SPOUSE MONTHLY COST

*** Age = Actual age immediately prior to and including the anniversary/effective date.**

****Spouse age is determined using Employee's date of birth.**

VISION INSURANCE

ABOUT THIS BENEFIT:

The value of vision insurance goes beyond saving money on new glasses and contact lenses every year. Most plans provide coverage that pays for annual eye exams and a portion of the cost for frames and lenses.

Eye exams are also effective in detecting medical conditions like diabetes, thyroid disease, and cancer. If you are considering buying vision insurance, just ask yourself one question: *"How much do I value my vision?"*

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Eyetopia 180/300H (Gold)
TAFG Block Summary of Benefits

Eyetopia Benefits

Eyetopia provides two vision benefits each eligibility period. You may have the opportunity to maximize your Eyetopia benefits by coordinating benefits with your Health Insurance coverage.

BENEFIT ONE [2] (choose either one of the following 2 options every 12 months):	**Allowance**	**Co-pay**[1]
1. Refractive Exam. One routine vision exam.	N/A	$5.00
2. Coverage toward medical eye exam co-pay or other services or materials. [2]	$65.00	None

BENEFIT TWO (choose only 1 of the following Vision Correction Options) Eyetopia provides you with 3 options for correcting your vision every 12 months. [3]

1. Prescription Lenses [3,4] Single Vision, Bi-focal or Tri-focal lenses	**Allowance** Covered	**Co-pay**[1] None
• Progressive (no line multifocal) lenses that retail for up to $219.	Covered	None
• Progressive (no line multifocal) lenses that retail for more than $219.	$200.00	None
• Lens Materials: polycarbonate, Trivex®, 1.60 or 1.67 index plastic.	Covered	None
• Basic Coating (ultraviolet protection and scratch resistant coating)	Covered	None
• Mid-Level Anti-Reflective Coatings that retail up to $99.	Covered	None
• Premium Anti-Reflective Coatings that retail for $100 or more.	$60.00	None
• Premium blue light blocking lenses or premium blue light blocking anti-reflective coating.	N/A	$50.00
• Tint (Solid and Gradient)	N/A	$12.00
• Photochromic or polarized lens upgrade	N/A	$90.00
♦ Medically necessary spectacles for Aniseikonia or Amblyopia.[5]	$400.00	None
♦ **Non-Prescription** Gaming/Computer (Anti-Fatigue) lenses (limited materials).	Covered	None
♦ **Frame**: The member may select any frame on display and is responsible for any amount exceeding the allowance.	$180.00	None
2. Contact Lens Option in lieu of spectacles. Allowance to be applied toward prescription contact lenses. ♦ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.[6]	$300.00	None
♦ Medically necessary contact lenses - $300.00 evaluation allowance and $400.00 contact lens allowance.[7]	$700.00	None
3. Refractive Surgery Option[8] in lieu of spectacles or contact lenses. A $500.00 per eye allowance with contracted surgeons or a $150.00 per eye allowance with non-contracted surgeons toward the fees for refractive surgery care for the following procedures: LASIK, PRK, ICL or RLE. The member pays any amount exceeding the per eye allowance.	$500/eye $150/eye	None
4. Hearing Aid Option. [9] If you do not use any of the other Materials options you can elect to apply your benefit toward hearing aids. Current year is a maximum benefit of $750.00 toward one or both hearing aids. If not used in year 1, the benefit increases to $1,600.00 in year 2. If not used in Year 2 or Year 1, the benefit increases to $2,550.00 for Year 3.	See full summary	None

