



**EAGLE MOUNTAIN
SAGINAW ISD**

Fostering a Culture of Excellence

Eagle Mountain Saginaw ISD

EMPLOYEE BENEFITS GUIDE

2023-2024 Plan Year



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This guide contains a summary of the benefits offered by your employer. If there is a conflict between the terms of this outline of benefits and the actual contracts, the terms of the contracts will prevail.

Eagle Mountain Saginaw ISD - Benefits Office
1600 Mustang Rock Rd, Fort Worth, TX 76179 | 817-232-0880

ELIGIBILITY

Eligible employees must be actively at work on the plan effective date for new benefits to be effective. Group health insurance coverage is available to all full time and part time (10 or more hours per week) employees.

BENEFITS ENROLLMENT

EMPLOYEE BENEFITS CENTER

The Employee Benefits Center (EBC) is a one-stop-shop for you to find all things benefits related. On the website, you'll find open enrollment and plan year dates, benefit descriptions, carrier contact information, product brochures, claim forms and enrollment details. Visit <https://benefits.ffga.com/eaglemountainsaginawisd> today!

NEW EMPLOYEES

You have 31 days from your actively-at-work date to make benefit elections. Your New Hire Enrollment elections will be made at the Eagle Mountain Saginaw ISD.

EXISTING EMPLOYEES

When it's time to enroll in your benefits, your First Financial Account Representative will be onsite to assist you with making your elections. Your elections can be made anytime during annual enrollment online from your work or home computer. Before enrollment, take time to educate yourself on the available benefits and what options would work best for you and your family by visiting the Employee Benefits Center.

MID-YEAR BENEFIT CHANGES

You may add or cancel coverage during the plan year if you have a change in family status. You must notify the benefits department within 31 days of the change.

QUALIFYING LIFE EVENTS INCLUDE:

- Changes in household, including marriage, divorce, legal separation, annulment, death of a spouse, birth, adoption, placement for adoption, or death of a dependent child
- Loss of health coverage, attributable to your spouse's employment, losing existing health coverage including job-based, individual & student plans, losing eligibility for Medicare, Medicaid, or CHIP, turning 26 and losing coverage through a parent's plan
- Change in place of residence or worksite, a student moving to or from the place they attend school, a seasonal worker moving to or from the place they both live & work, moving to or from a shelter or other transitional housing.

DECLINING COVERAGE

If you are eligible for benefits, but wish to DECLINE coverage, please complete the online enrollment either on your work or home computer. Under each option, you will need to select "waive." **You must still complete the beneficiary information.**

Medical



TRS-ACTIVECARE

The district's medical plans are offered through TRS. From in- and out-of-network options to comprehensive prescription drug coverage and special health and wellness programs, TRS-ActiveCare has been designed to flexibly meet the needs of nearly half a million public education employees.

Plans – Administered by BCBSTX

TRS-ActiveCare Primary

- Copays for doctor visits and generic prescriptions before you meet deductible
- Statewide Network
- Participants must select a primary care provider who will make referrals to specialists
- No out-of-network coverage

TRS-ActiveCare HD

- Must meet deductible before plan pays for non-preventive care
- In-network and out-of-network benefits – separate out-of-network deductible/out-of-pocket maximum
- Nationwide network
- Deductible applies to medical and pharmacy
- No requirement for PCP or referrals
- Compatible with health savings account (HSA)

TRS-ActiveCare Primary Plus

- Copays for many services and drugs
- Statewide Network
- Participants must select a primary care provider who will make referrals to specialists
- No out-of-network coverage

TRS-ActiveCare 2 – CLOSED TO NEW ENROLLEES

- Copays for many drugs and services
- Nationwide network with out-of-network coverage

Prescription Benefits

Express Scripts | www.express-scripts.com/trsactivecare | 844-367-6108

When you enroll in a BCBSTX Plan, you automatically receive prescription drug coverage through Express Scripts which gives you access to a large, national network of retail pharmacies.

For more information please refer to the TRS-ActiveCare website.

<https://www.trs.texas.gov/Pages/healthcare-trsactivecare-2023-24-plans.aspx>

HMO Plans

Baylor Scott & White HMO

- Copays for doctor visits and generic prescriptions before you meet deductible
- In-Network only – no out-of-network benefits

Eagle Mountain-Saginaw ISD

TRS Medical Rates 2023-2024

(Effective 09/01/2023- 08/31/2024)

			12 Pay	20 Pay	Bi-Weekly
TRS ACTIVECARE Primary	Total Cost	Employer Contribution	Your Monthly Cost	Your Twenty Pay Cost	Your Bi-Weekly Cost
Employee Only	\$461	\$300	\$161	\$96.60	\$74.31
Employee & Child(ren)	\$784	\$300	\$484	\$290.40	\$223.38
Employee & Spouse	\$1,245	\$300	\$945	\$567.00	\$436.15
Employee & Family	\$1,568	\$300	\$1,268	\$760.80	\$585.23
TRS ACTIVECARE HD	Total Cost	Employer Contribution	Your Monthly Cost	Your Twenty Pay Cost	Your Bi-Weekly Cost
Employee Only	\$475	\$300	\$175	\$105.00	\$80.77
Employee & Child(ren)	\$808	\$300	\$508	\$304.80	\$234.46
Employee & Spouse	\$1,283	\$300	\$983	\$589.80	\$453.69
Employee & Family	\$1,615	\$300	\$1,315	\$789.00	\$606.92
ACTIVECARE Primary +	Total Cost	Employer Contribution	Your Monthly Cost	Your Twenty Pay Cost	Your Bi-Weekly Cost
Employee Only	\$541	\$300	\$241	\$144.60	\$111.23
Employee & Child(ren)	\$920	\$300	\$620	\$372.00	\$286.15
Employee & Spouse	\$1,407	\$300	\$1,107	\$664.20	\$510.92
Employee & Family	\$1,786	\$300	\$1,486	\$891.60	\$685.85
ACTIVECARE 2	Total Cost	Employer Contribution	Your Monthly Cost	Your Twenty Pay Cost	Your Bi-Weekly Cost
Employee Only	\$1,013	\$300	\$713	\$427.80	\$329.08
Employee & Child(ren)	\$1,507	\$300	\$1,207	\$724.20	\$557.08
Employee & Spouse	\$2,402	\$300	\$2,102	\$1,261.20	\$970.15
Employee & Family	\$2,841	\$300	\$2,541	\$1,524.60	\$1,172.77
Scott & White HMO	Total Cost	Employer Contribution	Your Monthly Cost	Your Twenty Pay Cost	Your Bi-Weekly Cost
Employee Only	\$596.96	\$300	\$296.96	\$178.18	\$137.06
Employee & Child(ren)	\$960.68	\$300	\$660.68	\$396.41	\$304.93
Employee & Spouse	\$1,501.90	\$300	\$1,201.90	\$721.14	\$554.72
Employee & Family	\$1,728.86	\$300	\$1,428.86	\$857.32	\$659.47

Where the west begins is where TRS-ActiveCare rides with you on your health care journey.



TRS-ActiveCare Plan Highlights 2023-24



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.

2023-24 TRS-ActiveCare Plan Highlights

Sept. 1, 2023 – Aug. 31, 2024



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.*

New Rx Benefits!

- Express Scripts is your new pharmacy benefits manager! CVS pharmacies and most of your preferred pharmacies and medication are still included.
- Certain specialty drugs are still \$0 through SaveOnSP.

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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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
Employee Only	\$461	\$	\$541	\$
Employee and Spouse	\$1,245	\$	\$1,407	\$
Employee and Children	\$784	\$	\$920	\$
Employee and Family	\$1,568	\$	\$1,786	\$

Plan Features				
Individual/Family Deductible	Type of Coverage	In-Network Coverage Only	In-Network	Out-of-Network
		\$2,500/\$5,000	\$1,200/\$2,400	\$5,500/\$11,000
Individual/Family Maximum Out of Pocket	Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 50% after deductible
		\$7,500/\$15,000	\$6,900/\$13,800	\$20,250/\$40,500
Network		Statewide Network	Statewide Network	Nationwide Network
	PCP Required	Yes	Yes	No

Doctor Visits			
Primary Care	\$30 copay	\$15 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	Integrated with medical
Generics (31-Day Supply/90-Day Supply)	\$15/\$45 copay; \$0 copay for certain generics	\$200 deductible per participant (brand drugs only) \$15/\$45 copay You pay 20% after deductible; \$0 coinsurance for certain generics
Preferred	You pay 30% after deductible	You pay 25% after deductible
Non-preferred	You pay 50% after deductible	You pay 50% after deductible
Specialty (31-Day Max)	\$0 if SaveOnSP eligible; You pay 30% after deductible	\$0 if SaveOnSP eligible; You pay 30% 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
<ul style="list-style-type: none">• 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 SaveOnSP 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



This table shows you the changes between 2022-23 premium price and this year's 2023-24 regional price for your Education Service Center.

	2022-23 Total Premium	New 2023-24 Total Premium	Change in Dollar Amount	Key Plan Changes
TRS-ActiveCare Primary	Employee Only	\$417	\$461	\$44
	Employee and Spouse	\$1,176	\$1,245	\$69
	Employee and Children	\$751	\$784	\$33
	Employee and Family	\$1,405	\$1,568	\$163
TRS-ActiveCare HD	Employee Only	\$429	\$475	\$46
	Employee and Spouse	\$1,209	\$1,283	\$74
	Employee and Children	\$772	\$808	\$36
	Employee and Family	\$1,445	\$1,615	\$170
TRS-ActiveCare Primary+	Employee Only	\$525	\$541	\$16
	Employee and Spouse	\$1,284	\$1,407	\$123
	Employee and Children	\$845	\$920	\$75
	Employee and Family	\$1,614	\$1,786	\$172
TRS-ActiveCare 2 (closed to new enrollees)	Employee Only	\$1,013	\$1,013	\$0
	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, 2023

Compare Prices for Common Medical Services

REMEMBER:

Call a Personal Health Guide (PHG) any time 24/7 to help you find the best price for a medical service. Reach them at **1-866-355-5999**.

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/Independent Lab: You pay \$0	Office/Independent Lab: You pay \$0	You pay 30% after deductible	You pay 50% after deductible	Office/Independent Lab: You pay \$0	You pay 40% after deductible
	Outpatient: You pay 30% after deductible	Outpatient: You pay 20% after deductible			Outpatient: You pay 20% 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	Facility: You pay 20% after deductible	Not Covered	Not Covered	Facility: You pay 20% after deductible (\$150 facility copay per day)	Not Covered
	Professional Services: You pay \$5,000 copay + 30% after deductible	Professional Services: You pay \$5,000 copay + 20% after deductible			Professional Services: You pay \$5,000 copay + 20% after deductible	
	Only covered if rendered at a BDC+ facility	Only covered if rendered at a BDC+ facility			Only covered if rendered at a BDC+ facility	
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 PHG at **1-866-355-5999** with questions.

2023-24 Health Maintenance Organization (HMO) Plans and Premiums for Select Regions of the State

REMEMBER: Remember that when you choose an HMO, you're choosing a regional network.

TRS contracts with HMOs in certain regions to bring participants in those areas additional options.

HMOs set their own rates and premiums. They're fully insured products who pay their own claims.

	Central and North Texas Baylor Scott & White Health Plan <i>Brought to you by TRS-ActiveCare</i>	Blue Essentials - South Texas HMO <i>Brought to you by TRS-ActiveCare</i>	Blue Essentials - West Texas HMO <i>Brought to you by TRS-ActiveCare</i>
	You can choose this plan if you live in one of these counties: Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Collin, Coryell, Dallas, Denton, Ellis, Erath, Falls, Freestone, Grimes, Hamilton, Hays, Hill, Hood, Houston, Johnson, Lampasas, Lee, Leon, Limestone, Madison, McLennan, Milam, Mills, Navarro, Robertson, Rockwall, Somervell, Tarrant, Travis, Walker, Waller, Washington, Williamson	You can choose this plan if you live in one of these counties: Cameron, Hildalgo, Starr, Willacy	You can choose this plan if you live in one of these counties: Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crane, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Ector, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Howard, Hutchinson, Irion, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Llano, Loving, Lubbock, Lynn, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Upton, Ward, Wheeler, Winkler, Yoakum

Total Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	\$596.96	\$	N/A	\$	N/A	\$
Employee and Spouse	\$1,501.90	\$	N/A	\$	N/A	\$
Employee and Children	\$960.68	\$	N/A	\$	N/A	\$
Employee and Family	\$1,728.86	\$	N/A	\$	N/A	\$

Plan Features			
Type of Coverage	In-Network Coverage Only	N/A	N/A
Individual/Family Deductible	\$2,400/\$4,800	N/A	N/A
Coinsurance	You pay 25% after deductible	N/A	N/A
Individual/Family Maximum Out of Pocket	\$8,150/\$16,300	N/A	N/A

Doctor Visits			
Primary Care	\$20 copay	N/A	N/A
Specialist	\$70 copay	N/A	N/A

Immediate Care			
Urgent Care	\$40 copay	N/A	N/A
Emergency Care	\$500 copay after deductible	N/A	N/A

Prescription Drugs			
Drug Deductible	\$200 (excl. generics)	N/A	N/A
Days Supply	30-day supply/90-day supply	N/A	N/A
Generics	\$14/\$35 copay	N/A	N/A
Preferred Brand	You pay 35% after deductible	N/A	N/A
Non-preferred Brand	You pay 50% after deductible	N/A	N/A
Specialty	You pay 35% after deductible	N/A	N/A

www.trs.texas.gov



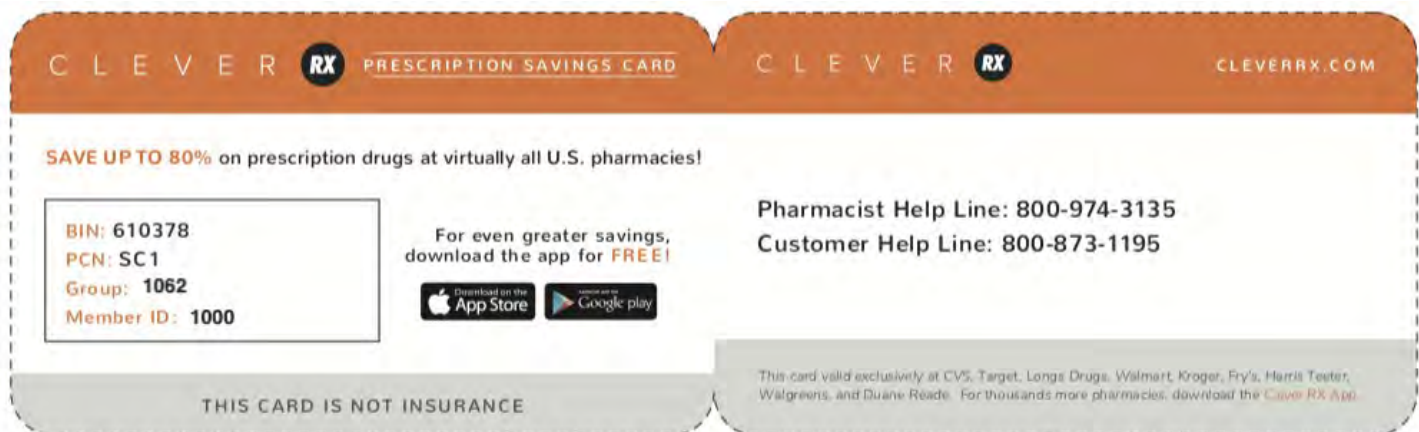
Clever RX | <https://partner.cleverrx.com/ffga> | 1.800.873.1195

Clever RX helps you save money by using a prescription drug savings card. They partner with the healthcare community to bring state-of-the-art, money-savings tools to participants. It helps you save up to 80% off prescriptions drugs and often beats the average copay. Plus, it's completely free. Thanks to Clever RX, you will never overpay for prescriptions again!

