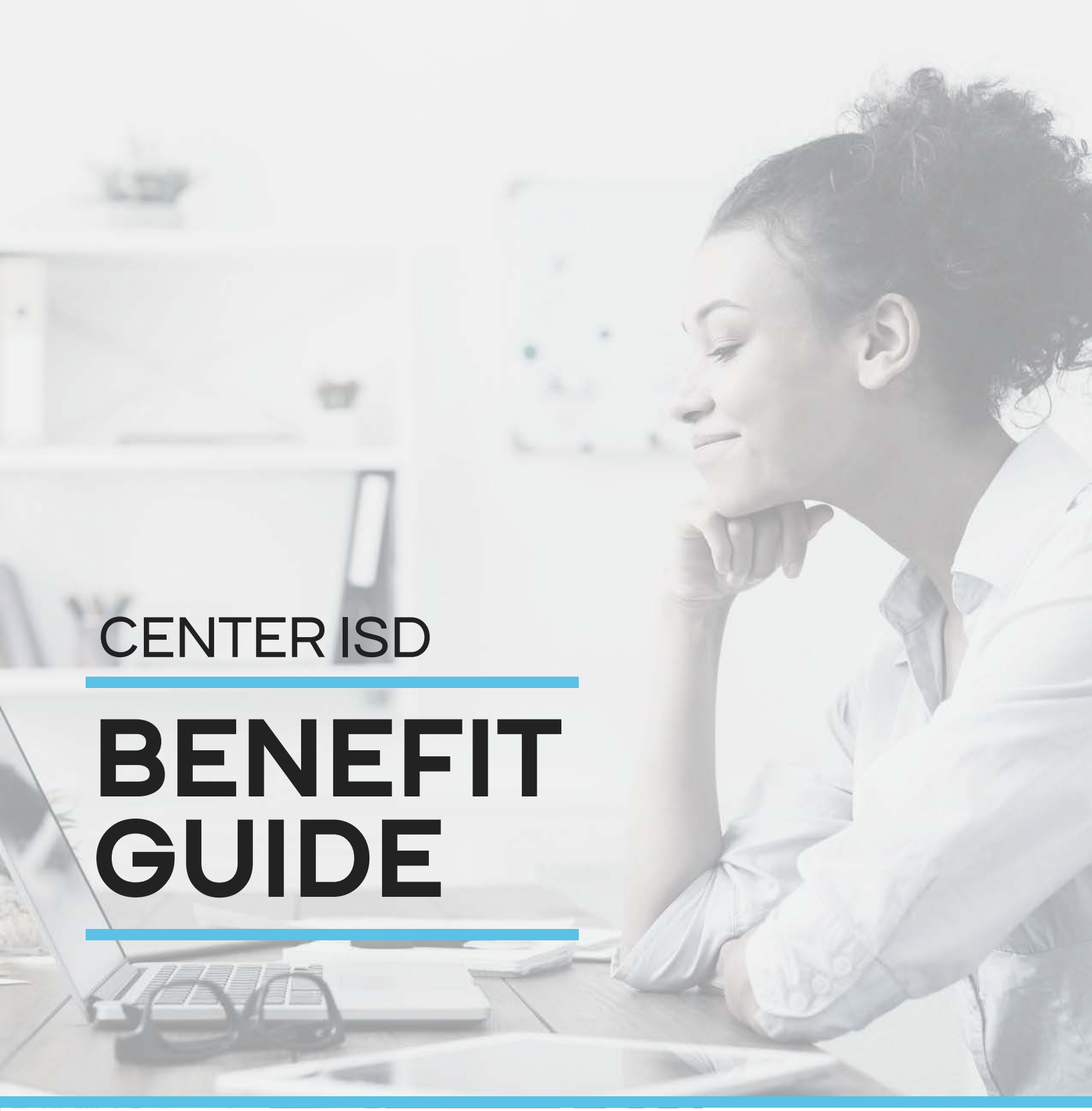


CENTER ISD

BENEFIT GUIDE

WWW.MYBENEFITSHUB.COM/CENTERISD

PLAN YEAR: 2020-2021

Center
INDEPENDENT SCHOOL DISTRICT

HOW TO LOG IN

1 VISIT WWW.MYBENEFITSHUB.COM/CENTERISD

2 CLICK **LOGIN**

3 ENTER USERNAME & PASSWORD

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

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

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

GENERAL INFORMATION

Center Independent School District offers a wide range of benefits to eligible employees and their family members. All new or newly eligible employees will go online to enroll in benefits . The district benefit site contains all plan summaries, rate summaries, claim forms and additional product information for employees to access online. Employees are encouraged to browse the plan information provided on the benefit site prior to enrolling. The Advanced Financial Group is the Third-Party Administrator for the district's supplemental benefits and will be assisting on site during the open enrollment period. The annual open enrollment period ends Friday August 21st. The plan options and coverage levels you select for the plan year will remain in effect from September 1, 2020 through August 31, 2021.