[1] The co-pay must be paid to the Participating Provider at the time of service.
[2] When Health Insurance Carriers offer a comprehensive medical eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, no co-pay is required to exercise these other options.
[3] If your prescription has changed at least ½ diopter or your eye doctor recommends a change of lenses, you may select one of three vision correction options every 12 months.
[4] Special Lens Materials and Non-covered Items: Ultra-light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.
[5] The Shaw Lens coverage includes a premium anti-reflective coating and an upgraded lens material.
[6] If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.
[7] Total maximum benefit allowance is $700.00. The Participating Provider must pre-authorize medical necessity.
[8] Non-covered Items and Exclusions – Facility fees, surgical procedures, medications and enhancements or treatments related to medical procedures.
[9] To access your hearing aid benefit, you must call Your Hearing Network at 888-284-8133 for an initial consult. You have access to five levels of hearing aid technology: Standard, Value, Mid-Level, Advanced and Premium. Your out-of-pocket costs will vary based on your choice of hearing aid and your total available allowance.

Exclusions & Limitations

Included Services and/or Eye Wear. Only those professional vision care services and/or vision correction options specifically referenced herein are included in the Eyetopia plan. In-Network coverage is available through Participating Providers. Out of network services are not covered.

Additional Professional Services and/or Vision Corrections. The member may select professional services and/or vision correction items not specifically referenced as included in Eyetopia. However, these services and/or items are the member's responsibility at the Participating Provider's (U&C) charge, payable at the time of service or of ordering.

Emp - $20
E+1 - $37
E+Ch - $44
Fam - $52

For more information, please contact customer service at (830) 964-6444 or toll free 800-662-8264
Support@Eyetopia.org or www.Eyetopia.org

Eyetopia 120/145 Standard
TAFG Block Summary of Benefits

Eyetopia Benefits

Eyetopia provides two vision benefits each eligibility period. You may have the opportunity to maximize your Eyetopia benefits by coordinating benefits with your Health Insurance coverage.

BENEFIT ONE [2] (choose either one of the following 2 options every 12 months):	**Allowance**	**Co-pay**[1]
1. Refractive Exam. One routine Vision Exam.	N/A	$10.00
2. Coverage towards a medical eye exam copay or other services or materials. [2]	$45.00	None

BENEFIT TWO (choose only 1 of the following Vision Correction Options): Eyetopia provides you with 3 options for correcting your vision every 12 months.[3]

1. Prescription Lenses [4] CR-39 plastic single vision, bifocal, trifocal lenses.	**Allowance** N/A	**Co-pay**[1] $20.00
• CR-39 plastic Progressive (no-line multi-focal) lenses that retail for up to $199.	N/A	$20.00
• CR-39 plastic Progressive (no-line multi-focal) lenses that retail for more than $199.	$200.00	$20.00
• Polycarbonate material upgrade	N/A	$25.00
• Polycarbonate material upgrade for child dependents (under age 26)	Covered	None
• Basic Coating (Ultraviolet Protection & Scratch Resistant Coating)	Covered	None
• Mid-Level Anti-Reflective Coatings that retail up to $99.	Covered	None
• Premium Anti-Reflective Coatings that retail for $100 or more copay not to exceed:	N/A	$130.00
• Premium blue light blocking lenses or premium blue light blocking anti-reflective coating.	N/A	$105.00
• Tint (Solid or Gradient)	N/A	$12.00
• Photochromatic or Polarized Lenses	N/A	$90.00
♦ Medically necessary spectacles for Aniseikonia or Amblyopia.[5]	$400.00	None
♦ **Non-Prescription** Gaming/Computer (Anti-Fatigue) lenses (limited materials).	Covered	None
♦ **Frame:** The member may select any frame on display and is responsible for any amount exceeding the allowance.	$120	None
2. Contact Lens Option: In lieu of spectacles. Allowance to be applied toward prescription contact lenses. ♦ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.[6]	$145.00	$20.00
♦ Medically necessary contact lenses - $145.00 evaluation allowance and $400.00 contact lens allowance.[7]	$545.00	None
3. Refractive Surgery Option.[8] In lieu of spectacles or contact lenses. A $350.00 per eye allowance with contracted surgeons or a $75.00 per eye allowance with non-contracted surgeons toward the fees for refractive surgery care for the following procedures: LASIK, PRK, ICL or RLE. The member pays any amount exceeding the per eye allowance.	$350/eye $75/eye	None

[1] The co-pay must be paid to the Participating Provider at the time of service.