HIGHLIGHTS

- 100% FREE to use.
- Unlock discounts on thousands of medications.
- Save up to 80% on prescription medication – Often beats your copay!
- Download the Clever RX app by using the information on your card below to unlock exclusive savings at over 60,000 pharmacies nationwide.
- Available to use now!

Use Clever RX every time you pay for a medication for instant savings! Download the app or visit the site to price a drug: <https://partner.cleverrx.com/ffga>.





Compassion. Care. Excellence.
Your health is our priority.

Now Partnering To Better Your Health Needs!



Be Well Azle
721 Southeast Pkwy,
Azle, TX 76020

Be Well Denton:
3200 Colorado Blvd, Ste 202
Denton, TX 76210

Hours: Monday–Friday, 8am–5pm
Wednesdays, open until 7pm

Be Well Keller:
3800 North Tarrant
Parkway, Suite 210,
Fort Worth, TX 76244

P R I M A R Y C A R E C L I N I C

SERVICES OFFERED FOR AGES 16 YEARS AND ABOVE:



Sick Visits –
Same or Next Day
Appointments



Physical Exams,
Well Women Exams



Weight Loss Management
Programs



Complex /Chronic disease management
such as diabetes, hypertension, thyroid
disorder, depression & anxiety, etc.



In clinic services such as vaccines,
injections, EKG, urine test, etc.



Pre-Surgical Clearance and
Post-op assessments

EMS ISD LIAISON KARINA MARTINEZ

Karina works solely as a liaison for EMS ISD
and is available to book appointments for EMS ISD
employees directly.

**SCHEDULE YOUR
APPOINTMENT TODAY!
682-593-1211**



Your Benefits

Insured employees

Annual physical is covered by your TRS health plan
Annual routine labs are covered under your TRS health plan, but any
extra lab work ordered by the physician outside of the routine labs
will be an additional cost to the employee billed by Quest
Diagnostics.

Identify yourself as an EMS ISD employee and receive \$75 gift card
for completion of you annual physical

Uninsured employees

\$35 co-pay for physical exam and routine labs. Any extra lab work
ordered by the physician will be an additional cost to the employee
billed by Quest Diagnostics. Cost of these services outside of this
partnership is approximately \$300.

Same-day or Next-day Appointments - This is with a scheduled
appointment. Walk-ins may see a longer wait time as they have to
be worked into the already scheduled appointments. This includes
appointments for sick care or maintenance of chronic/complex
health conditions.

Insured employees

District covers first \$200 of out-of-pocket cost

There is a charge for new patients that is above normal office visit
if the patient is not an already established patient. We encourage
everyone to have their annual physical exam done before they are
seen to eliminate this additional new patient set-up fee.

Uninsured employees

District covers cost of the appointment - up to two appointments
per year. Labs and prescriptions are the responsibility of the
employee.

Weight Loss Program

Ideal Protein, a medically developed and doctor-supervised weight
loss program that includes a 4-phase approach with weekly
individual coaching sessions. Only offered with support from a
medical office.

Program costs include:

Introductory education session

Meals & snacks

Weekly coaching visits

Daily online videos for questions and support

We encourage employees to consider this program individually.

TELEHEALTH

Recuro | www.recurohealth.com | 855.673.2876

Studies show that more than 50 percent of doctor's office visits can be handled over the phone. With the Telehealth program, you can get a diagnosis quicker and spend less time in the waiting room.

Board Certified physicians will diagnose your illness, recommend treatment, and prescribe medication via telephone or video. You can contact them from anywhere – home, work, school, even while on vacation. They can treat common health issues like acid reflux, allergies, asthma, cold and flu, sinus infections, rashes, sore throat and more.

It's like having a doctor on call whenever you need medical advice. Access is only a call or click away!

Virtual Care

Getting Started

INTRODUCTION

Access board-certified physicians 24/7, 365 days a year for **you and your family for only \$10/month!** Doctors will discuss your symptoms, confirm a diagnosis, and prescribe any needed medication. Video and telephone-based visits are available, with an average wait time of just ten minutes.

Consult Fee: \$0



HOW TO ACCESS

01

Sign up with the Recuro Care app or visit the webpage below to access:
["member.recurohealth.com"](https://member.recurohealth.com)

02

Enter your employer member ID

03

Create your username and password

04

Complete your medical history

05

Schedule your consult

Example Conditions Treated

- Acne / Rash
- Allergies
- Cold / Flu
- GI Issues
- Ear Problems
- Fever
- Insect Bites
- Nausea
- Pink Eye
- Respiratory
- UTI's
- And More...

*Registering your account is not required to use the service, you can call 855.6RECURO anytime for 24/7 access to doctors.





24/7 On-Demand Care Access

Don't wait to speak with a doctor, get the care when you need it

Getting sick is never planned. Here at Recuro we provide quality care around the clock to fit within your busy lifestyle.



Call 1.855.6RECURO

Call us, or download our app to speak with a doctor today!



Visit Us Online



Speak With an Agent



Download Our App

Common Conditions Treated



Sore Throat



Congestion



Cough



Cold & Flu



Yeast Infection



Insect Bites



Allergies



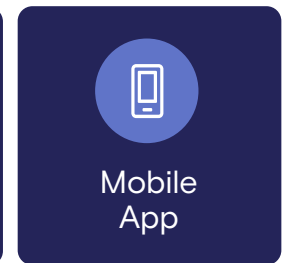
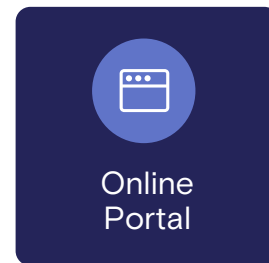
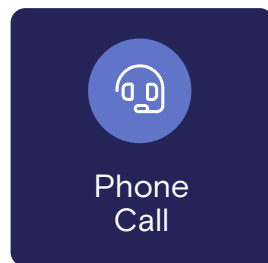
More




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- ➔ **Urgent Care**

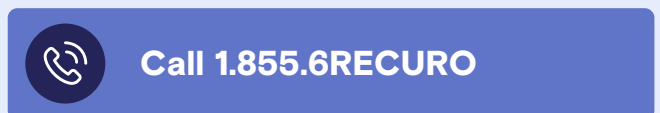


Healthcare that makes sense

Type of Visit	Average Cost
Primary Care	\$100
Urgent Care	\$150
Emergency Room	\$1400
 \$0-40	
2013 Medical Expenditure Panel Survey / MEPS	

Common Conditions Treated

- ✓ Acid Reflux
- ✓ Allergies
- ✓ Asthma
- ✓ Nausea
- ✓ Bronchitis
- ✓ Cold & Flu
- ✓ Infections
- ✓ Bladder Infection
- ✓ Rashes
- ✓ Sinus Conditions
- ✓ Sore Throat
- ✓ Thyroid Conditions
- ✓ UTIs
- ✓ And More...



Disclaimer: Recuro services are for non-emergency conditions only. Recuro does not replace the primary care physician, services are not considered insurance or a Qualified Health Plan under the Patient Protection and Affordable Care Act. Recuro doctors do not prescribe DEA controlled substances (schedule I-IV) and does not guarantee that a prescription will be written. For updated full disclosures, please visit www.recurohealth.com



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Notifications

- News Emails ☐
- Visit Emails ☐
- Visit Texts ☒



Dr. Lilly Patterson

Provider

Specialties	Physician
Rating	9.8/ 10

Visit Time Options

- 1 Sat, Jun 18 @ 07:30 AM >
- 2 Sat, Jun 18 @ 12:00 PM >
- 3 Sat, Jun 18 @ 09:30 AM >

Provider Background

Studying at the prestigious Oklahoma State University, Dr. Patterson graduated first in her class with a doctorate in veterinary medicine. After quickly discovering that the pay was terribl...



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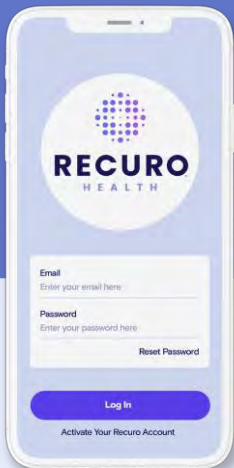
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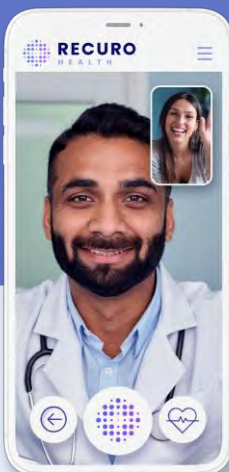
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Dental Insurance



Metlife | www.askmetlife.com | 1.800.942.0854

Taking care of your oral health is not a luxury, it is a necessity to long-term optimal health. Dental insurance can greatly reduce your costs when it comes to preventative, restorative, and emergency procedures. Review the plan benefits to the right to see which option is best for you and your family's dental needs. A range of procedures may be covered, such as:

- Comprehensive Exams
- Cleanings
- X-Rays
- Fillings
- Tooth Extractions
- General Anesthesia
- Crowns
- Root Canals

DENTAL MONTHLY PREMIUMS		
	HIGH PPO	LOW PPO
EMPLOYEE ONLY	\$54.04	\$28.00
EMPLOYEE + 1	\$96.55	\$51.64
EMPLOYEE + FAMILY	\$152.09	\$79.71

Dental Insurance

Network: PDP Plus

	Plan option 1 High Plan		Plan option 2 Low Plan	
	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ of R&C Fee ^{**}	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of Maximum Allowable Charge [*]
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	50%	50%	50%	50%
Deductible[†]				
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
Annual Maximum Benefit				
Per Person	\$2,000	\$2,000	\$1,000	\$1,000
Orthodontia Lifetime Maximum				
Per Person ^{***}	\$1,000	\$1,000	\$750	\$750

Child(ren)'s eligibility for dental coverage is from birth up to age 26 if a full-time student.

¹ "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

² Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

†Applies only to Type B & C Services.

*** Orthodontia excluded for adults. Available for dependent children up to age 19.

Dental Insurance

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Plan Type	Plan Option 1: High Plan How Many/How Often	Plan Option 2: Low Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment every 12 months for dependent children up to his/her 18th birthday	One fluoride treatment every 12 months year for dependent children up to his/her 18th birthday
X-rays	<ul style="list-style-type: none"> Full mouth X-rays; one per 36 months Bitewings X-rays; two sets per calendar year 	<ul style="list-style-type: none"> Full mouth X-rays; one per 36 months Bitewing X-rays; two sets per calendar year
Sealants	One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday	One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday
Type B — Basic Restorative		
Fillings	<ul style="list-style-type: none"> Replacement once every 24 months 	<ul style="list-style-type: none"> Replacement once every 24 months
Simple Extractions		
Crown, Denture and Bridge Repair/ Recementations	<ul style="list-style-type: none"> Repair once every 12 months Recementation once every 12 months 	<ul style="list-style-type: none"> Repair once every 12 months Recementation once every 12 months
Oral Surgery		
Endodontics		
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday. Once per tooth area, per lifetime	Space maintainers for dependent children up to his/her 14th birthday. Once per tooth area, per lifetime
Type C — Major Restorative		
Implants	Replacement once every 5 years	Replacement once every 5 years

Dental Insurance

Bridges and Dentures	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the plan Dentures and bridgework replacement; one every 5 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed 	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the plan Dentures and bridgework replacement; one every 5 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 5 years	Replacement once every 5 years
Endodontics		
Periodontics	<ul style="list-style-type: none"> Periodontal scaling and root planing once per quadrant, every 24 months Periodontal surgery once per quadrant, every 36 months Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year 	<ul style="list-style-type: none"> Periodontal scaling and root planing once per quadrant, every 24 months Periodontal surgery once per quadrant, every 36 months Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year
Type D — Orthodontia		
	<ul style="list-style-type: none"> Your children, up to age 19, are covered while Dental insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia Payments are on a repetitive basis 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary Orthodontic benefits end at cancellation of coverage 	<ul style="list-style-type: none"> Your children, up to age 19, are covered while Dental insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia Payments are on a repetitive basis 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Dental Insurance

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - Scaling and polishing of teeth; or
 - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
 - Covered under any workers' compensation or occupational disease law;
 - Covered under any employer liability law;
 - For which the employer of the person receiving such services is not required to pay; or
 - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
 - Claim form completion;
 - Infection control such as gloves, masks, and sterilization of supplies; or
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for

Dental Insurance

Dental Insurance, except for congenitally missing natural teeth;

- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance Policy form GPNP99 issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Questions & Answers

Q. Who is a participating dentist?

- A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.[†]

Q. How do I find a participating dentist?

- A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating PDP Plus dentists online at www.metlife.com or call 1-800-942-0854 to have a list faxed or mailed to you.

Q. What services are covered under this plan?

- A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q. May I choose a non-participating dentist?

- A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

- A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.^{††} The website and phone number are for use by dental professionals only.

Dental Insurance

Q. What are incentive provisions?

- A.** These features could increase your annual maximum and or increase your plan coinsurance percentages and or decrease your plan deductible based on claims behavior or utilization. You must meet the criteria to receive the incentive. The criteria is based on your plan design.

Q. What is Connected Benefits?

- A.** Connected Benefits would apply for people with certain medical conditions that have been found to be associated with an increased risk for dental disease. Your dental plan offers this program and it may reimburse your out-of-pocket costs for specific services used to treat dental disease.

Q. How are claims processed?

- A.** Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

- A.** Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of \$300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

- A.** Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

- A.** Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q. Do I need an ID card?

- A.** No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Vision Insurance



Metlife | www.askmetlife.com | 1.855.638.3931

Proper vision care is essential to your overall wellbeing. Regular eye exams at any age will help prevent eye disease and keep your vision strong for years to come.

Your employer provides you with a vision plan to take care of you and your family's needs. You must enroll in the vision plan each plan year and premiums are typically paid through payroll deduction. Here are just a few of the areas where you will save money with your plan:

- Eye exams
- Eyeglasses
- Contact lenses
- Eye surgeries
- Vision correction

VISION MONTHLY PREMIUMS	
VSP CHOICE PLAN	
EMPLOYEE ONLY	\$9.88
EMPLOYEE + ONE	\$16.82
EMPLOYEE + FAMILY	\$24.71

Vision Plan Summary

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in-network.
- Choose from a large network of ophthalmologists, optometrists and opticians from private practices to retailers like Costco® Optical and Visionworks.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out-of-network.

In-network value added features:

Additional lens enhancements:¹
Average 20-25% savings on all other lens enhancements.

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.

Laser vision correction:²
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

We're here to help

Find a Vision provider at www.metlife.com/vision

Download a claim form at www.metlife.com/mybenefits

For general questions go to www.metlife.com/mybenefits or call 1-855-MET-EYE1 (1-855-638-3931)

In-network benefits

There are no claims for you to file when you go to an in-network vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every 12 months
<ul style="list-style-type: none"> • Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a \$10 copay. • Retinal imaging:¹ Up to a \$39 copay on a routine retinal screening performed by a private practice. 	
Frame	Once every 24 months
<ul style="list-style-type: none"> • Allowance: \$150 • Costco: \$85 allowance <p>You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.¹</p>	

Standard corrective lenses	Once every 12 months
<ul style="list-style-type: none"> • Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after \$25 eyewear copay. 	

Standard lens enhancements¹	Once every 12 months
<ul style="list-style-type: none"> • Polycarbonate (child up to age 18), and Ultraviolet(UV) coating Covered in full. • Progressive, Polycarbonate (adult), Photochromic, Anti-reflective and Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits. 	