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

MAKING CHANGES/SPECIAL ENROLLMENT EVENTS

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

ALL CURRENT BENEFIT ELECTIONS FROM 2019/20 WILL BE ROLLED FORWARD WITH THE EXCEPTION OF FSA. FLEXIBLE SPENDING ACCOUNT ANNUAL AMOUNTS MUST BE ENTERED EACH YEAR.
WE HIGHLY ENCOURAGE EMPLOYEES TO LOGIN AND REVIEW BENEFITS AND BENFICIARIES.

CHANGES & NEW PRODUCTS

CHANGES FOR THE 2020 PLAN YEAR

Blue Cross Blue Shield of Texas will be the new plan administrator for the health insurance offering for TRS ActiveCare members. Please use the TRS BCBSTX site at https://www.bcbstx.com/trsactivecare to access plan highlights and to utilize the provider search for the HMO and PPO networks. Every employee needs to make sure their doctors are in the network of the plan they select.

NEW BENEFIT OFFERINGS

-CISD employees who elect the TRS- ActiveCare HD (High Deductible) plan will have the option to setup a Health Savings Account with HSA Bank. This option is only for participants enrolled in ActiveCare HD. Participants cannot enroll in an HSA and FSA account during the same plan year. Please find more information about both options on the district benefit site or inside the benefits booklet.

-CISD will offer an Emergency Transport Benefit this year through MASA. This service is designed to drastically reduce if not completely cover a participants out of network costs associated with air or ground emergency ambulance transport. Please find more information on the district benefit site or in this booklet.

-CISD has made Lifelock services available to the employee, spouse and dependent children. Identity theft claims millions of victims each year and is the fastest growing crime in the United States. Identity Theft Protection is an affordable service that can protect everything from your social security number to your social media profiles. It actively monitors and flags any suspicious activity via identity and credit monitoring. If fraud does occur, experts will help you recover your identity and restore your credit.

Helping Employees

Choosing Between an FSA & HSA

Reducing your out-of-pocket healthcare costs

The cost of health benefits is rising at an exponential rate. Tax-advantaged benefit accounts represent a compelling way to help offset the increase in your out-of-pocket healthcare costs. Flexible spending accounts (FSAs) and health savings accounts (HSAs) empower you to save for and better manage your healthcare costs. Every dollar that you contribute will reduce your tax liability. Understanding the differences between these accounts helps you to make the right choice for your situation.

Differences between FSA & HSA

What is an FSA?

An FSA can be paired with any health plan and is set up and controlled by the employer. The account is funded by pre-tax payroll deferment in an amount elected during open enrollment. Participants can then use that money to pay for qualified healthcare expenses throughout the year. FSAs truly are a "spending" account, in that participants are required to spend the funds by the end of the plan year when they are forfeited—though certain plans may have features that allow for added flexibility. Expenses must be IRS-qualified medical expenses to be eligible for reimbursement with tax-free FSA dollars.

What is an HSA?

Unlike an FSA, an HSA requires that the insured be covered by a high-deductible health plan (HDHP). It also differs from an FSA because the account is individually owned. While most HSA participants enjoy the convenience of account contributions being deducted pre-tax from their paychecks, HSAs may also be funded by an employer or family member. The account owner can spend the funds on current eligible expenses or save them for future expenses. Because the account is owned by the individual, the participant is solely responsible for the substantiation of expenses and is not required to send receipts to their employer or administrator.