[2] When Health Insurance Carriers offer a comprehensive medical eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, no co-pay is required to exercise these other options.

[3] If your prescription has changed at least ½ diopter or your eye doctor recommends a change of lenses, you may select one of three vision correction options every 12 months.

[4] Special Lens Materials and Non-covered Items: Ultra-light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.

[5] The Shaw Lens coverage includes a premium anti-reflective coating and an upgraded lens material.

[6] If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.

[7] Total maximum benefit allowance is $545.00. The Participating Provider must pre-authorize medical necessity.

[8] Non-covered Items and Exclusions – Facility fees, surgical procedures, medications and enhancements or treatments related to medical procedures.

Exclusions & Limitations

Included Services and/or Eye Wear. Only those professional vision care services and/or vision correction options specifically referenced herein are included in the Eyetopia.

In-Network coverage is available through Participating Providers. Out of network services are not covered.

Emp - $10
E+1 - $17
E+Ch - $20
Fam - $24

Additional Professional Services and/or Vision Corrections. The member may select professional services and/or vision correction items not specifically referenced as included in Eyetopia. However, these services and/or items are the member's responsibility at the Participating Provider's (U&C) charge, payable at the time of service or of ordering.

Find us on Facebook.com/eyetopiavision

For more information please contact customer service at (830) 964-6444 or toll free 800-662-8264
Support@Eyetopia.org or www.Eyetopia.org

Continuation of Coverage for RETIREMENT or TERMINATION

HOW DO I CONTINUE INSURANCE COVERAGE AFTER RETIREMENT OR TERMINATION?

Upon retirement of termination of employment, you may be eligible to continue some of your insurance coverages through COBRA, Portability and/or Conversion. Here is a brief definition of each:

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows eligible employees to continue health insurance coverage for a period of time after termination of employment. COBRA allows former employees, retirees, spouses, and dependent children to retain the same health insurance coverage at group rates that otherwise would be lost with the job.

While these individuals will likely pay more for health insurance coverage through COBRA than they would have as an employee, COBRA coverage is typically less expensive than an individual health insurance plan would be. You should receive information about your COBRA rights within 14 days of your end of employment. You have up to 60 days to elect or decline COBRA coverage.

The following chart shows the maximum period for which continuation coverage must be offered for the specific qualifying event reasons:

Qualifying Event	Qualified Beneficiaries	Maximum Period of Coverage Continuation
Termination (except gross misconduct) or reduction in hours of employment	Employee, Spouse, Dependent Child	18 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of employee	Spouse, Dependent Child	36 months
Loss of dependent child status under the plan	Spouse, Dependent Child	36 months
Employee enrollment in Medicare	Spouse, Dependent Child	36 months

PORTABILITY

Portability allows eligible insured employees to “port” or continue the group insurance coverage that was in force when employment ends. Depending on the policy, ported coverage may continue at the same rates or your premiums may change to a ported class. With portability, you continue to have group policy at the same level of coverage that was in force prior to your employment termination. Some restrictions or limitations may apply, please refer to your policy.

Please note that you must complete an application for Portability within 30 days of your employment end date.

CONVERSION

Conversion transitions your group coverage into an individual policy. You can keep the same level of coverage as you had in force prior to employment ending or you may choose to reduce your level of coverage. Depending on the product, the conversion coverage may be a different form of insurance, especially with life insurance. Conversion premiums are typically higher than your group coverage, but conversion gives you ownership of the policy. Some restrictions or limitations may apply, please refer to your policy.

Please note that you must complete an application for Conversion within 30 days of your employment end date.