Contact lenses¹(instead of eye glasses)	Once every 12 months
<ul style="list-style-type: none"> • Contact fitting and evaluation:¹ Covered in full with a maximum copay of \$60. • Elective lenses: \$150 allowance. • Necessary lenses: Covered in full after \$25 eyewear copay. 	

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **in-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

• Eye exam: up to \$45	• Single vision lenses: up to \$30	• Lined trifocal lenses: up to \$65
• Frames: up to \$70	• Lined bifocal lenses: up to \$50	• Progressive lenses: up to \$50
• Contact lenses:	• Lenticular lenses: up to \$100	
- Elective up to \$105		
- Necessary up to \$210		

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments

SERVICES AND EYEWEAR

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state, and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.

- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Plano lenses (lenses with refractive correction of less than ± 0.50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

TREATMENTS

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

MEDICATIONS

- Prescription and non-prescription medications.

¹ All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm your availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

² Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Eagle Mountain-Saginaw ISD

Long-Term Disability Income Insurance

Plan Benefit Highlights

Eligibility

All permanent employees in covered group working 20 hours or more per week. Regarding your eligibility, we may require proof of good health and will rely on answers given on your application to determine if coverage can be issued. Regardless of your health at the time of application, if coverage is approved and issued, claims incurred while coverage is in force will be subject to all terms of the Policy including any Pre-Existing Condition limitation.

Benefits are Payable

Benefits are payable up to age 65 for a covered Injury or Sickness. After age 65, the benefit period will be extended to the greater of 12 months or your Social Security Normal Retirement Age.

Disability Benefit - PLANS 1-6

50% of your Monthly Compensation, not to exceed a maximum covered Monthly Compensation of \$20,000; and the amount for which premium is being paid. If applicable, the insured's Disability Benefit will be reduced by Deductible Sources of Income.

Disability Benefit - 50% of Your Monthly Compensation		
Plan 1	On the 8th day of Disability due to a covered injury or Sickness.	*\$1.70
Plan 2	On the 15th day of Disability due to a covered injury or Sickness.	*\$1.52
Plan 3	On the 31st day of Disability due to a covered injury or Sickness.	*\$1.20
Plan 4	On the 61st day of Disability due to a covered injury or Sickness.	*\$0.98
Plan 5	On the 91st day of Disability due to a covered injury or Sickness.	*\$0.82
Plan 6	On the 151st day of Disability due to a covered injury or Sickness.	*\$0.60

Disability Benefit - PLANS 7-12

66^{2/3}% of your Monthly Compensation, not to exceed a maximum covered Monthly Compensation of \$15,000; and the amount for which premium is being paid. If applicable, the insured's Disability Benefit will be reduced by Deductible Sources of Income.

Disability Benefit - 66 ^{2/3} % of Your Monthly Compensation		
Plan 7	On the 8th day of Disability due to a covered injury or Sickness.	*\$2.26
Plan 8	On the 15th day of Disability due to a covered injury or Sickness.	*\$2.02
Plan 9	On the 31st day of Disability due to a covered injury or Sickness.	*\$1.60
Plan 10	On the 61st day of Disability due to a covered injury or Sickness.	*\$1.30
Plan 11	On the 91st day of Disability due to a covered injury or Sickness.	*\$1.10
Plan 12	On the 151st day of Disability due to a covered injury or Sickness.	*\$0.80

Physician Expense Benefit

Injury - \$150.00 per Injury

If you need personal treatment by a Physician due to an Injury, we will pay the amount shown above provided no other claim has been paid under the Policy. You are not required to miss one full day of work in order to receive the Injury benefit.

Hospital Confinement Benefit

A Hospital Confinement Benefit will be paid each day you are confined as a patient in a Hospital due to an Injury or Sickness, for up to 60 days. The amount payable is 1 times the Disability Benefit which will be pro-rated on a daily basis. This benefit will not be reduced by Deductible Sources of Income. The Hospital confinement must be at least 18 continuous hours in duration. This benefit will begin on your first day of Hospital confinement. **The remainder of your elimination period will be waived (APPLIES ONLY TO PLANS 1-3 & 7-9).**

Hospital: "Hospital" shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Waiver of Premium

No premium payments are required while you are receiving payments under the plan after disability payments have been received for 90 consecutive days. We will require proof annually that you remain disabled during that time.

Donor Benefit

If you are disabled as a result of being an organ or tissue donor, we will pay your benefit as any other sickness under the terms of the plan.

Offsets With Other Sources of Income

Deductible Sources of Income include, Other group disability income, Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits, United States Social Security Act or similar plan or act, including any amounts due your dependent(s) on account of your disability, State Disability, Unemployment compensation, Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond 365 calendar days from the date of disability. We reserve the right to estimate these Deductible Sources of Income that you may receive as defined in your Certificate.

Minimum Disability Benefit

The Minimum Disability Benefit is 10% of the Monthly Disability Benefit or \$100.00, whichever is greater.

If You Are Disabled Due to a Covered Disability and Not Working

For the first 12 months you are disabled due to a covered disability and not working, we will pay the disability benefit described in the schedule. After 12 months, your disability payment will be the disability benefit less any deductible sources of income you receive or are entitled to receive. No disability payment will be provided for any period in which you are not under the regular and appropriate care of a physician.

Disability or disabled for the first 24 months of disability means that you are unable to perform the material and substantial duties of your regular occupation. After that, disability means you are unable to perform the material and substantial duties of any gainful occupation for wage or profit for which you are reasonably qualified by training, education, or experience.

Return To Work Incentives: Disabled and Working

If you are disabled and working, you may be eligible to continue to receive a percentage of your disability payment in addition to your disability earnings. If your disability earnings exceed 80% of your monthly compensation, payments will stop and your claim will end.

Family Care Benefit

If you are disabled and working and have one or more eligible family members, you may be eligible for a family care benefit. This benefit is for expenses incurred up to 25% of your monthly disability benefit. Your disability earnings, gross disability benefit, and family care benefit cannot exceed 100% of your monthly compensation. Payment of this benefit ends when you cease to be eligible for benefits under the Disabled and Working provision of the policy.

Worksite Accommodation

As a part of our claims evaluation process, if worksite modifications may assist your return to work, we will evaluate your claim for appropriate action.

Mental Illness Limited Benefit

If you are disabled due to a mental illness, benefits will be provided for up to 2 years, not to exceed the maximum disability period.

Alcoholism and Drug Addiction Limited Benefit

If you are disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each disability will be paid. Benefits will not be paid beyond the maximum benefit period. If drug addiction is sustained at the hands of, or while under the regular and appropriate care of a physician in the course of treatment for injury or sickness, it will be covered the same as any other sickness.

Special Conditions Limited Benefit

If you are disabled due to special conditions and under the regular and appropriate care of a physician, benefits will be provided for up to 2 years. Special conditions mean: chronic fatigue syndrome; fibromyalgia; any disease, disorder, accident or injury of the neck or back not resulting in hemiplegia, paraplegia, or quadriplegia; environmental allergic illness including, but not limited to sick building syndrome and multiple chemical sensitivity; and self-reported symptoms. Self-reported symptoms are symptoms that the insured tells their physician that are not verifiable using tests, procedures or clinical examinations. Examples include: headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, or loss of energy.

Pre-Existing Condition Limitation

If Disability is caused by or resulting from a Pre-Existing Condition and begins before you have been continuously covered under the Policy for 12 months, no disability benefit will be payable.

Pre-existing condition means a disease, Injury, Sickness, physical condition or mental illness for which you: had treatment; incurred expense; took medication; received care or services including diagnostic testing or related measures; or received a diagnosis or advice from a physician, during the 3-month period immediately before your effective date of coverage. The term pre-existing condition will also include conditions which are related to such disease, injury, sickness, physical condition, or mental illness.

Exclusions

The Policy does not cover any loss, fatal or non-fatal, resulting from:

- Intentionally self-inflicted injury while sane or insane.
- An act of war, declared or undeclared.
- Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- Committing a felony.
- Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
- Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation.

The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements that occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which you are entitled to Workers' Compensation benefits.

Your coverage may be continued for up to 1 year during a leave of absence approved in writing by your employer. Coverage will continue as long as the group policy remains in force, the premiums are paid and you remain eligible for the coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, or your employment terminates. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

Optional Riders

See your Account Representative regarding available riders, including Survivor Benefit Rider, COBRA Funding Rider, Hospital Indemnity Rider, Critical Illness Rider, and Accident Only Spousal Rider.



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LIFE INSURANCE HIGHLIGHTS

For the employee

PURELIFE-PLUS

Voluntary permanent life insurance can be an ideal complement to the group term and optional term life insurance your employer might provide. This voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term may be portable if you change jobs, but even if you can keep them after you retire, they usually cost more and decline in death benefit.

The policy, PURELIFE-PLUS, is underwritten by Texas Life Insurance Company, and it has the following features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite,¹ PURELIFE-PLUS gives your loved ones peace of mind, knowing there will be life insurance in force when you die.
- **Refund of Premium.** Unique in the marketplace, PURELIFE-PLUS offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Due to Terminal Illness Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a \$150 (\$100 in Florida) administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.)*
(Form ICCo7-ULABR-07 or Form Series ULABR-07)
- **Accelerated Death Benefit for Chronic Illness Rider.**² Included for employees at a small extra cost, this rider will be triggered by the loss of two activities of daily living³ or permanent cognitive impairment. It pays the insured 92% of the death benefit minus a small administrative fee, should the insured decide to exercise it. This valuable living benefit can help offset the cost of either in-home care or care in a resident facility. *(Conditions apply.)* *(Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15)*



Additional Features

- **Minimal Cash Value.** Designed to provide a high death benefit at a reasonable premium, PURELIFE-PLUS provides peace of mind for you and your beneficiaries while freeing investment dollars to be directed toward such tax-favored retirement plans as 403(b), 457 and 401(k).
- **Long Guarantees.** Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).

You may apply for this permanent coverage, not only for yourself, but also for your spouse, children and grandchildren.⁴



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?

Flexible Premium Adjustable Life Insurance to age 121. Policy Form ICC-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.

¹ Voluntary Whole and Universal Life Products, Eastbridge Consulting Group, December 2018

² Chronic Illness Rider available for an additional cost for employees only. Conditions apply. Rider not available in CA. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15.

³ Six Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that: (1) places the Insured in jeopardy of harming him/herself or others and, therefore, the Insured requires Substantial Supervision by another individual; and (2) is measured by clinical evidence and standardized tests which reliably measure impairment in: (a) short or long-term memory; (b) orientation to people, places or time; and (c) deductive or abstract reasoning.

⁴ 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.

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
17-20		13.05	23.85	34.65	45.45	67.05	88.65	110.25	131.85	75
21-22		13.33	24.40	35.48	46.55	68.70	90.85	113.00	135.15	74
23		13.60	24.95	36.30	47.65	70.35	93.05	115.75	138.45	75
24-25		13.88	25.50	37.13	48.75	72.00	95.25	118.50	141.75	74
26		14.43	26.60	38.78	50.95	75.30	99.65	124.00	148.35	75
27-28		14.70	27.15	39.60	52.05	76.95	101.85	126.75	151.65	74
29		14.98	27.70	40.43	53.15	78.60	104.05	129.50	154.95	74
30-31		15.25	28.25	41.25	54.25	80.25	106.25	132.25	158.25	73
32		16.08	29.90	43.73	57.55	85.20	112.85	140.50	168.15	74
33		16.63	31.00	45.38	59.75	88.50	117.25	146.00	174.75	74
34		17.45	32.65	47.85	63.05	93.45	123.85	154.25	184.65	75
35		18.55	34.85	51.15	67.45	100.05	132.65	165.25	197.85	76
36		19.10	35.95	52.80	69.65	103.35	137.05	170.75	204.45	76
37		19.93	37.60	55.28	72.95	108.30	143.65	179.00	214.35	77
38		20.75	39.25	57.75	76.25	113.25	150.25	187.25	224.25	77
39		22.13	42.00	61.88	81.75	121.50	161.25	201.00	240.75	78
40	10.75	23.50	44.75	66.00	87.25	129.75	172.25	214.75	257.25	79
41	11.52	25.43	48.60	71.78	94.95	141.30	187.65	234.00	280.35	80
42	12.40	27.63	53.00	78.38	103.75	154.50	205.25	256.00	306.75	81
43	13.17	29.55	56.85	84.15	111.45	166.05	220.65	275.25	329.85	82
44	13.94	31.48	60.70	89.93	119.15	177.60	236.05	294.50	352.95	83
45	14.71	33.40	64.55	95.70	126.85	189.15	251.45	313.75	376.05	83
46	15.59	35.60	68.95	102.30	135.65	202.35	269.05	335.75	402.45	84
47	16.36	37.53	72.80	108.08	143.35	213.90	284.45	355.00	425.55	84
48	17.13	39.45	76.65	113.85	151.05	225.45	299.85	374.25	448.65	85
49	18.12	41.93	81.60	121.28	160.95	240.30	319.65	399.00	478.35	85
50	19.22	44.68	87.10	129.53	171.95					86
51	20.54	47.98	93.70	139.43	185.15					87
52	21.97	51.55	100.85	150.15	199.45					88
53	23.07	54.30	106.35	158.40	210.45					88
54	24.17	57.05	111.85	166.65	221.45					88
55	25.38	60.08	117.90	175.73	233.55					89
56	26.48	62.83	123.40	183.98	244.55					89
57	27.80	66.13	130.00	193.88	257.75					89
58	29.01	69.15	136.05	202.95	269.85					89
59	30.33	72.45	142.65	212.85	283.05					89
60	31.18	74.58	146.90	219.23	291.55					90
61	32.61	78.15	154.05	229.95	305.85					90
62	34.37	82.55	162.85	243.15	323.45					90
63	36.13	86.95	171.65	256.35	341.05					90
64	38.00	91.63	181.00	270.38	359.75					90
65	40.09	96.85	191.45	286.05	380.65					90
66	42.40									90
67	44.93									91
68	47.68									91
69	50.43									91
70	53.29									91

CHILDREN AND GRANDCHILDREN (NON-TOBACCO)
 with Accidental Death Rider
 Grandchild coverage available through age 18.

Issue Age	Premium		Guaranteed Period
	\$25,000	\$50,000	
15D-1	9.25	16.25	81
2-4	9.50	16.75	80
5-8	9.75	17.25	79
9-10	10.00	17.75	79
11-16	10.25	18.25	77
17-20	12.25	22.25	75
21-22	12.50	22.75	74
23	12.75	23.25	75
24-25	13.00	23.75	74
26	13.50	24.75	75

Indicates Spouse Coverage Available

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".

Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO

Accelerated Death Benefit for Chronic Illness Rider Form ICC15-ULABR-CI-15, ULABR-CI-15 or CA-ULABR-CI-18

Accidental Death Benefit Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
17-20		18.55	34.85	51.15	67.45	100.05	132.65	165.25	197.85	71
21-22		19.38	36.50	53.63	70.75	105.00	139.25	173.50	207.75	71
23		20.20	38.15	56.10	74.05	109.95	145.85	181.75	217.65	72
24-25		20.75	39.25	57.75	76.25	113.25	150.25	187.25	224.25	71
26		21.30	40.35	59.40	78.45	116.55	154.65	192.75	230.85	72
27-28		21.85	41.45	61.05	80.65	119.85	159.05	198.25	237.45	71
29		22.13	42.00	61.88	81.75	121.50	161.25	201.00	240.75	71
30-31		24.88	47.50	70.13	92.75	138.00	183.25	228.50	273.75	72
32		25.70	49.15	72.60	96.05	142.95	189.85	236.75	283.65	72
33		25.98	49.70	73.43	97.15	144.60	192.05	239.50	286.95	72
34		26.25	50.25	74.25	98.25	146.25	194.25	242.25	290.25	71
35		28.18	54.10	80.03	105.95	157.80	209.65	261.50	313.35	72
36		29.00	55.75	82.50	109.25	162.75	216.25	269.75	323.25	72
37		30.93	59.60	88.28	116.95	174.30	231.65	289.00	346.35	73
38		31.75	61.25	90.75	120.25	179.25	238.25	297.25	356.25	73
39		33.95	65.65	97.35	129.05	192.45	255.85	319.25	382.65	74
40	16.14	36.98	71.70	106.43	141.15	210.60	280.05	349.50	418.95	76
41	17.13	39.45	76.65	113.85	151.05	225.45	299.85	374.25	448.65	77
42	18.34	42.48	82.70	122.93	163.15	243.60	324.05	404.50	484.95	78
43	19.88	46.33	90.40	134.48	178.55	266.70	354.85	443.00	531.15	80
44	20.65	48.25	94.25	140.25	186.25	278.25	370.25	462.25	554.25	80
45	21.75	51.00	99.75	148.50	197.25	294.75	392.25	489.75	587.25	81
46	22.63	53.20	104.15	155.10	206.05	307.95	409.85	511.75	613.65	81
47	23.73	55.95	109.65	163.35	217.05	324.45	431.85	539.25	646.65	82
48	24.72	58.43	114.60	170.78	226.95	339.30	451.65	564.00	676.35	82
49	26.15	62.00	121.75	181.50	241.25	360.75	480.25	599.75	719.25	83
50	27.36	65.03	127.80	190.58	253.35					83
51	28.57	68.05	133.85	199.65	265.45					83
52	30.33	72.45	142.65	212.85	283.05					84
53	31.87	76.30	150.35	224.40	298.45					85
54	33.30	79.88	157.50	235.13	312.75					85
55	34.84	83.73	165.20	246.68	328.15					85
56	36.60	88.13	174.00	259.88	345.75					85
57	38.36	92.53	182.80	273.08	363.35					86
58	40.23	97.20	192.15	287.10	382.05					86
59	42.10	101.88	201.50	301.13	400.75					86
60	43.28	104.83	207.40	309.98	412.55					86
61	45.81	111.15	220.05	328.95	437.85					86
62	48.23	117.20	232.15	347.10	462.05					87
63	50.65	123.25	244.25	365.25	486.25					87
64	53.07	129.30	256.35	383.40	510.45					87
65	55.71	135.90	269.55	403.20	536.85					87
66	58.57									88
67	61.65									88
68	64.84									88
69	68.25									88
70	71.88									89

CHILDREN AND GRANDCHILDREN (TOBACCO)
 with Accidental Death Rider
 Grandchild coverage available through age 18.

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".

Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO

Accelerated Death Benefit for Chronic Illness Rider Form ICC15-ULABR-CI-15, ULABR-CI-15 or CA-ULABR-CI-18

Accidental Death Benefit Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07

23M014-C-M FFGA-T 1012 (exp0325)

Issue Age	Premium		Guaranteed Period
	\$25,000	\$50,000	
17-20	17.25	32.25	71
21-22	18.00	33.75	71
23	18.75	35.25	72
24-25	19.25	36.25	71
26	19.75	37.25	72

Indicates Spouse Coverage Available

Critical Illness Insurance Plan Summary

COVERAGE OPTIONS

Critical Illness Insurance		
Eligible Individual	Initial Benefit	Requirements
Employee	\$5,000 to \$50,000 in \$5,000 increments	Coverage is guaranteed provided you are actively at work. ³
Spouse/Domestic Partner ¹	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ³
Dependent Child(ren) ²	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ³

BENEFIT PAYMENT

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit⁴ for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or \$15,000 or \$150,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer ⁵	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer ⁵	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke ⁶	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft ⁷	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease ⁸	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions	25% of Initial Benefit	Not applicable

22 Listed Conditions

MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one benefit payment for one Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Example of Initial & Recurrence Benefit Payments

The example below illustrates an employee who elected an Initial Benefit of \$50,000 and has a Total Benefit of 3 times the Initial Benefit Amount or \$150,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of \$50,000 or 100%	\$100,000
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of \$25,000 or 50%	\$75,000
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of \$50,000 or 100%	\$25,000

In most states there is a preexisting condition limitation. If advice, treatment or care was sought, recommended, prescribed or received during the three months prior to the effective date of coverage, we will not pay benefits if the covered condition occurs during the first six months of coverage. The preexisting condition limitation does not apply to heart attack or stroke.

SUPPLEMENTAL BENEFITS

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit¹⁰

MetLife will provide an annual benefit of \$75 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

Eligible screening/prevention measures may include:

• annual physical exam	• flexible sigmoidoscopy
• biopsies for cancer	• hemoccult stool specimen
• blood test to determine total cholesterol	• hemoglobin A1C
• blood test to determine triglycerides	• human papillomavirus (HPV) vaccination
• bone marrow testing	• lipid panel
• breast MRI	• mammogram
• breast ultrasound	• oral cancer screening
• breast sonogram	• pap smears or thin prep pap test
• cancer antigen 15-3 blood test for breast cancer (CA 15-3)	• prostate-specific antigen (PSA) test
• cancer antigen 125 blood test for ovarian cancer (CA 125)	• serum cholesterol test to determine LDL and HDL levels
• carcinoembryonic antigen blood test for colon cancer (CEA)	• serum protein electrophoresis
• carotid doppler	• skin cancer biopsy
• chest x-rays	• skin cancer screening
• clinical testicular exam	• skin exam
• colonoscopy	• stress test on bicycle or treadmill
• digital rectal exam (DRE)	• successful completion of smoking cessation program
• Doppler screening for cancer	• tests for sexually transmitted infections (STIs)
• Doppler screening for peripheral vascular disease	• thermography
• echocardiogram	• two hour post-load plasma glucose test
• electrocardiogram (EKG)	• ultrasounds for cancer detection
• endoscopy	• ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
• fasting blood glucose test	• virtual colonoscopy
• fasting plasma glucose test	



Critical Illness with Cancer Insurance

MetLife
(800) 638-5433
<https://www.askmetlife.com>

MetLife

Critical Illness Insurance protects you and your family in the event of a serious illness or other medical condition with coverage that is portable (meaning you can take it with you, if you leave).

Depending on the diagnosis you receive, your benefit payment may be 100% or 25% of your selected benefit amount. Payments are made directly to the employee and can be applied to claims, household bills, or other expenses as needed.

Rates will be based on the amount you have selected, your age upon issuance, and whether you use tobacco.

Please speak with a Benefits Counselor for personalized rates.

Benefit	Critical Life Events
	Benefit Amount
Coverage Amounts	
Employee	\$10,000 to \$50,000
Spouse	50% of employee amount
Child	50% of employee amount
Heart Attack	
Stroke	
Major Organ Transplant	
Coronary Artery Bypass Graft	
End Stage Renal Failure	
Alzheimer's Disease	
Full Cancer Benefit	
100%	
ALS	
Cerebral Palsy	
Cystic Fibrosis	
Partial Cancer Benefit	
25%	
Pre-Existing Conditions	
	3-month look back / 6-month waiting
Health Screening Benefit	
Annual Wellness Exam	\$75

Critical Illness Monthly Deductions per \$1,000 (Non-Tobacco)						
Age	18 – 29	30 – 39	40 – 49	50 – 59	60 – 69	70+
Employee	\$0.47	\$0.74	\$1.48	\$2.56	\$3.74	\$4.89
Employee + Spouse	\$0.80	\$1.27	\$2.51	\$4.30	\$6.16	\$8.01
Employee + Child(ren)	\$0.70	\$0.97	\$1.71	\$2.79	\$3.97	\$5.12
Family	\$1.03	\$1.50	\$2.74	\$4.53	\$6.39	\$8.24

Critical Illness Monthly Deductions per \$1,000 (Tobacco)						
Age	18 – 29	30 – 39	40 – 49	50 – 59	60 – 69	70+
Employee	\$0.68	\$1.15	\$2.40	\$4.22	\$6.27	\$8.35
Employee + Spouse	\$1.13	\$1.93	\$4.03	\$7.07	\$10.33	\$13.71
Employee + Child(ren)	\$0.91	\$1.38	\$2.63	\$4.45	\$6.50	\$8.58
Family	\$1.36	\$2.16	\$4.26	\$7.30	\$10.56	\$13.94

QUESTIONS & ANSWERS

How do I enroll?

Enroll for coverage at mybenefits.metlife.com.

Who is eligible to enroll?

Regular active full-time employees who are actively at work along with their spouse/domestic partner and dependent children can enroll for MetLife Critical Illness Insurance coverage.³

How do I pay for coverage?

Coverage is paid through convenient payroll deduction.

If I Leave the Company, Can I Keep My Coverage?¹¹

Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Who do I call for assistance?

Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

Footnotes:

¹ Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.

² Dependent Child coverage varies by state. Please contact MetLife for more information.

³ Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

⁴ We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.

⁵ Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NH-situated cases and NH residents, there is an initial benefit of \$100 for All Other Cancers.

⁶ In certain states, the covered condition is Severe Stroke.

⁷ In NJ situated cases, the Covered Condition is Coronary Artery Disease.

⁸ Please review the Outline of Coverage for specific information about Alzheimer's disease.

¹⁰ The Health Screening Benefit is not available in all states. See your certificate for any applicable waiting periods. There is a separate mammogram benefit for MT residents and for cases situated in CA and MT.

¹¹ Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. In most plans, there is a preexisting condition exclusion. After a covered condition occurs, there is a benefit suspension period during which benefits will not be paid for a recurrence, except in the case of individuals covered under a New York certificate. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. A more detailed description of the benefits, limitations, and exclusions applicable can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.



Voluntary Term Life Insurance

Unum's Group Voluntary Term Life Insurance provides employees, spouses and children with the opportunity for an additional safeguard against financial worries.

- As employees, you can purchase from **\$10,000 up to 5 times your annual salary to a maximum of \$500,000**; spouses can purchase from \$5,000 up to \$100,000; and child coverage from \$1,000 up to \$10,000 (not to exceed 100% of the employee amount).
- Guarantee Issue is equal to, **\$200,000** for an Employee and **\$50,000** for a Spouse
- During your initial enrollment you can purchase up to the guarantee issue amount with **no medical underwriting required**. Benefit amounts can be increased at annual enrollment up to guarantee issue with no medical underwriting.
If you choose to purchase at the next annual enrollment, all benefit amounts elected are subject to medical underwriting.

Benefit Reduction Schedule – Coverage amounts will reduce to 65% of original amount at age 70 and 50% of original amount at age 75.

Delayed Effective Date of Coverage - Insurance 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.

Questions ? - This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

Underwritten by: **Unum Life Insurance Company of America**
2211 Congress Street, Portland, ME 04122
www.Unum.com

<i>Monthly Rates</i>		
<i>Age</i>	<i>Employee Rates per \$10,000</i>	<i>Spouse Rates per \$5,000</i>
15-24	\$0.60	\$0.30
25-29	\$0.60	\$0.30
30-34	\$0.80	\$0.40
35-39	\$1.10	\$.55
40-44	\$1.60	\$0.80
45-49	\$2.70	\$1.35
50-54	\$4.60	\$2.30
55-59	\$7.75	\$3.875
60-64	\$11.25	\$5.625
65-69	\$18.70	\$9.35
70-74	\$36.80	\$18.40
75+	\$36.80	\$18.40
Child Monthly Rates	Option 1: \$1,000 - \$0.20 Option 2: \$2,000 - \$0.39 Option 3: \$4,000 - \$0.78 Option 4: \$5,000 - \$0.98 Option 5: \$10,000 - \$1.96	

Group Life Plan

Features Include:

- Life Planning Financial and Legal Resources
- Accelerated Benefit
- Employee Life Insurance Premium Waiver
- Portability/Conversion

CANCER INSURANCE

American Fidelity | www.americanfidelity.com | 1.800.654.8489

Thousands of Americans are diagnosed with cancer each day. No doubt, the news is devastating, both personally and financially. It's impossible to anticipate a cancer diagnosis, but it is possible to prepare for it with a cancer insurance plan.

It is likely that your major medical coverage will not cover all the costs associated with a cancer diagnosis. Supplementing your major medical with cancer insurance may help you pay for related expenses, such as copays and deductibles, specialists, experimental treatment, specialty hospitals, travel expenses, in-home care and more.

Premiums are paid through convenient payroll deduction to ensure your policy remains in force if you should need it. Benefits are paid directly to you, so you can choose how to spend the money. Visit the Employee Benefits Center and view policy for more details.



AF™ Group Cancer Insurance

Focus on the fight.

A cancer diagnosis may be both a physical and emotional drain. But thanks to advances in medicine and procedures to treat cancer, more and more people are beating the disease. However, with the arrival of these advances also comes the continuing rise in the cost of cancer treatment.

AF™ **Limited Benefit Group Cancer Insurance** offers a solution to help you and your family focus on fighting the disease.

Did You Know?

New cancer cases in America are diagnosed at the rate of about 4,626 per day.

American Cancer Society: Cancer Facts and Figures 2017, pg. 4.

Plan Highlights

- **Helps cover expenses**
for the treatment of cancer, transportation, hospitalization, and more.
- **Benefits paid directly to you**
to be used however you see fit.
- **Portable to take with you**
even if you leave employment.
- **Coverage options available**
for you, your spouse, and your children under age 26.

Cancer Insurance Benefits

With over 25 benefits specifically designed to help with the financial impact of being diagnosed, AF™ **Group Cancer Insurance** may help pay for expenses not covered by your major medical insurance.

Example cancer insurance benefits include:



Diagnostic and Prevention

Annual benefit to help pay for covered diagnostic testing or screening. This benefit also qualifies for our AFQuickClaims®.



Travel Expenses

This benefit may help pay for qualified transportation and lodging for the patient and family.