nbs national benefit services

Criteria	FSA	HSA
Overview		
General Purpose	Funding predictable healthcare expenses in the current year with pre-tax dollars.	Funding a lifetime of healthcare expenses with pre-tax dollars.
Account Owner	**Employer** Because the account belongs to your employer, your participation in the plan ends when your employment is terminated.	**Employee** Because the account belongs to the employee, they maintain ownership after they leave the company.
Health Plan Pairings	Can be paired with any health plan.	Must be paired with a qualified HDHP: • Deductible not less than $1,400 for single or $2,800 for family (2020). • Annual out-of-pocket expenses do not exceed $6,900 for single or $13,800 for family (2020).
Distribution of Funds	**Eligible Medical Expenses Only** Funds may be used to pay for eligible medical expenses only; cannot access for non-medical reasons.	**Eligible Medical Expenses with Exceptions** Funds are to be used to pay for eligible medical expenses, but may be withdrawn for non-medical expenses with 10% penalty.
Timing of Usage	**Check with your employer to see if you have rollover or grace period for your FSA.** **FSA with Rollover** Up to $500 of remaining balance may be rolled over to be used in the following plan year. **FSA with Grace Period** Account balance must be used by the end of the grace period for that plan year; unused balance is forfeited.	**Funds are Never Forfeited** Reimbursement can be made for any eligible expense incurred from the HSA open date to the current date. Funds do not expire, making an HSA an excellent savings vehicle.
Earnings Investments	No earnings paid.	Some HSA offerings provide integrated investment options and/or interest benefits.
Tax Savings	**Tax-deductible** Employer contributions are tax-deductible. **Tax-free** Employee contributions made via payroll deduction are taken out prior to income tax assessment.	**Tax-deductible** Employer contributions and contributions made by employees (i.e. from their bank account) are tax-deductible. Employee contributions by payroll deferal are pre-tax.
Contributions		
Source of Contributions	Employer: optional Payroll deferral: optional From employee bank account: not allowed	Employer: optional Payroll deferral: optional From employee bank account: optional
Contributions	Annual election amount is determined by the participant during open enrollment and deducted evently per pay period; Changes may only be made due to a qualified life event (marriage, birth, etc.).	Annual election amount is determined by the participant during open enrollment and deducted evently per pay period; Employees can adjust contributions throughout the year up to IRS limit; Employers may also contribute.
Contribution Limit	IRS limit of $2,750 (2020)	IRS limit of Single: $3,550 Family: $7,100 (2020)
Disbursements		
Access to Funds	Pay providers directly via debit card or submit claims for reimbursement.	Pay providers directly via debit card or online bill pay, or on the provider's website via ACH.
Claims for Reimbursements	Submit a claim for reimbursement and receipts online, by fax, or using the mobile app.	There are no claims. Employees pay for eligible expenses directly from the account.
Substantiation Requirement	Receipts and Explanation of Benefits (EOBs) should be kept for all purchases. Your plan administrator will require them for reimbursement.	There is no requirement for substantiation. The participant is solely responsible for proper use of funds. Documentation should be kept in case of IRS audit.
Cash Withdrawal	Not permitted.	Cash withdrawals are allowed. The cash must be used on an eligible expense or be subject to a 20% penalty. After age 65, cash withdrawals can be made for non-eligible expenses penalty-free but subject to income taxes.

Primary Benefit of Both Plans

Both plans provide advantages for both the employee and the employer:

- Tax-free treatment of healthcare expenses.
- Contributions that are payroll-deferred are not reported as income to the employee, resulting in income tax savings for the employee.
    - Employees making contributions will save 15-40% by avoiding federal and state income taxes and the employee half of payroll taxes.

** These figures are based on the employer half of FICA and FUTA. The information detailed is for illustrative purposes only and is not legal or tax advice.*

Which Plan to Choose?

FSA

FSAs do not require participation in a HDHP, so they are most frequently offered in conjunction with traditional health plans. Traditional health plans limit out-of-pocket expenses for participants and make it easy for an employee to estimate annual medical expenses by calculating projected copays, deductible amounts, and co-insurance. Although the addition in 2013 of the rollover feature minimizes forfeited funds, employers still have the benefit of retaining any funds that are forfeited.

HSA

HSAs offer employees a broader value proposition: the ability to pay for current or future expenses without fear of forfeiting dollars, triple tax advantage, investment growth potential, and the option to pay for non-medical expenditures if necessary.

nbs national benefit services

Salt Lake City, UT - Headquarters
Dallas, TX | San Diego, CA | Honolulu, HI

(800) 274-0503 | service@nbsbenefits.com
www.nbsbenefits.com

MEDICAL INSURANCE

ABOUT THIS BENEFIT:

Medical insurance, also known as health insurance, is coverage that helps you pay the high cost of medical and hospital expenses.

Depending on the coverage you choose, this insurance will help pay toward or completely annual physicals, doctor visits, hospitalization and emergency room visits. Many times you will be offered more than one plan to choose from, so please review the summary of benefits in detail to determine which plan is right for you.

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

ACTIVATE YOUR HEALTH:
TRS-ActiveCare Plan Highlights 2020-21

This new year brings new opportunities to unlock your potential and take charge of your wellness.

After connecting with your district leaders to learn how we could enhance the quality of your coverage, we're providing improved pricing, more network choices, simplified coverage and a new plan with a lower premium and copays.

Welcome to the 2020-21 TRS-ActiveCare, where you can empower the best you.

What to Know

How to Calculate Your Monthly Premium

Total Monthly Premium

− Your District and State Contributions

= **Your Premium**

Calculate Your Monthly Premium

_____

− _____

_____

= _____

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

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.

2020-21 TRS-ActiveCare Plan Highlights Sept. 1, 2020 – Aug. 31, 2021

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

What's New

- Primary plan with a **lower premium and copays**
- Primary+ (formerly Select) **decreased premiums** by up to 8%
- **Broader networks** of health care providers
- **Lower premiums** for families with children

Leverage Your $0 Preventive Care*

- Annual routine physicals (ages 12+)
- Annual mammogram (ages 40+)
- Annual OBGYN exam & pap smear (ages 18+)
- Annual prostate cancer screening (ages 45+)
- Well-child care (unlimited up to age 12)
- Healthy diet/obesity counseling (unlimited to age 22; ages 22+ get twenty-six visits per year)
- Smoking cessation counseling (8 visits per year)
- Breastfeeding support (six per year)
- Colonoscopy (ages 50+ once every ten years)

Available for all plans. See benefits guides for more details.