COBRA ELIGIBLE BENEFITS:

Medical -- (TRS Medical)
Continue medical coverage under the group policy for up to 18 months or longer. After termination with your employer, you will receive a COBRA enrollment packet in the mail 2-3 weeks after the termination date. You have 60 days to enroll in this option.

For eligibility questions with TRS-ActiveCare Medical plans, bSwift by calling 833.682.8972.
For eligibility questions with Scott and White Medical plans, contact Conexis at 877.722.2667.

Dental – (UNUM)
Continue dental coverage under the group policy for up to 18 months or longer. After termination with your employer, you will receive a COBRA enrollment packet in the mail 2-3 weeks after the termination date. You have 60 days to enroll in this option. For more information, please contact The Advanced Financial Group at 936.634.3378.

Vision --
Continue vision coverage under the group policy for up to 18 months or longer. After termination with your employer, you will receive a COBRA enrollment packet in the mail 2-3 weeks after the termination date. You have 60 days to enroll in this option. For more information, please contact The Advanced Financial Group at 936.634.3378.

BENEFIT PLANS OFFERING PORTABILITY AND/OR CONVERSION:

Basic Life Insurance -- (UNUM)
Basic or Employer paid life insurance is available for conversion only. A conversion application and initial premium payment must be submitted to the insurance carrier within 30 days of your employment end date. Conversion forms are located on the districts benefit website. For more information, please contact UNUM at 1.800.421.0344 or call The Advanced Financial Group at 936.634.3378.

Voluntary Group Term Life Insurance -- (UNUM)
Voluntary Employee, Spouse and Dependent Life insurance are eligible for conversion or portability. A conversion or portability application and initial premium payment must be submitted to the insurance carrier within 30 days of your employment end date. Some restrictions may apply, please refer to your policy. Conversion and Portability information and forms are located on the districts benefit website. For more information or assistance, please contact The Advanced Financial Group at 936.634.3378.

Accident/Critical Illness/ Hospital Indemnity Insurance -- (The Hartford)
The accident coverage for you and your covered dependents are eligible for portability when you leave active employment. An application and initial premium payment must be submitted to the insurance carrier within 30 days of your employment end date. Some restrictions may apply, please refer to your policy. Portability information and forms are located on the districts benefit website. For more information, please contact The Hartford at 877.320.0484 or call The Advanced Financial Group at 936.634.3378.

Cancer Insurance -- (APL)

The cancer coverage for you and your covered dependents are eligible for portability when you leave active employment if the policy has been in place for more than 12 months. APL sends notification to the employee with the portability application upon your termination of employment. Initial premium payment must be submitted to the insurance carrier within 0 days of your employment end date. Some restrictions may apply, please refer to your policy. For more information, please contact APL at 1.800.256.8606.

Individual/Permanent Life Insurance -- (Texas Life)

Since this coverage is an individual policy, you can simply contact the insurance carrier and set up direct premium payment. Please contact Texas Life at 1.800.283.9233 or go online to https://www.texaslife.com/PolicyOwner.html .

Identity Theft Protection – (Norton LifeLock)

Identity Theft coverage may be continued through a direct billing basis. A portability flyer is included on the districts benefit site. For detailed information, please contact Norton LifeLock at 1.800.607.9174.

OTHER BENEFIT PLANS AND CONTINUATION OF COVERAGE:

Health Savings Account – (HSA Bank or NBS)

Funds with your Health Savings Account will continue to be available after separation from your employer. Please contact HSA BANK at 1.800.357.6246 or National Benefit Services (NBS) at 1.800.274.0503 for details about future HSA deposit options.

Emergency Medical Transportation -- (MASA)

Eligible for continuation through direct billing basis by moving to the MASA Platinum Membership. For detailed information, please contact MASA Medical Transport Services at 1.954.334.8261.

CONTACT US FOR MORE INFORMATION

The Advanced Financial Group
936-634-3378
info@tafgonline.com