**AMERICAN
FIDELITY** 
a different opinion

Choose Your Coverage

TREATMENT BENEFITS	BASIC	ENHANCED PLUS
Radiation Therapy/Chemotherapy/Immunotherapy Benefit (per 12-month period) (actual charges)	\$10,000	\$15,000
Administrative/Lab Work Benefit (per calendar month)	\$50	\$75
Hormone Therapy Benefit (per treatment - max 1 treatment/calendar month)	\$50	\$50
Experimental Treatment Benefit	Paid in the same manner and under the same maximums as any other treatment	
Blood, Plasma, and Platelets Benefit (\$10,000 Basic, \$15,000 Enhanced Plus per calendar year max)	\$200/day	\$300/day
Medical Imaging Benefit (per image - max 2 per calendar year)	\$200	\$300
Surgical Benefit	\$20 surgical unit/ Max per operation: \$2,000	\$40 surgical unit/ Max per operation: \$4,000
Anesthesia Benefit	25% of the amount paid for covered surgery	
Second and Third Surgical Opinion Benefit(per diagnosis)	\$300	\$300
Outpatient Hospital or Ambulatory Surgical Center Benefit	\$200/day of surgery	\$600/day of surgery
Bone Marrow or Stem Cell Transplant Benefit		
Patient Provided (per calendar year)	\$500	\$1,500
Donor Provided (per calendar year)	\$1,500	\$4,500
Prosthesis and Orthotic Benefit and Related Services	\$1,000	\$2,000
Surgical (1/site; lifetime max 2/covered person)	\$100	\$200
Non-surgical (1/site; lifetime max 3/covered person)	\$100	\$200
Hair Prosthesis (once per life)		
Hospital Confinement Benefit		
Day 1-30	\$100/day	\$300/day
Day 31+	\$200/day	\$600/day
U.S. Government/Charity Hospital Benefit (paid in lieu of most benefits) (inpatient and outpatient)	\$100/day	\$300/day
Extended Care Facility Benefit (up to the same number of days of paid hospital confinement)	\$100/day	\$300/day
Home Health Care (up to the same number of days of paid hospital confinement)	\$100/day	\$300/day
Hospice Care Benefit (\$18,000 lifetime max for Basic; \$54,000 lifetime max for Enhanced Plus)	\$100/day	\$300/day
Inpatient Special Nursing Services Benefit	\$100/day	\$300/day
Dread Disease Benefit (paid per day while hospital confined)		
Day 1-30	\$100/day	\$300/day
Day 31+	\$200/day	\$600/day

TREATMENT BENEFITS	BASIC	ENHANCED PLUS
Donor Benefit	\$1,000/donation	
Drugs and Medicine Benefit		
Inpatient (payable per confinement)	\$50	\$200
Outpatient (\$50/prescription/calendar month up to max shown)	\$50	\$100
Attending Physician Benefit (while hospital confined)	\$50/day	\$50/day
Transportation & Lodging Benefit (Patient & Family Member)		
Transportation (\$1,500 max per round trip; max 12 trips/calendar year)	Coach fare or \$.50/mile by car	Coach fare or \$.50/mile by car
Lodging (per day up to 90 days per calendar year)	\$50	\$75
Ambulance Benefit		
Ground (per trip, up to 2 per confinement)	\$200	\$200
Air (per trip, up to 2 per confinement)	\$2,000	\$2,000
Physical or Speech Therapy Benefit (per visit up to 4 per calendar month - lifetime max of \$1,000)	\$50	\$50
Diagnostic and Prevention Benefit (one per calendar year)	\$25	\$75
Cancer Screening Follow-Up Benefit (one per calendar year)	\$25	\$75
Waiver of Premium (employee only)	After 90 days of continuous disability	
Internal Cancer Diagnosis Benefit (paid once/Covered Person/Lifetime; Benefits reduce 50% at age 70)	\$2,500	\$5,000
Heart Attack or Stroke Diagnosis Benefit (paid once/covered person/lifetime; benefits reduce 50% at age 70)	N/A	\$5,000
Hospital Intensive Care Unit Benefit (per day; max 30 days/confinement; benefits reduce 50% at age 70)		\$600
Ambulance		\$100

Unless otherwise indicated, benefits are for a specified indemnity amount listed in the above schedule and are subject to applicable maximums. Refer to Plan Benefit Highlights for more complete Benefit Descriptions and limits on the Cancer Insurance Plan.

Monthly Premium

	BASIC	ENHANCED PLUS
Individual	\$15.80	\$31.62
Family	\$26.86	\$53.80

Plan Benefit Highlights

Only loss for cancer Unless otherwise indicated, benefits are payable only for loss pays only for loss resulting from definitive Cancer diagnosis or treatment including direct extension, metastatic spread, or recurrence. Proof must be submitted to support each claim. The Policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. The Policy does not cover any other disease, sickness, or incapacity, even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically covered under the Dread Disease Benefit or Hospital Intensive Care Unit Benefit; or Heart Attack or Stroke Diagnosis Benefit, if included.

Cancer Means a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratosis; aplastic anemia; atypia; non-malignant monoclonal gammopathy; or pre-malignant lesions, benign tumors or polyps.

Such Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. Diagnosis must be made based on a microscopic examination of fixed tissue, or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue and/or specimen.

Radiation Therapy, Chemotherapy or Immunotherapy Benefit We will pay the actual charges up to the benefit listed in the schedule per 12 month period. If Proof of Loss regarding actual charges for treatment is not submitted, we will pay the daily amount shown in your certificate for each day treatment is received, up to the actual charges maximum per 12-month period. Upon receipt of actual charges Proof of Loss, we will pay the difference, up to the maximum per 12-month period. Actual charges are the amount actually paid by or on behalf of the Covered Person and accepted by the provider for services provided.

This benefit does not cover other related procedures such as treatment planning, treatment management or consultation, design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, scans, medical supplies and equipment used in administration (IV solutions, needles, dressings, pumps, catheters, etc.).

Administrative and Lab Work Benefit Paid only if the Covered Person is also receiving the Radiation Therapy, Chemotherapy or Immunotherapy Benefit during the same calendar month.

Hormone Therapy Benefit Drugs and medicines covered under the Drugs and Medicine Benefit or the Radiation Therapy, Chemotherapy or Immunotherapy Benefit are not included. This benefit does not cover associated administrative processes.

Experimental Treatment Benefit Benefits for experimental treatment prescribed by a physician for treatment of Cancer will be provided the same as non-experimental treatment. Coverage for treatments received outside of the United States or its territories is not provided.

Blood, Plasma and Platelets Benefit Laboratory processes are not included. Colony stimulating factors are not covered. Benefits for blood, plasma and platelets are only provided under this benefit.

Medical Imaging Benefit Payable for a Covered Person who has been diagnosed with Cancer who receives either an MRI, CT scan, CAT scan, PET scan, or RAIU (thyroid) test when performed at the request of a physician.

Surgical Benefit Payable when a surgical operation is performed for covered diagnosed Cancer, Skin Cancer, or reconstructive surgery due to Cancer. Benefits are calculated up to a maximum benefit by multiplying the surgical unit value assigned to the procedure, as shown in the most current Physician's Relative Value Table, by the unit dollar amount shown in your certificate schedule. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Bone marrow surgeries, surgeries to implant a permanent prosthetic device, surgeries required for administration of Radiation Therapy, Chemotherapy or Immunotherapy are not covered under this benefit.

Anesthesia Benefit Services of an anesthesiologist for Skin Cancer or surgical prosthesis implantation are not covered.

Second and Third Surgical Opinion Benefit Payable once per diagnosis of Cancer for a second surgical opinion, and a third if the second disagrees with the first. Surgical opinions for reconstructive, Skin Cancer, or prosthesis surgeries are not covered.

Outpatient Hospital or Ambulatory Surgical Center Benefit Surgical procedures for Skin Cancer are not covered.

Bone Marrow or Stem Cell Transplant Benefit Harvesting of bone marrow or stem cells from a donor are not covered under this benefit.

Prosthesis and Orthotic Benefit and Related Services Payable for a Prosthetic or Orthotic Device and, if surgery required, its surgical implantation. Prosthetic related supplies such as special bras or ostomy pouches and supplies are not covered. Benefits for a hair prosthesis will only be covered under the Hair Prosthesis Benefit.

Covered benefits under this provision are limited to the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Physician or podiatrist and prosthetist or orthotist, as applicable. The Prosthesis Benefit will include repair and replacement of a Prosthetic Device or Orthotic Device, unless the repair or replacement is necessitated by misuse by the Covered Person.

Hospital Confinement Benefit Pays when the Covered Person requires Hospital confinement for at least 18 continuous hours. Hospital shall not include an institution, or part thereof, used by the Covered Person as a place for rehabilitation; a hospice unit, including any bed designated as a hospice or swing bed; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

U.S. Government or Charity Hospital Benefit Payable when an itemized list of services is not available and the Covered Person is confined in a charity Hospital or a Hospital owned or operated by the U.S. government as a result of Cancer or Dread Disease or covered under a Diagnostic Related Group where no charges are made to the Covered Person for treatment of Cancer or Dread Disease. This benefit will be paid in lieu of most benefits listed on the schedule.

Extended Care Facility Benefit Pays a daily benefit for physician authorized confinement that begins within 14 days after a Hospital confinement.

Home Health Care Benefit Pays a daily benefit for physician authorized private nursing care that begins within 14 days of a hospital confinement. This benefit does not include nutrition counseling, medical social services, medical supplies, prosthesis or orthopedic appliances, rental or purchase of durable medical equipment, drugs or medicines, child care, meals or housekeeping services, or physical or speech therapy.

Plan Benefit Highlights (cont.)

Hospice Care Benefit Pays a daily benefit when a physician determines terminal illness with life expectancy of 6 months or less and approves hospice care at home or in a hospice facility. This benefit does not include well baby care, volunteer services, meals, housekeeping services, or family support after the death.

Inpatient Special Nursing Services Benefit Pays a daily benefit when receiving physician authorized special nursing care (other than that regularly furnished by a Hospital) of at least 8 consecutive hours during a 24 hour period.

Dread Disease Benefit Covered Dread Diseases are: Addison's Disease; Amyotrophic Lateral Sclerosis; Cystic Fibrosis; Diphtheria; Encephalitis; Grand Mal Epilepsy; Legionnaire's Disease; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Niemann-Pick Disease; Osteomyelitis; Poliomyelitis; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Systemic Lupus Erythematosus; Tay-Sach's Disease; Tetanus; Toxic Epidermal; Toxic Shock Syndrome; Tuberculosis; Tularemia; Typhoid Fever; Whipple's Disease.

Donor Benefit Blood donor expenses are not covered.

Drugs and Medicine Benefit Pays a benefit for anti-nausea and pain medication for treatment of Cancer. It does not include associated administrative processes or drugs or medicines covered under the Radiation Therapy, Chemotherapy or Immunotherapy Benefit or the Hormone Therapy Benefit.

Transportation and Lodging Benefits Pays a benefit for transportation by scheduled bus, plane or train, or by car and outpatient lodging for Radiation Therapy, Chemotherapy, or Immunotherapy treatment, Bone Marrow or Stem Cell Transplant, or surgery in a Hospital not available locally and at least 50 miles from the Covered Person's residence. Payable for the Covered Person and one adult family member. If traveling in the same car or lodging in the same room, the benefit is payable only for the Covered Person.

Ambulance Benefit If air and ground ambulance services are both required on the same day, we will only pay the higher benefit amount. Covered Person must be admitted as an inpatient and hospital confined for at least 18 consecutive hours.

Waiver of Premium Premium waived if you are disabled due to Cancer for longer than 90 continuous days. This benefit does not apply if your spouse or children become disabled.

Physical or Speech Therapy Benefit Therapy must be provided by a caregiver licensed in physical or speech therapy.

Diagnostic and Prevention Benefit Pays for a generally medically recognized screening test to detect Internal Cancer. This benefit is not payable for any test covered under the Medical Imaging Benefit.

Cancer Screening Follow Up Benefit Payable for one follow-up invasive screening test when a Covered Person receives abnormal results from a covered screening test. For tests involving an incision or surgery, payable only for tests that result in a negative diagnosis of Cancer.

Internal Cancer Diagnosis Benefit Payable if a physician diagnoses the Covered Person with Internal Cancer after coverage is in force for that person.

Heart Attack or Stroke Diagnosis Benefit Payable if a physician diagnoses the Covered Person as having a Heart Attack or Stroke after coverage is in force for that person. This benefit is payable only for the first to occur of either the Heart Attack or Stroke.

Pre-existing condition Means a Specified Disease for which the Covered Person: (a) had treatment; or (b) received advice from a Physician, during the 12-month period immediately before the Covered Person's Effective Date of coverage.

Pre-existing condition limitation No benefit will be payable for any loss which is caused by or resulting from a Pre-Existing Condition which occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months. Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered. Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

Hospital intensive care unit benefit limitations No benefits will be payable during the first 2 years of coverage for confinement caused by any heart condition that was diagnosed or treated prior to 30 days following the Effective Date of coverage. (The heart condition causing confinement need not be the same condition diagnosed or treated prior to the Effective Date).

Exclusions We will not pay benefits resulting from or caused by:

- (a) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
- (b) alcoholism or drug addiction;
- (c) war or acts of war, declared or undeclared, while serving in the military or an auxiliary unit thereto;
- (d) military service for any country at war;
- (e) participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or
- (f) participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.)

Benefits are also not payable for services performed by a Physician who is related to the Covered Person.

Termination of Insurance Your coverage may be continued for up to 1 year during a leave of absence approved in writing by your employer. Coverage will continue as long as the group policy remains in force, the premiums are paid and you remain eligible for the coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, your employment terminates, or you die. Your dependent's coverage will end if your coverage ends, premiums are not paid, they no longer meet the definition of a dependent or the policy is modified to exclude dependents. Your coverage can be terminated or premiums may be increased on any premium due date with 60 days advance written notice.



American Fidelity Assurance Company
9000 Cameron Parkway, Oklahoma City, Oklahoma 73114
800-662-1113 • americanfidelity.com

This product may contain limitations, exclusions, and waiting periods. This brochure highlights important features of the policy. Please refer to your certificate for complete details. If you reside in a state other than your employers state domicile, where required by law, policy provisions and benefits may vary. This product is inappropriate for people who are eligible for Medicaid coverage.

Accident Insurance



Metlife | www.askmetlife.com | 1.800.638.5433

The costs associated with an injury can add up. Between hospital visits, exams and treatment, out-of-pocket costs could put you in a financial hardship. An accident plan pays benefits directly to you, so you can determine where to spend the money. It's comforting to know that an accident insurance policy can be there through all stages of your care, from initial treatment to follow-up care. Accident coverage is available to you through payroll deduction and may provide a benefit for costs associated with:

- Concussions
- Lacerations
- Broken teeth
- Emergency room visits
- Ambulance, ground or air
- Intensive care unit

ACCIDENT INSURANCE MONTHLY PREMIUM		
	LOW PLAN	HIGH PLAN
EMPLOYEE ONLY	\$13.07	\$17.23
EMPLOYEE + SPOUSE	\$26.24	\$35.53
EMPLOYEE + CHILDREN	\$26.67	\$36.27
FAMILY	\$33.46	\$45.40

Accident Insurance Plan Summary

ACCIDENT INSURANCE BENEFITS

With MetLife, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

Benefit Type ¹	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures ²	\$100 – \$6,000	\$150 – \$9,000
Dislocations ²	\$100 – \$6,000	\$150 – \$9,000
Second and Third Degree Burns	\$100 – \$10,000	\$150 – \$15,000
Concussions	\$400	\$600
Cuts/Lacerations	\$50 – \$400	\$75 – \$600
Eye Injuries	\$300	\$400
Medical Services & Treatment		
Ambulance	\$300 – \$1,000	\$400 – \$1,500
Emergency Care	\$50 – \$100	\$100 – \$150
Non-Emergency Care	\$50	\$50
Physician Follow-Up	\$75	\$100
Therapy Services (including physical therapy)	\$25	\$35
Medical Testing Benefit	\$200	\$300
Medical Appliances	\$100 – \$1,000	\$200 – \$1,500
Inpatient Surgery	\$200 – \$2,000	\$300 – \$3,000
Hospital³ Coverage (Accident)		
Admission	\$1,000 (non-ICU) – \$2,000 (ICU) per accident	\$2,000 (non-ICU) – \$4,000 (ICU) per accident
Confinement	\$200 a day (non-ICU) – up to 365 days \$400 a day (ICU) – up to 365 days	\$400 a day (non-ICU) – up to 365 days \$800 a day (ICU) – up to 365 days
Inpatient Rehab (paid per accident)	\$200 a day, up to 15 days	\$300 a day, up to 15 days
Benefit Type¹	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	\$50,000 \$150,000 for common carrier ⁵	\$50,000 \$150,000 for common carrier ⁵
Dismemberment, Loss & Paralysis		
Dismemberment, Loss & Paralysis	\$500 - \$50,000 per injury	\$500 - \$50,000 per injury

Other Benefits		
Lodging ⁶ - Pays for lodging for companion up to 30 nights per calendar year	\$200 per night, up to 31 nights	\$300 per night, up to 31 nights
Health Screening Benefit (Wellness) ⁷ benefit provided if the covered insured takes one of the covered screening/prevention tests	\$100 Payable 1x per calendar year	\$100 Payable 1x per calendar year

BENEFIT PAYMENT EXAMPLE

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event ¹	Benefit Amount ⁸
Ambulance (ground)	\$400
Emergency Care	\$150
Physician Follow-Up (\$100 x 2)	\$200
Medical Testing	\$300
Concussion	\$600
Broken Tooth (repaired by crown)	\$200
Benefits paid by MetLife Group Accident Insurance	\$1,850

QUESTIONS & ANSWERS

Who is eligible to enroll for this accident coverage?