Did You Know

- Our provider search tool will be available in June.
- Choosing a PCP helps you meet your health goals faster.
- Generic medications save money! Ask your provider if your medicine has a generic.

All TRS-ActiveCare participants have **three plan options**. Each is designed with the unique needs of our members in mind.

	NEW: TRS-ActiveCare Primary	TRS-ActiveCare HD	TRS-ActiveCare Primary+
Plan summary	• Lower premium • Copays for doctor visits before you meet deductible • Statewide network • PCP referrals required to see specialists • Not compatible with health savings account (HSA) • No out-of-network coverage	• Similar to current 1-HD • Lower premium • Compatible with health savings account (HSA) • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet deductible before plan pays for non-preventive care	• Simpler version of the current Select plan • Lower deductible than 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
If you make no changes during Annual Enrollment, you'll have the following plan...	Only employees that choose this new plan during Annual Enrollment will be enrolled in it.	If you're currently in TRS-ActiveCare 1-HD and you make no change during Annual Enrollment, this will be your plan next year.	If you're currently in TRS-ActiveCare Select and you make no changes during Annual Enrollment, this will be your plan next year.

Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$386	$ 106	$397	$ 117	$514	$ 234
Employee and Spouse	$1,089	$ 809	$1,120	$ 840	$1,264	$ 984
Employee and Children	$695	$ 415	$715	$ 435	$834	$ 554
Employee and Family	$1,301	$ 1021	$1,338	$ 1058	$1,588	$ 1308

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

Doctor Visits				
Primary Care	$30 copay	You pay 20% after deductible	You pay 40% after deductible	$30 copay
Specialist	$70 copay	You pay 20% after deductible	You pay 40% after deductible	$70 copay
TRS Virtual Health	$0 per consultation	$30 per consultation		$0 per consultation

Immediate Care				
Urgent Care	$50 copay	You pay 20% after deductible	You pay 40% after deductible	$50 copay
Emergency Care	You pay 30% after deductible	You pay 20% after deductible		You pay 20% after deductible
TRS Virtual Health	$0 per consultation	$30 per consultation		$0 per consultation

Prescription Drugs			
Drug Deductible	Integrated with medical	Integrated with medical	$200 brand deductible
Generics (30-Day Supply / 90-Day Supply)	$15/$45 copay	$0 for certain generic drugs	$15/$45 copay
Preferred Brand	You pay 30% after deductible	You pay 25% after deductible	You pay 25% after deductible
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible

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

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in plan • Lower deductible • Copays for many drugs and services • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals
If you're currently in TRS-ActiveCare 2, and you make no changes during Annual Enrollment, you will remain in TRS-ActiveCare 2 next year.

Total Premium	Your Premium
$937	$ 657
$2,222	$ 1942
$1,393	$ 1113
$2,627	$ 2347

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
$0 per consultation

$50 copay / You pay 40% after deductible
You pay a $250 copay plus 20% after deductible
$0 per 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)
You pay 20% after deductible ($200 min/$900 max)/ No 90-Day Supply of Specialty Medications

Compare Pricing for Common Medical Services

REMEMBER: You can use the cost estimator tool on www.bcbstx.com/trsactivecare starting Sept. 1 to shop for the best prices through different providers.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare HD		TRS-ActiveCare Primary+	TRS-ActiveCare 2	
	In-Network Only	In-Network Only	Out-of-Network	In-Network Only	In-Network	Out-of-Network
Diagnostic Labs*	Office/Indpendent Lab: You pay $0	You pay 20% after deductible	You pay 40% after deductible	Office/Indpendent Lab: You pay $0	Office/Indpendent 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 40% after deductible	You pay 20% after deductible	You pay 20% after deductible + $100 per procedure copay	You pay 40% after deductible + $100 per procedure copay
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% 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 40% after deductible ($500 facility per day maximum)	You pay 20% after deductible	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 20% after deductible + $500 copay	You pay 40% after deductible + $500 copay	You pay $500 copay + 20% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility – You pay 30% after deductible	Not Covered	Not Covered	Facility – You pay 20% after deductible	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 Examination (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay 20% after deductible	You pay 40% after deductible	You pay $70 copay	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	You pay $70 copay	You pay 20% after deductible	You pay 40% after deductible	You pay $70 copay	You pay $70 copay	You pay 40% after deductible

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

ACCIDENT INSURANCE

ABOUT THIS BENEFIT:

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

LEARN MORE

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

[1]2013 National Institute of Health

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

GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

More than 3.5 million children ages 14 and younger get hurt annually playing sports or participating in recreational activities.[1]

Advanced Financial School Block

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

To learn more about Accident insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

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

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

Hernia Repair	Once per accident	$100
Joint Replacement	Once per accident	$1,500
Knee Cartilage	Once per accident	Up to $1,000
Laceration	Once per accident	Up to $200
Ruptured Disc	Once per accident	$1,000
Tendon/Ligament/Rotator Cuff	Up to 1 per accident	Up to $1,500
CATASTROPHIC		
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$40,000
Common Carrier Death	Within 90 days	5 times death benefit
Coma	Once per accident	$20,000
Dismemberment	Once per accident	Up to $40,000
Home Health Care	Up to 30 days per accident	$50
Paralysis	Once per accident	Up to $30,000
Prosthesis	Up to 2 per accident	Up to $2,000
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM2] – Administrative & clinical support following serious illness or injury		Included

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 15 hours per week on a regularly scheduled basis, and are less than age 80.

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

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

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

AM I GUARANTEED COVERAGE?

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

HOW DO I PAY FOR THIS INSURANCE?

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

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

The initial effective date of this coverage is September 1, 2019. Subject to any eligibility waiting period established by your employer, if you enroll for coverage prior to this date, insurance will become effective on this date. If you enroll for coverage after this date, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

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

CRITICAL ILLNESS

ABOUT THIS BENEFIT:

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

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

LEARN MORE

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

GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

65% of American cancer survivors did not have sufficient income to cover **out-of-pocket expenses** for cancer treatment and other incurred debts **related to the illness**.[1]

Advanced Financial School Block

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

To learn more about critical illness insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

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

COVERAGE AMOUNT	
Employee Coverage Amount	$10,000 or $20,000
Spouse Coverage Amount	50% of your coverage amount
Child(ren) Coverage Amount	$5,000
COVERED ILLNESSES	**BENEFIT AMOUNTS**
VASCULAR CONDITIONS	
Heart Attack*; Heart Transplant*; Stroke*	100% of coverage amount
Aneurysm; Angioplasty/Stent; Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
Coma*; End Stage Renal Failure; Loss of Hearing; Loss of Speech; Loss of Vision; Major Organ Transplant*; Paralysis;	100% of coverage amount
Bone Marrow Transplant	25% of coverage amount
NEUROLOGICAL CONDITIONS	
Advanced Multiple Sclerosis; Advanced Parkinson's; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	100% of coverage amount
CHILD CONDITIONS	
Cerebral Palsy; Congenital Heart Disease; Cystic Fibrosis; Muscular Dystrophy; Spina Bifida;	100% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount
Transportation	$100 per trip up to 5 trips
Lodging	$100 per night up to 5 nights
Health Screening Benefit	$50 once per year per covered person
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured & Spouse	500% of coverage amount
Coverage Maximum – Child(ren)	300% of coverage amount
Ability Assist® EAP[2]– 24/7/365 access to help for financial, legal or emotional issues	
HealthChampion℠[2] – Administrative and clinical support following serious illness or injury	

PREMIUMS

See the Premium Worksheet.[3]

CANCER INSURANCE

ABOUT THIS BENEFIT:

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

LEARN MORE

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

[2]The American Journal of Medicine

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

DENTAL INSURANCE

ABOUT THIS BENEFIT:

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

LEARN MORE

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

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

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

Unum Dental℠

A smile-worthy dental plan

The Advanced Financial Group School Block

Effective date: 09/01/2020
Dual Option Plan

Plan features:

- See any dentist or maximize your benefits by utilizing our national network of more than 323,000+ dental access points[1] with discounted fees for in-network services.
- Find an in-network provider at unumdentalcare.com
- Manage benefits online with AlwaysAssist.com and on-the-go with the AlwaysAssist mobile app.

AlwaysAssist.com
Online benefits management

AlwaysAssist App
Available on the App Store | GET IT ON Google play

Monthly Premium Rates*:

*Rates guaranteed for 24 months from the effective date with 50% participation and at least 5 enrolled in each plan.

HIGH OPTION		LOW OPTION	
Employee Only	$34.32	Employee Only	$23.28
Employee & Spouse	$79.38	Employee & Spouse	$53.86
Employee & Children	$78.56	Employee & Children	$48.56
Employee & Family	$119.32	Employee & Family	$75.08

Outstanding Customer Service

- Professionally-staffed customer service with extended hours from 8:00 a.m. to 8:00 p.m. Monday-Friday and Saturday 10 a.m. to 4 p.m. (ET).
- Our service statistics exceed the industry average:[2]
  - 80% calls answered within 30 seconds on average.
  - Less than 2% of our calls are abandoned.
  - We resolve 95% of issues during the first call.
- An interactive voice response system is available 24/7 for benefit and eligibility information.
- We are highly skilled in the area of "takeover" business and offer an extremely smooth business transition process.