You are eligible to enroll yourself and your eligible family members!⁹ You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

How do I pay for my accident coverage?

Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?

Yes, you can take your coverage with you.¹⁰ You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Who do I call for assistance?

Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

¹ Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

² Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.

³ Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

⁵ Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.

⁶ The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from insured's primary residence.

⁷ The Health Screening Benefit is not available in all states. For Texas situated policies and Texas residents covered under policies situated in other states, when the Health Screening Benefit is included in an Accident-only plan, the covered screening measures are: physical exam, blood chemistry panel, complete blood count (CBC), chest x-rays, electrocardiogram (EKG), and electroencephalogram (EEG).

⁸ Benefit amount is based on a sample MetLife plan design. Actual plan design and plan benefits may vary.

⁹ Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

¹⁰ Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. And, like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.



Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
L1018509328[exp1219][All States] © 2018 MetLife Services and Solutions, LLC



HELP WITH YOUR MEDICAL COSTS

TRANSCONNECT® SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

***TransConnect*, underwritten by Transamerica Life Insurance Company**

Andrea was 33 weeks along when she was involved in a car accident, immediately putting her into pre-term labor. After the whirlwind of the ambulance ride, ER, emergency C-section, and hospital stay, she's nervous about how much her major medical insurance will pay. It's a relief to remember that she signed up for *TransConnect*® at her employer's last open enrollment, which can pay for out-of-pocket expenses like deductibles, co-insurance, and co-payments.

INPATIENT HOSPITAL BENEFITS

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determines your calendar year maximum benefit (multiplied by three for an insured family).

OUTPATIENT HOSPITAL BENEFITS

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) tests performed in a physician's office (X-rays and lab fees are not included)
- Cardiac cauterizations and stress tests
- Accident injury treatment in a hospital ER or urgent care center
- ER charges for illness if admitted to the hospital
- Diagnostic testing for illness in the ER
- Treatment in the ER for an Appendicitis

AMBULANCE BENEFIT

This benefit pays up to \$350 per calendar year for ground or air ambulance transportation provided by a licensed professional company within 72 hours of an accident or if you are hospitalized for the illness requiring the transportation.

MONTHLY PREMIUM

- You -
- You and your spouse -
- You and your child(ren) -
- You, your spouse, and your child(ren) -



Visit:

transamerica.com



Customer Service:

888-763-7474



TRANSAMERICA®

ELIGIBILITY

You must be actively employed qualifying as an eligible insured (defined by the employer) and have an employer's basic, major medical, or comprehensive medical plan.

IMPORTANT POLICY PROVISIONS

Your employer selects benefit amounts, paid only for deductibles, co-insurance, and co-pays incurred when your major medical plan pays for specified treatments and care.

HOW TO SUBMIT A CLAIM

The ID card you'll receive after enrollment should be presented at time of service so providers are paid directly after your major medical carrier determines what you owe. If you don't do so at time of service, simply submit a *TransConnect*® claim form, UB92 or HCFA (the itemized service provider's bill), and the Explanation of Benefits (EOB) from the major medical carrier showing what you owe after what they paid.

EXCLUSIONS

No benefits are payable under this policy/certificate for any expenses incurred:

- Late enrollees are subject to a 30-day waiting period
- During any period the insured person does not have coverage under another medical plan
- As the result of suicide or any attempted suicide, while sane or insane. In the event of suicide, the company's liability may be limited to only the return of premiums paid.
- For any intentionally self-inflicted injury or sickness
- For rest care or rehabilitative care and treatment, outpatient physical therapy, durable medical equipment (DME), and observation including sleep apnea
- For voluntary abortion except, with respect to the insured or insured spouse where the insured or the insured's dependent spouse's life would be endangered if the fetus were carried to term; or where medical complications have arisen from abortion
- As a result of commission of a felony
- As a result of participation in a riot, civil commotion, civil disobedience, or unlawful assembly. Excludes loss occurring while acting in a lawful manner within the scope of authority
- As a result of participation in a contest of speed in power-driven vehicles, parachuting, or hang gliding
- As a result of air travel, except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member
- As a result of intoxication as determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred
- For alcoholism or drug use, unless such drugs were taken on the advice of a physician and taken as prescribed while hospital confined as an inpatient
- As a result of performing police duty as a member of any military or naval organization (this exclusion includes accident sustained

or sickness contracted while in the service of any military, naval, or air force of any country engaged in war. The company will refund the pro rata unearned premium for any such period the insured person is not eligible for benefits)

- For pregnancy of a dependent child
- For sex changes
- For experimental treatment, drugs, or surgery
- For accident or sickness arising out of and in the course of any occupation for compensation, wage, or profit (doesn't apply to sole proprietors or partners not covered by workers' compensation)
- For mental illness or functional or organic nervous disorders — regardless of the cause
- For dental or vision services, including, but not limited to, treatment, surgery, extractions, or X-rays, unless resulting from an accident occurring while the insured person's insurance under this policy is in force and if performed within 12 months of the date of such accident; or due to congenital disease or anomaly of an insured newborn child
- For routine examinations, other than well child examinations if the optional physicians office outpatient treatment benefit is listed on the schedule of benefits, such as health exams, periodic check-ups, or routine physicals
- For any expense for which benefits are excluded under the insured person's other medical plan

TERMINATION OF INSURANCE

INSURANCE ON AN INSURED WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The end of the last period for which premium has been paid
- The policy is terminated
- The employer ceases to participate in this insurance
- The insured retires
- The insured ceases to be on active service
- The insured's coverage in the underlying medical plan ends

INSURANCE ON A DEPENDENT WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The insured's insurance terminates
- The end of the last period for which premium has been paid
- The dependent no longer meets the definition of dependent
- The dependent's coverage in the underlying medical plan ends
- The policy is modified so as to exclude dependent insurance

THE COMPANY MAY END THE INSURANCE IF:

- Any insured person submits a fraudulent claim
- Participation requirements are not met
- On any premium due date, if the company or employer sends written notice 31 days in advance requesting termination
- If the underlying medical plan terminates

This is a brief summary of *TransConnect*® Supplemental medical expense insurance, **underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA.** Policy form series CP201200 and CC200200. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate, and riders for complete details.

Up-to-date information regarding our compensation practices can be found in the disclosures section of our website at tebcs.com.



Less stress

Aetna Hospital Indemnity Plan

Be prepared for what lies ahead

Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

What is the Hospital Indemnity Plan?

The plan pays benefits when you have a planned, or unplanned hospital stay for an illness, injury, surgery or having a baby. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?

Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?

It's completely up to you. You can use the money any way you want, like:

- deductibles or copays
- mortgage or rent
- groceries or utility bills

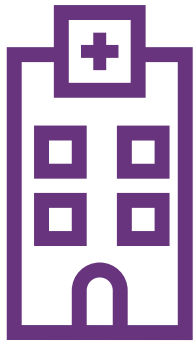
...or for anything else you choose.

Rest assured

Enrollment is easy. And, you get benefits paid directly to you by check or direct deposit.

Because it happens

More than 35 million Americans were hospitalized in 2016¹. The average hospital stay in the U.S. costs \$10,700².



Ready...or not

Carter* is a hard worker, so he doesn't always slow down to listen to his body. Before he knew it, a little cough turned into pneumonia — and a hospital stay.

Good thing he had the Aetna Hospital Indemnity Plan. He filed his claim and the benefits were deposited right into his bank account.

That money helped make up for the time he missed while recovering, and paid some of his deductible. Now, he can focus more on his health.

A Simplified Claims Experience™

Register on the **My Aetna Supplemental** app or on the member portal at **Myaetnasupplemental.com** to view plan documents, submit and track claims, and sign up for direct deposit.

Filing a claim is easy! Click "Report New Claim", answer a few quick questions, and upload or take a picture of your medical bill. You can also print and mail a paper claim form to Aetna Voluntary Plans.



¹American Hospital Association. Fast facts on U.S. hospitals, 2018. February 2018. Available at: aha.org/research/rc/stat-studies/fastfacts.shtml. Accessed April 25, 2018.

²Michaels M. The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do. Business Insider. March 1, 2018. Available at:

businessinsider.com/most-expensive-health-conditions-hospitalcosts-2018-2. Accessed April 25, 2018.

*This is a fictional example of how the plan could work.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna). The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. This plan provides limited benefits. It pays fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. For more information about Aetna plans, refer to **Aetna.com**.

Policy forms issued in Missouri and Oklahoma include: GR-96172 01, AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.

BENEFIT SUMMARY

**Eagle Mountain-Saginaw Independent School District
802765**

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:



Unless otherwise indicated, all benefits and limitations are per covered person.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at www.medicare.gov.

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

Inpatient Stays

Covered Benefit	Low	High
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. <i>Maximum 1 stay per plan year</i>	\$1,000	\$2,000
Hospital stay - Daily Pays a daily benefit, beginning on day one of your stay in a hospital. <i>Maximum 30 days per plan year</i>	\$200	\$200
Important Note: All daily inpatient stay benefits begin on day one and count toward the plan year maximum .		

Waiver of premium
If you are in a hospital for more than 30 days in a row, we will waive the premium beginning on the first premium due date that occurs after the 30th day of your stay, through the next 6 months of coverage. During your stay, you must remain employed with the policyholder.

Portability
If your employment ends, and as a result your coverage under the policy ends, you can choose to continue your coverage by enabling the portability provision in your coverage. Such coverage will be available to you and any of your covered dependents.

Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual policy and certificate to determine which benefits are not payable. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

1. Certain competitive or recreational activities, including but not limited to: ballooning, bungee jumping, parachuting, skydiving;
2. Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment;
3. Act of war, riot, war;
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not;
5. Assault, felony, illegal occupation, or other criminal act;
6. Care provided by a spouse, parent, child, sibling or any other household member;
7. Cosmetic services and plastic surgery, with certain exceptions;
8. Custodial Care;
9. Hospice services, except as specifically provided in the Benefits under your plan section of the certificate;
10. Self-harm, suicide, except when resulting from a diagnosed disorder;
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle;
12. Care or services received outside the United States or its territories;
13. Education, training or retraining services or testing;
14. Mental disorders;
15. Treatment of substance abuse in a hospital or substance abuse treatment facility;
16. Accidental injury sustained while intoxicated or under the influence of any drug intoxicant;
17. Exams except as specifically provided in the Benefits under your plan section of the certificate;
18. Dental and orthodontic care and treatment;
19. Family planning services;
20. Any care, prescription drugs, and medicines related to infertility;
21. Nutritional supplements, including but not limited to: food items, infant formulas, vitamins;
22. Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason;
23. Vision-related care

Do I have to be actively at work to enroll in coverage?

Yes, you must be actively at work in order to enroll and for coverage to take effect. You are actively at work if you are working, or are available to work, and meet the criteria set by your employer to be eligible to enroll.

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?

Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?

A stay is a period during which you are admitted as an inpatient; and are confined in a: hospital, non-hospital residential facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay does not include routine nursery and newborn expenses. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.

If I lose my employment, can I take the Hospital Indemnity Plan with me?

Yes, you are able to continue coverage under the Portability provision. You will need to pay premiums directly to Aetna.

How do I file a claim?

Go to **myaetnasupplemental.com** and either “Log In” or “Register”, depending on if you’ve set up your account. Click the “Create a new claim” button and answer a few quick questions. You can even save your claim to finish later. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail you a printed form.

What should I do in case of an emergency?

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What if I don’t understand something I’ve read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives **Monday through Friday, 8 a.m. to 6 p.m.**, by calling **1-800-607-3366**. We’re here to answer questions before and after you enroll.

Important information about your benefits

IN ORDER FOR THE HOSPITAL INDEMNITY BENEFITS TO BE PAYABLE, THE INITIAL DAY OF YOUR STAY AND OTHER SERVICES MUST BE ON OR AFTER YOUR EFFECTIVE DATE OF COVERAGE.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-607-3366** or visit us at **www.aetna.com**.

If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-800-607-3366, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at **1-877-MA-ENROLL (1-877-623-6765)** or visit the Connector website (**www.mahealthconnector.org**). THIS POLICY, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling **1-617-521-7794** or visiting its website at **www.mass.gov/doi**.

Financial Sanctions Exclusions Clause

If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit

<http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Plans are underwritten by Aetna Life Insurance Company (Aetna).

This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Hospital Indemnity Policy forms issued in Idaho, Oklahoma and Missouri include: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.





RATE SHEET

Rates shown are based on monthly deductions. Your payroll deductions will be taken after taxes are taken.



Hospital Indemnity Plan

You may enroll in one option only.

<u>Low</u>	<u>Cost</u>	<u>High</u>	<u>Cost</u>
Yourself only	\$11.42	Yourself only	\$17.62
Yourself & spouse	\$23.41	Yourself & spouse	\$35.25
Yourself plus child(ren)	\$20.30	Yourself plus child(ren)	\$31.40
Yourself and family	\$33.74	Yourself and family	\$51.65

THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE ARE A SUPPLEMENT TO HEALTH INSURANCE AND NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

Plans are underwritten by Aetna Life Insurance Company (Aetna). Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Supplemental health plans provide limited benefits. The benefit payments are not intended to cover the full cost of medical care. Providers are independent contractors and are not agents of Aetna. This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

Financial Sanctions Exclusions Clause: If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit

<http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Policy forms issued in Oklahoma and Idaho include: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.



MEDICAL TRANSPORT

MASA Transport | www.masamts.com | 1.877.503.0585

Americans today suffer from a false sense of security that their medical coverage will pay for all costs associated with emergency or critical care transport. The reality is that most Americans are only partially covered for these high costs.

Most medical plans will only pay a portion of costs leaving you with the remainder of the bill. There is also the possibility of your medical provider denying your claim altogether, which means you would be responsible for paying the entire bill.

With medical transport protection, you will have zero out-of-pocket expenses for any emergent air or ground transport from anywhere in the United States, regardless of who transports you. You will receive medical emergency transportation solutions to help cover your out-of-pocket medical transport costs when your insurance falls short.



DID YOU KNOW?

25 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year*.

Insurance companies **may not** cover all air and ground ambulance expenses which can result in max in-network out-of-pocket** costs of:



\$8,700 Individual
\$17,400 Family



Ground ambulance **out-of-network transportation costs may be even higher than in-network** since the No Surprises Act does not apply to ground ambulance at this time.

EMERGENT PLUS MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage¹

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage¹

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage¹

MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage¹

MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Contact Your Representative, to learn more:





DID YOU KNOW?

28M
emergency transports are
dispatched by 911 annually.*

MASA MTS steps in where insurance falls short by helping protect families against uncovered costs for emergency transportation.

NEW! Emergent Premier membership plan

Ensure you and your family are protected from unexpected costs when you use emergency transportation by adding MASA MTS to your benefits. While our critical benefits are included in all core plans, Emergent Premier offers coverage for additional expenses like returning a child or pet to a guardian, medical transport to a non-hospital facility, and pandemic quarantining.

MASA's solution is simple — with us, there is no “out-of-network.” We work as a payer, not a provider. You simply call 911 when there is an emergency, and you'll never have to worry about what ambulance provider picks you up. When the ambulance bill arrives, send it to MASA. We'll advocate for you to ensure the ambulance charges are accurate and your insurance company has paid its portion; then we cover the remaining balance including your deductibles and co-pays.

Our benefits

Emergency Air Ambulance Coverage³

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for the Member and when the Dependents require the same services.

Emergency Ground Ambulance Coverage³

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for the Member and when the Dependents require the same services.

* National Association of EMS Officials, 2020



DID YOU KNOW?

25 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year*.

Insurance companies **may not** cover all air and ground ambulance expenses which can result in max in-network out-of-pocket** costs of:



\$8,700 Individual
\$17,400 Family



Ground ambulance **out-of-network transportation costs may be even higher than in-network** since the No Surprises Act does not apply to ground ambulance at this time.

PLATINUM MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage³

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage³

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage³

MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage¹

MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Patient Return Transportation Coverage¹

MASA MTS provides services and covers the out-of-pocket expenses associated with coordinating a Member's transportation when hospitalized more than one hundred (100) miles from home, after discharge from the medical facility, by a regularly scheduled commercial airline to the commercial airport nearest the Member's home.

PLATINUM MEMBERSHIP BENEFITS

Companion Transportation Coverage²

MASA MTS provides services associated with the coordination of transportation for the Member's spouse, other family member, or companion to accompany the Member's emergency transport by a medically equipped, rotary (i.e., helicopter) or fixed-wing aircraft, giving due priority to the medical personnel and/or equipment and the welfare and safety of the patient.

Hospital Visitor Transportation Coverage²

MASA MTS provides services and covers air transportation expenses associated with coordinating a round-trip, regularly scheduled, commercial airfare for Member's spouse, other family Member or companion to join the Member in the event of in-patient hospitalization more than one hundred (100) statute miles from Member's home.

Minor Return Transportation Coverage²

MASA MTS provides services and covers out-of-pocket expenses associated with minor return transportation to a parent, legal guardian, or another person that can be responsible for the minor in the event that the minor is unattended as a result of Member's Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, or Mortal Remains Transportation coverages. MASA MTS also provides for a qualified attendant to accompany the minor during travel when the minor's age and/or medical condition may require such care.

Vehicle & RV Return Coverage²

MASA MTS provides services and covers the out-of-pocket expenses associated with vehicle return transportation for one (1) a safe operational car, truck, van, motorcycle, travel trailer, or motor home to the Member's home. This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages. MASA MTS pays the cost of fuel, oil and driver.

Pet Return Transportation Coverage²

MASA MTS provides services and covers out-of-pocket expenses for the return transportation to a Member's home for up to two (2) pet(s) belonging to the Member that includes either a dog, cat or other small animal(s). This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages.

Organ Retrieval & Organ Recipient Transportation Coverage⁴

MASA MTS provides services and covers air transportation expenses associated with coordinating transportation for an organ when the Member requires an organ transplant. MASA MTS will also provide service and cover transportation costs of Member and Member's spouse, other family Member or a companion should the Member need to travel to the location where the procedure will occur. If medically necessary, the organ will be transported by a medically equipped fixed-wing aircraft; otherwise, the organ is delivered by a commercial airline to the suitable airport nearest the location of the operation.

Mortal Remains Transportation Coverage¹

MASA MTS covers the air transportation expense for a Member's mortal remains in the event of their death when it occurs more than one hundred (100) statute miles from home. Remains are transported by a regularly scheduled commercial airline to the commercial airport nearest a Member's home.

Contact Your Representative, to learn more.



The information provided in this product information sheet is for informational purposes only. The benefits listed and the descriptions thereof do not represent the full terms and conditions applicable for usage and may only be offered in some memberships. Premiums and benefits vary depending on the benefits selected. Commercial air and Worldwide coverage are not available in all territories. For a complete list of benefits, premiums, and full terms, conditions, and restrictions, please refer to the applicable member services agreement for your territory. MASA MTS products and services are not available in AK, NY, WA, ND, and NJ. MASA MTS utilizes third-party transportation service providers for all transportation services. MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation. Void where prohibited by law.

~If a member has a high deductible health plan that is compatible with a health savings account, benefits will become available under the MASA membership for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

COVERAGE TERRITORIES:

1. Worldwide Coverage - Repatriation to Hospital Near Home Coverage, Patient Return Transportation Coverage, and Mortal Remains Transportation Coverage benefits shall extend Worldwide. Worldwide Coverage shall automatically extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda (collectively, "Basic Coverage Area") (excluding countries referenced on the Office of Foreign Assets Control ("OFAC") countries, and Antarctica), and extend elsewhere contingent upon ten (10) day prior notice of such travel. Notice may be provided by (i) certified mail, return receipt requested, to the MASA Corporate office; (ii) electronic mail, including delivery confirmation; or (iii) facsimile, including confirmation of delivery, and MASA's written acknowledgment of such notice. Notice must include a travel itinerary of travel destinations and dates. Unless otherwise authorized by MASA MTS in writing, Worldwide coverage shall apply up to ninety (90) days per trip.
2. Basic Coverage Area - Companion Transportation Coverage, Hospital Visitor Transportation Coverage, Minor Return Transportation Coverage, Vehicle & RV Return Coverage, and Pet Return Transportation Coverage benefits shall extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda. Vehicle & RV Return Coverage shall be limited to only rental vehicles in Hawaii, the Caribbean (excluding Cuba), the Bahamas and Bermuda.
3. United States and Canada Only - Emergency Air Ambulance Coverage, Emergency Ground Ambulance Coverage, and Hospital to Hospital Ambulance Coverage benefits shall only be provided in the United States and Canada.
4. United States Only - Organ Retrieval & Organ Recipient Transportation benefits shall only be provided in the United States.

SOURCES:

**ACEP NOW 2014*

** *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards. May 5, 2021.*



1250 S. Pine Island Rd., Suite 500,
Plantation, FL 33324

800-643-9023 | www.masamts.com

Hospital to Hospital Ambulance Coverage³

MASA MTS will cover out-of-pocket expenses incurred by the Member associated with a medically necessary hospital-to-hospital transfer by a medically-equipped ground ambulance, rotary (i.e., helicopter) or fixed-wing aircraft when ordered by the treating physician at the medical facility where the Member is presently admitted to the nearest and most appropriate medical facility capable of providing the necessary, specialized level of care required and that is not available at the sending facility.

Repatriation Near Home Coverage²

MASA MTS provides services and covers out-of-pocket expense for the coordination of the Member and the Dependents' non-emergency transportation by a medically equipped air ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' medical director says it is medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Minor Return Transport Coverage²

MASA MTS provides services and covers out-of-pocket expenses associated with minor return transportation to a parent, legal guardian, or another person that can be responsible for the minor in the event that the minor is unattended as a result of Member's Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, or Mortal Remains Transportation coverages. MASA MTS also provides for a qualified attendant to accompany the minor during travel when the minor's age and/or medical condition may require such care.

Hospital to Rehab, Skilled Nursing, Long Term Care, or Home Coverage⁴

MASA MTS covers the Member for out-of-pocket expenses that result from medically necessary non-emergency ground transportation from a hospital to a rehabilitation facility, skilled nursing facility, long-term care facility, hospice, or the Member's home for up to \$500 per year.

Pet Return Transportation Coverage²

MASA MTS provides services and covers out-of-pocket expenses for the return transportation to the Member's home for two (2) pet(s) belonging to the Member that, including either a dog, cat or other small animal(s). This service is available when the Member uses Emergency Air Ambulance or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages.

Pandemic Quarantine Expense Protection¹

MASA MTS covers out-of-pocket expenses for hotel, food, and flight changes incurred by the Member in the event the Member contracts a communicable disease while traveling and is required to quarantine more than one hundred (100) statute miles from home for up to \$5,000 per year.

Coverage Territories

1: Worldwide Coverage – coverage shall automatically extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda (collectively, "Basic Coverage Area") (excluding countries referenced on the Office of Foreign Assets Control ("OFAC") countries, and Antarctica), and extend elsewhere contingent upon ten (10) day prior notice of such travel. Notice may be provided by (i) certified mail, return receipt requested, to the MASA Corporate office; (ii) electronic mail, including delivery confirmation; or (iii) facsimile, including confirmation of delivery, and the MASA's written acknowledgment. Notice must include a travel itinerary of travel destinations and dates. Unless otherwise authorized by MASA MTS in writing, worldwide coverage shall apply to up to ninety (90) days per trip.

2: Basic Coverage Area – benefits, shall extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

3: United States and Canada Only – benefits shall only be provided in the United States and Canada.

4: United States Only – benefits shall only be provided in the United States.

Contact your representative to learn more:



This material is for informational purposes only and does not provide any coverage. Not all MASA MTS products and services are available to residents of all states. The benefits listed, and the descriptions thereof, do not represent the full terms and conditions applicable for usage and may only be offered in some memberships. Premiums and benefits vary depending on the plan selected. For a complete list of coverage and exclusions, please refer to the applicable member services agreement for your state. MASA MTS utilizes third-party transportation service providers and does not own or lease any vehicles. MASA, MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation and an affiliated company with Medical Air Services Association, Inc. (MASA).

If a member has a high deductible health plan ("HDHP") that is compatible with a health savings account ("HSA"), benefits may become available under the MASA plan for expenses incurred for medical care (as defined under Internal Revenue Code (IRC) section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for HDHP coverage that is compatible with a HSA.

The information provided in this product information sheet is for informational purposes only. The benefits listed and the descriptions thereof do not represent the full terms and conditions applicable for usage and may only be offered in some memberships. Premiums and benefits vary depending on the benefits selected. Commercial air and Worldwide coverage are not available in all territories. For a complete list of benefits, premiums, and full terms, conditions, and restrictions, please refer to the applicable member services agreement for your territory. MASA MTS products and services are not available in AK, NY, WA, ND, and NJ. MASA MTS utilizes third-party transportation service providers for all transportation services. MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation. Void where prohibited by law.

~If a member has a high deductible health plan that is compatible with a health savings account, benefits will become available under the MASA membership for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

COVERAGE TERRITORIES:

1. All coverage provided by this membership is limited to the continental United States, Alaska, Hawaii, and Canada, and must originate and conclude therein.

SOURCES:

*ACEP NOW 2014

** *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards. May 5, 2021.*



1250 S. Pine Island Rd., Suite 500,
Plantation, FL 33324

800-643-9023 | www.masamts.com

SUPPORTLINC

THE EMPLOYEE ASSISTANCE PROGRAM FOR EAGLE MOUNTAIN SAGINAW

EMOTIONAL WELLBEING & WORK-LIFE BALANCE RESOURCES FOR YOU AND YOUR FAMILY

Life can sometimes present challenges or situations that are difficult to work out alone. The SupportLinc Employee Assistance Program (EAP) is a confidential resource offering in-the-moment support and expert guidance to help you resolve concerns as well as balance home and work. You can access up to three (3) sessions of face-to-face counseling for a wide variety of concerns, such as:

**ANXIETY • DEPRESSION • MARRIAGE AND RELATIONSHIP PROBLEMS • GRIEF AND LOSS
SUBSTANCE ABUSE • ANGER MANAGEMENT • WORK-RELATED PRESSURES • STRESS**

EXPERT REFERRALS AND CONSULTATION

Whether you are a new parent, a caregiver, selling your home or looking for budgeting advice, you're likely to need guidance and referrals to expert resources.

- **LEGAL CONSULTATION** By phone or in-person with a local attorney
- **FINANCIAL EXPERTISE** Planning and consultation with a licensed financial counselor
- **CONVENIENCE RESOURCES** Referrals for childcare, elder care, home repair, housing needs, education, pet care, adoption and so much more

CONFIDENTIALITY

SupportLinc upholds strict confidentiality standards. No one, including your employer, will know you have accessed the program unless you specifically grant permission or express a concern that presents us with a legal obligation to release information.

SUPPORT LINC
EMPLOYEE ASSISTANCE PROGRAMS



GET STARTED



1-800-475-3EAP (3327)



TEXT 'SUPPORT' TO 51230



WWW.SUPPORTLINC.COM

Username: eaglemtnsaginaw

CHOOSE HOW TO GET ASSISTANCE

IN-THE-MOMENT SUPPORT

- Reach a licensed clinician by phone 24/7/365

WEB PORTAL

- Explore on-demand training and practical resources to boost wellbeing and life balance
- Use search engines, financial calculators and career resources
- Find discounted gym memberships
- Access the secure video counseling portal
- Content in English and Spanish

ECONNECT® MOBILE APP

- Program support and resources at your fingertips. Call or live chat with a licensed counselor and explore expert, searchable content

TEXT THERAPY

- Use Textcoach® to exchange text messages, voicenotes and resources with a licensed counselor. Available Monday – Friday, on desktop or mobile app, for up to three (3) weeks per issue

ANIMO

- Strengthen mental health and overall wellbeing using self-guided content, practical resources and daily inspiration from your desktop or mobile app

NAVIGATOR

- Take the guesswork out of your emotional fitness. Click the Navigator icon on the web portal or mobile app and complete a short survey. You'll receive personalized guidance for accessing program support and resources.

AMERICAN FIDELITY
a different opinion



Flexible Spending Accounts



First Financial Administrators, Inc. | www.ffga.com | 1.866.853.3539
P.O. Box 161968 | Altamonte Springs, FL 32716

HEALTHCARE FSA

A Health Flexible Spending Account (Health FSA) is an IRS-approved program to help you save taxes and pay for out-of-pocket medical expenses not covered under your medical plan. If your plan includes a grace period option, you have additional time to incur and claim against unused funds in the new plan year. Keep in mind that remaining balances after the grace period is exhausted will be forfeited under the use-it-or-lose-it rule.

Your maximum contribution amount for 2023 is \$3,050.

HIGHLIGHTS

- Contributions are automatically deducted from your paycheck on a pre-tax basis, which helps reduce your taxable income and increase your spendable income.
- Your full election will be available to you at the beginning of the plan year.
- Be conservative – any money left in your account at the end of the plan year will be forfeited.
- Use your benefits card to pay for qualified expenses upfront so you don't have to spend money out of pocket.
- Keep all receipts in case you need to substantiate a claim for tax purposes.

NOTE: The IRS requires proof that all expenses are eligible. Keep all receipts in case you need to substantiate a claim for tax purposes. Your receipt must include: Date of purchase or service, amount you were required to pay after insurance, description of the product or service, merchant or provider name, and the patient name.

DEPENDENT CARE FSA

With a Dependent Care Flexible Spending Account, you can set aside part of your pay on a pre-tax basis to pay for eligible dependent care expenses like child care, babysitters and adult day care.

You may allocate up to \$5,000 per tax year for reimbursement of dependent care services. If you are married and file a separate tax return, the limit is \$2,500.

HIGHLIGHTS

- Eligible dependents must be claimed as an exemption on your tax return.

FLEXIBLE SPENDING ACCOUNTS CONTINUED

- Eligible dependents must be children under age 13 or an adult dependent incapable of self-care.
- Contributions are not loaded upfront. Funds become available as contributions are made to your account.
- Keep all receipts in case you need to substantiate a claim for tax purposes.
- Balances will be forfeited at the end of the runoff or grace period.

FSA RESOURCES

BENEFITS CARD

The First Financial Benefits Card is available to all employees that participate in Medical FSA and/or a Dependent Care FSA. The Benefits Card gives you immediate access to your money at the point of purchase. Cards are available for participating employees, their spouse, and eligible dependents that are at least 18 years old.

- **The IRS requires validation of most transactions for FSAs.** You must submit receipts for validation of expenses when requested. If you fail to substantiate by providing a receipt to First Financial within 90 days of the purchase or date of service your card will be suspended until the necessary, receipt or explanation of benefits from your insurance provider is received.
- **Dependent Care FSA Contributions are not loaded upfront.** Funds become available as contributions are made to your account.