1. Netminder data (September 2016)
2. Starmount/AlwaysCare Benefits internal data (2016).

Overview:

Outline of Benefits	High Option	Low Option
Calendar Year Maximum	$1250 for Class A, B, C.	$500 for Class A, B, C.
Deductible	$50 per calendar year. Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.	$50 per calendar year. Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.
Carryover Benefit	Included (Takeover Applies)	Included (Takeover Applies)
Coinsurance	In-Network / Non-Network Class A 100% / 100% Class B 80% / 80% Class C 50% / 50% Class D 50% / 50%	In-Network / Non-Network Class A 100% / 100% Class B 70% / 70% Class C 40% / 40%

Covered procedures and waiting periods:

Outline of Benefits	High Option	Low Option

Class A
Preventative Services
	Waiting Period: None
	• Routine exams (2 per 12 months)
	• Prophylaxis (2 per 12 months)
	  ○ (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy)
	• Bitewing x-rays (max 4 films; 1 per 12 months)
	• Full mouth x-ray (1 per 24 months)
	• Emergency pain (1 per 12 months)
	• Fluoride to age 16 (1 per 12 months)
	• Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)
	• Sealants to age 16 (permanent molars, 1 per 36 months)
	• Space maintainers to age 16 (1 per 24 months)
		Waiting Period: None
		• Routine exams (2 per 12 months)
		• Prophylaxis (2 per 12 months)
		  ○ (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy)
		• Bitewing x-rays (max 4 films; 1 per 12 months)
		• Full mouth x-ray (1 per 24 months)
		• Emergency pain (1 per 12 months)
		• Fluoride to age 16 (1 per 12 months)
		• Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)
		• Sealants to age 16 (permanent molars, 1 per 36 months)
		• Space maintainers to age 16 (1 per 24 months)

Class B Basic Services	Waiting Period: None • Fillings • Posterior composite restorations • Simple extractions • Periodontal Maintenance (2 per 12 months in addition to Prophylaxis) • Repair of Crown, denture, or bridge	Waiting Period: None • Fillings • Posterior composite restorations • Simple extractions • Periodontal Maintenance (2 per 12 months in addition to Prophylaxis) • Repair of Crown, denture, or bridge
Class C Major Services	Waiting Period: None • Inlays and Onlays • Non-surgical periodontics • Oral surgery (surgical extractions & impactions) • Endodontics (root canals) • Surgical periodontics (gum treatments) • Anesthesia (subject to review, covered with complex oral surgery) • Crowns, Bridges, Dentures and Endosteal Implants (in lieu of an approved 3-unit bridge)	Waiting Period: None • Inlays and Onlays • Non-surgical periodontics • Oral surgery (surgical extractions & impactions) • Endodontics (root canals) • Surgical periodontics (gum treatments) • Anesthesia (subject to review, covered with complex oral surgery) • Crowns, Bridges, Dentures and Endosteal Implants (in lieu of an approved 3-unit bridge)
Class D Orthodontics	Waiting Period: None • Separate Lifetime maximum: $1500 • Up to 25% of lifetime allowance may be payable on initial banding. • Dep. Children to age 19 only	Not Covered

Dental carryover benefit

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! If an Insured submits qualifying claims for covered expenses during a benefit year and, in that benefit year, receives benefits that are less than their group's threshold limit, the insured will be credited a carryover benefit. Carryover benefits will be accrued and stored in the insured's carryover account to be used in the next benefit year. If an insured reaches his or her certificate year maximum benefit, we will pay a benefit from the insured's carryover account up to the amount stored in the insured's carryover account. The accrued carryover benefits stored in the carryover account may not be greater than the carryover account limit.

The limits for this policy/certificate are:

- High Option - Carryover benefit **$300**, threshold limit **$600**, carryover account Limit **$1200**.
- Low Option - Carryover benefit **$100**, threshold limit **$200**, carryover account Limit **$500**.

Other specifications:

- An insured's carryover account will be eliminated, and the accrued carryover benefits lost, if the insured has a break in coverage of any length of time, for any reason.
- Eligibility for a carryover benefit will be established or reestablished at the time the first qualifying claim in a benefit year is received for covered expenses incurred during that benefit year.
- In order to be eligible to accumulate the carryover benefit, an insured must be enrolled in the plan at least four months prior to the start of the new policy year. Example: If the plan effective date is January 1st, the insured must be enrolled by September 1st.
- Only claims incurred on or after the start of the next policy year will count toward the threshold Limit.
- Carryover benefits will not be applied to an insured's carryover account until the policy year that starts one year from the date the rider first applies.
- If charges for Class C services are not payable for an insured due to a benefit waiting period for certain covered procedures, this rider will not apply to the insured until the end of such waiting period. And, if the waiting period ends within the three months prior to the start of this plan's next benefit year, this rider will not apply to the insured until the next benefit year.
- Carryover benefits will not be applied to an insured's carryover account until the benefit year that starts one year from the date the rider first applies.

Definitions:

- "Benefit year" means calendar year or policy year, according to the type of plan applicable under the policy/certificate to which this rider is attached.
- "Carryover account" means the amount of an insured's accrued carryover benefits.
- "Carryover account limit" means the maximum amount of cumulative Carryover benefits that an insured can store in his or her carryover account.
- "Carryover benefit" means the dollar amount, which will be added to an insured's carryover account when he or she receives benefits in a benefit year that do not exceed the threshold limit.
- Qualifying claim means a claim under procedure classes A, B, C, and class D, orthodontia and must include 1 exam & 1 cleaning.
- "Threshold limit" means the maximum amount of benefits for all procedure classes A, B, C and D that an insured can receive during a benefit year and still be entitled to receive the carryover benefit.

Dependent children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at (888) 400-9304.

Services not listed: If you expect to require a dental or vision service not included on this brochure, it may still be covered. Please contact customer service at (888) 400-9304 to confirm your exact benefits.

Alternate treatment: Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.

Exclusions/limitations:

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Other implants or implant related services are not covered.

The following dental services are not covered:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- the correction of congenital malformations;
- the replacement of lost, discarded, or stolen appliances;
- replacement of bridges, dentures, crowns, inlays, onlays or dentures unless more than [5] years old and cannot be made serviceable;
- appliances, services or procedures relating to: (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition, abrasion, erosion or a fraction; (v) bite registration; or (vi) bite analysis;
- services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments, and related procedures;
- dentures for teeth missing prior to effective date of coverage; some exceptions apply and are detailed in the Certificate of Coverage;
- multiple x-rays done on same date of service will be combined to a full-mouth x-ray;
- cosmetic restorations on posterior permanent teeth and all primary teeth will be given alternate benefit;
- Anesthesia is covered with complex oral surgery only. Charges are subject to review. Pre-treatment estimate is recommended.

Takeover benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to us.

Application of takeover benefits is subject to Underwriting review and approval.

New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, certificate of creditable coverage, etc.).

Late entrants: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with Unum will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.

The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series DN2002, DN2007, and DN2015 or contact your Unum Dental representative.

Starmount Life Insurance Company
8485 Goodwood Boulevard • Baton Rouge, LA 70806
PH: (888) 400-9304
Policy Forms: Dental – DN2002, DN2007, and DN2015

(06-18)

Dental plans are marketed by Unum, administered and underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

EDUCATOR DISABILITY

ABOUT THIS BENEFIT:

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

LEARN MORE

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

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

[3]GoBanking

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

unum
Better benefits at work.

Why buy Long Term Disability Insurance?

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

Leading causes of Unum long term disability claims[1]

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

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

The risk of becoming disabled may be greater than you think

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

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

Workers' compensation or Social Security disability may not help

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

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

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

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

Unum is the smart solution

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

years.[7]

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

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

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

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

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

9 Unum internal claims data (2016)

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

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

FOR BROKERS, EMPLOYERS AND EMPLOYEES

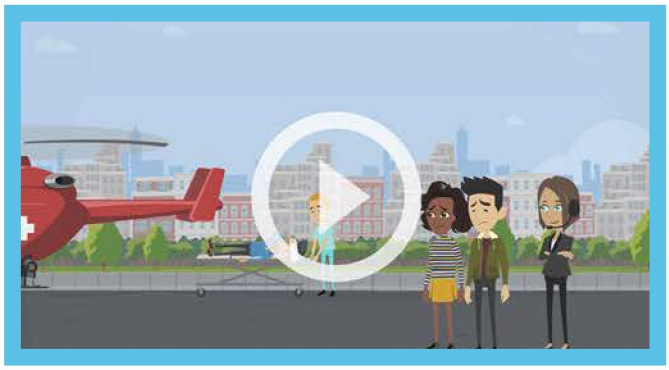
MK-3703 (5-18)

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

EMERGENCY TRANSPORTATION

ABOUT THIS BENEFIT:

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



LEARN MORE

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

EMERGENCY TRANSPORTATION COSTS

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

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

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

HOW MASA IS DIFFERENT

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

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

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

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

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

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

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

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

EVERY FAMILY DESERVES A MASA MEMBERSHIP

The Ultimate Peace of Mind for Employees and Their Families

The Harrison's Story

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

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

MASA Medical™ Transport Solutions

And then, the Bills came!

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

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

Any Ground. Any Air. Anywhere.™

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

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

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

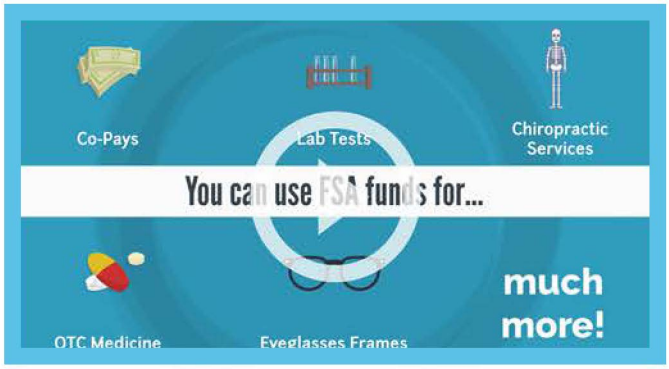
For more information, please contact your local MASA MTS representative or visit www.masamts.com

FLYER_COMP_B2B

FLEXIBLE SPENDING ACCOUNT

ABOUT THIS BENEFIT:

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



LEARN MORE

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

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

Employees can "carryover" no more than $550 of unused funds to the 2021-22 plan-year.