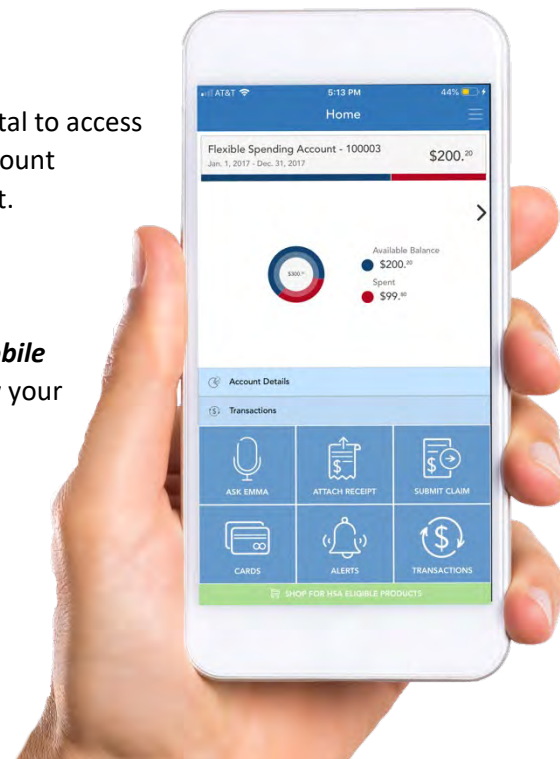
ONLINE FSA PORTAL

Flexible Spending Account participants can log in to their online FSA portal to access account balances, check on claims, upload receipts and access other account details. Visit <https://ffga.com/individuals> to login or set up your account.

FF FLEX MOBILE APP

Managing your benefit accounts on the go is made easy with **FF Flex Mobile App**. This powerful, intuitive mobile application gives you access to view your account balances, update your profile, submit a claim and much more – right from your Android or Apple device.

- Access account Information
- View card details and profile information
- Submit FSA claims using an electronic claim form
- View pending claims
- Upload receipts and documentation
- Receive alerts
- Update direct deposit information



FSA STORE

First Financial has partnered with the FSA Store to bring you an easy to use online store to better understand and manage your FSA. An online marketplace that connects consumers to FSA-eligible products, seasonal deals, and account support resources such as open enrollment guides and educational videos.

Visit <http://www.ffga.com/fsaextras> for more details & special deals!

- Shop for eligible items from bandages to wheelchairs and thousands of products in between
- Browse or search for eligible products and services using the Eligibility List
- Visit the Learning Center to help find answers to questions you may have about your account.

Health Plans Must Cover OTC COVID-19 Tests

Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) are laws passed which include requiring group health coverage to cover the costs of over-the counter (OTC) COVID-19 diagnostic tests (up to \$12.00). The Department of Labor (DOL) and the Internal Revenue Service (IRS) has provided additional guidance to prevent fraud and abuse, the insurer or plan provider, may require an attestation, the OTC COVID-19 test was purchased by the participant, beneficiary, or enrollee for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

Health Savings Accounts



First Financial Administrators, Inc. | www.ffga.com | 1.866.853.3539
P.O. Box 161968 | Altamonte Springs, FL 32716

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is a great way to help you control your healthcare costs. It works in conjunction with a qualified High Deductible Health Plan (HDHP) to combine tax-free savings earmarked for qualified medical expenses. An HSA allows you to set aside money to pay for higher deductibles associated with a lower monthly premium HDHP. The money you save in monthly insurance premiums is reserved for eligible medical expenses you incur in the future. Eligible expenses include things like co-pays and deductibles, prescriptions, vision expenses, dental care, therapy and medical supplies.

HIGHLIGHTS

- Balances roll over from year to year and earn interest along the way.
- Portable – you keep it even after you leave employment.
- Tax advantages – invest money in mutual funds to grow your tax savings for either future healthcare costs or retirement.
- Pay for expenses with a benefits debit card that gives you immediate access to your money at the time of purchase.
- Expenses also can be reimbursed through our online portal, online bill pay directly to your provider or submitting a distribution request form.
- Receipts are not required for reimbursement but be sure to save them for tax purposes.



HEALTH SAVINGS ACCOUNTS

Administered by First Financial Administrators, Inc.

What is a Health Savings Account (HSA)?

HSAs were created to help control healthcare costs. They provide a savings vehicle that allows you to set aside money to pay for higher deductibles associated with lower monthly premium High Deductible Health Plans (HDHP). The money you save in monthly insurance premiums may be aside for eligible medical expenses you incur in the future. Your HSA balance rolls over from year-to-year earning interest along the way. The account is portable. Upon retirement or separation of service, you take the HSA with you because it's your money and your account.

HSAs Offer a Triple Tax Advantage

- » The money you put in to the account is deducted from your paycheck before tax
- » The interest and earnings you make on the account grow tax free
- » Distributions for eligible medical expenses are tax free

Key Advantages of an HSA

- » No end-of-year forfeiture of funds
- » Portable account
- » Provides an excellent savings vehicle for healthcare expenses
- » No monthly account fees
- » Free eStatements when you opt in for electronic delivery

Year-to-year Comparison

Minimum Health Insurance Plan Deductible Amounts for the Qualifying HDHP

	2023	2024
Individual coverage	\$1,500	\$1,600
Family coverage	\$3,000	\$3,200

Annual Maximum Contribution Levels

	2023	2024
Individual coverage	\$3,850	\$4,150
Family coverage	\$7,750	\$8,300

Catch up allowed for those 55 and over - \$1,000

Maximums for HDHP Out-of-Pocket Expenses

	2023	2024
Individual coverage	\$7,500	\$8,050
Family coverage	\$15,000	\$16,100

Who can participate in an HSA and are there any restrictions?

- » You must be enrolled in a qualified High Deductible Health Plan (HDHP)
- » You cannot be enrolled in Tricare or Medicare or covered under your spouse's traditional (non-HDHP) health care plan
- » You cannot participate in a general purpose Flexible Spending Account (FSA) or Health Reimbursement Arrangement
 - » *Limited Purpose Flexible Spending Accounts are permitted (dental and vision expenses only)*
- » You cannot participate if your spouse has a general purpose FSA or HRA at their place of employment
- » You cannot participate if you are being claimed as a dependent on another person's tax return



FFGA-2048-0623

PO Box 161968, Altamonte Springs, FL 32716 | Online: www.ffga.com | Email: hsa@ffga.com
Phone: 866-853-3539 | Fax number: 800-298-7785 | Tech Support: techsupport@ffga.com

Examples of Eligible HSA Expenses

For a complete list, visit <https://www.ffga.com/individuals>

- » Copays & Deductibles
- » Prescriptions
- » Dental Care
- » Contacts & Eyeglasses
- » Hearing aids
- » Laser Eye Surgery
- » Orthodontia
- » Chiropractic Care

Your HSA as an Investment Account

HSA's are often overlooked as powerful retirement tools. The more you save, the more you earn. The account offers significant tax advantages and provides opportunities to invest in mutual funds. Account holders can choose to invest any funds over the minimum threshold the bank requires for various investment options. This is a great way to potentially grow your savings for future healthcare costs or retirement.

Distributions and accessing the funds in your HSA

Online Reimbursement

You can request funds online and receive a check or a direct deposit into your selected account.

Online Bill Pay

You can request funds online to pay your provider directly from your HSA account.

Distribution Request Form

You can fax or mail a Distribution Request Form to receive your funds by check or direct deposit.

Is it possible to get a distribution without an eligible medical expense?

- » If you are 65 and older, the funds may be used for any expense with no penalty. The distribution is subject to taxation.
- » If you are under 65, you may incur a 20% penalty and the funds are subject to taxation.

Keep good records of your expenses

Receipts are NOT required at the time of distribution. Be sure to keep receipts for all of your medical expenses, for which you received a reimbursement, for at least three years for tax-reporting purposes. Keep track of your receipts and payments by using the portal to see balances, view transactions, create reports, and upload receipts.

HSA RESOURCES

Benefits Card

The Benefits Card is available to all employees that participate in a Health Savings Account (HSA) and Limited Purpose Flexible Spending Account. The Benefits Card gives you immediate access to your money at the point of purchase. Cards are available for participating employees, their spouse, and eligible dependents that are at least 18 years old.

Online & Mobile Access

Get account information from our easy-to-use online portal and mobile application. See your account and investment balances in real time, request distributions, and save receipts by snapping a photo!

Visit www.ffga.com to set up your online account.

Search for **FF Mobile Account App** from your Apple or Android device to download the mobile app today!

HSA Store

<https://www.ffga.com/individuals>

First Financial has partnered with the HSA Store to bring you an easy to use online store to better understand and manage your HSA. Shop at the HSA Store for eligible items from bandages to wheel chairs and thousands of products in between, browse or search for eligible products and services using the HSA Eligibility List, and visit the HSA Learning Center to help find answers to questions you may have about your HSA.



HSA RESOURCES

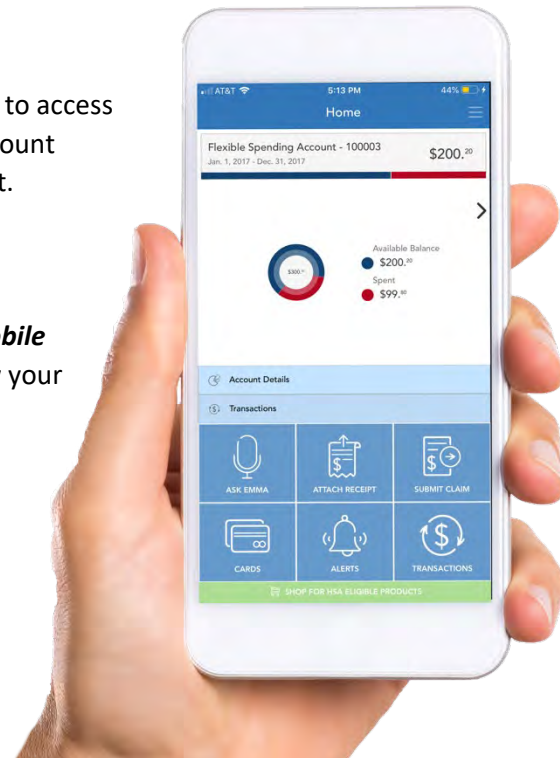
ONLINE HSA PORTAL

Health Savings Account participants can log in to their online HSA portal to access account balances, check on claims, upload receipts and access other account details. Visit <https://ffga.com/individuals> to login or set up your account.

FF FLEX MOBILE APP

Managing your benefit accounts on the go is made easy with **FF Flex Mobile App**. This powerful, intuitive mobile application gives you access to view your account balances, update your profile, submit a claim and much more – right from your Android or Apple device.

- Request distributions
- Invest in HSA funds
- Make additional contributions
- Pay a provider or pay yourself
- Download tax forms



HSA STORE

First Financial has partnered with the HSA Store to bring you an easy to use online store to better understand and manage your HSA. An online marketplace that connects consumers to HSA-eligible products, seasonal deals, and account support resources such as a national database of providers as well as an HSA Learning Center.

Visit <http://www.ffga.com/fsaextras> for more details & special deals!

- Shop for eligible items from bandages to wheel chairs and thousands of products in between
- Browse or search for eligible products and services using the Eligibility List
- Visit the Learning Center to help find answers to questions you may have about your account.

COBRA

First Financial Cobra Administrators | www.cobrapoint.benaissance.com | 1.800.523.8422, option 4

Life is full of unexpected events that may impact your health insurance coverage. Under the Consolidated Omnibus Budget Reconciliation Act, better known as COBRA, you have the right to continue your group health coverage such as medical, dental, vision insurance and flexible spending accounts for a limited period of time.

HIGHLIGHTS

- Temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work, divorce, death or a child no longer qualifying as a dependent. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
- Either you or your family member are responsible for notifying your employer of a divorce, legal separation or child losing dependent status within 60 days of the event. In the case of termination, death or reduction in hours, your employer will be responsible for letting the provider know that you have the right to continue coverage under COBRA.
- Benefits will remain identical to what you had while employed. However, you will be responsible for paying the full premium, plus any applicable fees.

403(b) Retirement Plans



U S Omni | www.omni403b.com | 1.877.544.6664

The 403(b) can be an excellent way to save money for retirement. It can serve as a supplement to a traditional pension plan or other retirement plan(s), or as a stand-alone plan. The 403(b) is a tax deferred retirement plan available to employees of educational institutions and certain non-profit organizations as determined by section 501(c)(3) of the Internal Revenue Code. Contributions and investment earnings in a 403(b) grow tax deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income. The 403(b) is named after the section of the IRS code governing it.

HOW A 403(b) WORKS

Employees enroll and participate through their employer. Contributions to a 403(b) are made on a pre-tax basis through a Salary Reduction Agreement. This is an arrangement where the participating employee agrees to take a reduction in salary. The amount by which the salary is reduced is directed to investments offered through the employer and selected by the employee. These contributions are called elective deferrals and are excluded from the employee's taxable income. Contributions grow tax-deferred until the time of retirement, when withdrawals are taxed as ordinary income.

BENEFITS

- Tax deferred growth: no annual taxation on earnings
- Investment options: fixed annuities, variable annuities, or mutual funds
- Competitive interest rates
- Flexibility: start, stop, and adjust your contributions as allowed by your employer's plan.
- Receive periodic account statements

457(b) Retirement Plans



U S Omni | www.omni403b.com | 1.877.544.6664

A 457(b) plan is a Tax Deferred Retirement Plan available to employees of state and local governmental agencies, including public school employees. They are similar to 401k plans because they allow you to place a percentage of your salary into an employer-sponsored plan that helps you save for retirement. You will not have to pay taxes on what you contribute or earnings made until you withdraw the money.

BENEFITS

- Investment options: fixed annuities, variable annuities, or mutual funds
- Flexibility: start, stop, and adjust your contributions as allowed by your employer's plan
- Receive periodic account statements
- No 10% federal penalty on interest or earnings for early withdrawal
- No current federal income taxes on the money you put into the plan until it is time to take withdrawals

CONTRIBUTION LIMITS FOR THE 403b AND 457b

Participants may contribute up to \$22,500 for year 2023. Participants age 50 and older at any time during the calendar year are permitted to contribute an additional \$7,500 for 2023, for a total of \$30,000.

CONTACT INFORMATION

EAGLE MOUNTAIN SAGINAW ISD BENEFITS OFFICE

1600 MUSTANG ROCK RD | FORT WORTH, TX 76179

817.232.0880 x 2486

FIRST FINANCIAL GROUP OF AMERICA

RYAN HANCOCK, ACCOUNT MANAGER

800.883.0007 / RYAN.HANCOCK@FFGA.COM

CONTACTS			
BENEFIT	CARRIER	WEBSITE	PHONE
Medical	BCBS	https://www.trs.texas.gov/	866.355.5999
Pharmacy	Express Scripts	https://www.express-scripts.com/rx	866.355.5999
EMS Wellness Clinic	Be Well Primary Care	www.bewellprimarycare.com	682-593-1211
Dental	Metlife	www.askmetlife.com	800.942.0854
Vision	Metlife/VSP	www.askmetlife.com	855.638.3931
Telehealth	Recuro	www.recurohealth.com	855.673.2876
FSA/HSA	First Financial Administrators	www.ffga.com	866.853.3539
Term Life Insurance	UNUM	www.unum.com	866.679.3054
Disability Insurance	American Fidelity	www.americanfidelity.com	800.654.8489
Accident	Metlife	www.askmetlife.com	800.638.5433
Critical Illness Insurance	Metlife	www.askmetlife.com	800.638.5433
Cancer Insurance	American Fidelity	www.americanfidelity.com	800.654.8489
Medical Transport	MASA	www.masamts.com	800-643-9023
Permanent Life Insurance	Texas Life	www.texaslife.com	800-283-9233
Hospital Indemnity Group	Aetna	www.myaetnasupplemental.com	855.800.3862
Hospital GAP	TransAmerica	www.transamerica.com	800.797.9176
Employee Assistance Program	Support Linc	www.supportlinc.com	800.475.3327
403B/457B	US OMNI	www.omni403b.com	877-544-6664