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

Flexible Spending Account (FSA)

Two types of FSAs

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

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

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

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

What's a cafeteria plan?

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

Partial List of Eligible Expenses:

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

Enrollment Considerations

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

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

How to Spend

Spending is easy

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

Account access is easy

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

What if I don't use it all?

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

Your employer may offer a grace period or a $500 rollover to help if you miss the mark a little bit. *Just make sure to plan carefully when you enroll.*

Healthcare Expense Account

Sample Expenses

Medical Expenses

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

Dental Expenses

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

Vision Expenses

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

Items that generally do not qualify for reimbursement

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

nbs national benefit services

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

Best Practices

Using your NBS Benefits Card

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

Understanding Claim Substantiation

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

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

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

Before you leave, ask for a detailed receipt.

Receipt must include:

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

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

HEALTH SAVINGS ACCOUNT

ABOUT THIS BENEFIT:

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

LEARN MORE

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

The benefit of an HSA account is that it can be taken out of your paycheck pre-tax, which means it's not included in your gross income and therefore, not subject to federal income tax.

The best part about this policy is that funds roll over from year to year, so you can save for future healthcare expenses.

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

Health Savings Accounts

Start saving more on healthcare.

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options[1].

How an HSA works:

- You can contribute to your HSA via payroll deduction, online banking transfer, or by sending a personal check to HSA Bank. Your employer or third parties, such as a spouse or parent, may contribute to your account as well.
- You can pay for qualified medical expenses with your Health Benefits Debit Card directly to your medical provider or pay out-of-pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.
- Unused funds will roll over year to year. After age 65, funds can be withdrawn for any purpose without penalty (subject to ordinary income taxes).
- Check balances and account information via HSA Bank's Member Website or mobile device 24/7.

Are you eligible for an HSA?

If you have a qualified High Deductible Health Plan (HDHP) - either through your employer, through your spouse, or one you've purchased on your own - chances are you can open an HSA. Additionally:

- You cannot be covered by any other non-HSA-compatible health plan, including Medicare Parts A and B.
- You cannot be covered by TriCare.
- You cannot be claimed as a dependent on another person's tax return (unless it's your spouse).
- You must be covered by the qualified HDHP on the first day of the month.

When you open an account, HSA Bank will request certain information to verify your identity and to process your application.

What are the annual IRS contribution limits?

Contributions made by all parties to an HSA cannot exceed the annual HSA limit set by the Internal Revenue Service (IRS). Anyone can contribute to your HSA, but only the accountholder and employer can receive tax deductions on those contributions. Combined annual contributions for the accountholder, employer, and third parties (i.e., parent, spouse, or anyone else) must not exceed these limits.[2]

2019 Annual HSA Contribution Limits	2020 Annual HSA Contribution Limits
Individual = $3,500	Individual = $3,550
Family = $7,000	Family = $7,100

According to IRS guidelines, each year you have until the tax filing deadline to contribute to your HSA (typically April 15 of the following year). Online contributions must be submitted by 2:00 p.m., Central Time, the business day before the tax filing deadline. Wire contributions must be received by noon, Central Time, on the tax filing deadline, and contribution forms with checks must be received by the tax filing deadline.

Catch-up Contributions

Accountholders who meet these qualifications are eligible to make an HSA catch-up contribution of $1,000: Health Savings accountholder; age 55 or older (regardless of when in the year an accountholder turns 55); not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated). Spouses who are 55 or older and covered under the accountholder's medical insurance can also make a catch-up contribution into a separate HSA in their own name.

How can you benefit from tax savings?

An HSA provides triple tax savings.[3] Here's how:

- Contributions to your HSA can be made with pre-tax dollars and any after-tax contributions that you make to your HSA are tax deductible.
- HSA funds earn interest and investment earnings are tax free.
- When used for IRS-qualified medical expenses, distributions are free from tax.

IRS-Qualified Medical Expenses

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. Funds used to pay for IRS-qualified medical expenses are always tax-free.

HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to HSA Bank, you must save your bills and receipts for tax purposes.

Examples of IRS-Qualified Medical Expenses[4]:

- Acupuncture
- Alcoholism treatment
- Ambulance services
- Annual physical examination
- Artificial limb or prosthesis
- Birth control pills (by prescription)
- Chiropractor
- Childbirth/delivery
- Convalescent home (for medical treatment only)
- Crutches
- Doctor's fees
- Dental treatments (including x-rays, braces, dentures, fillings, oral surgery)
- Dermatologist
- Diagnostic services
- Disabled dependent care
- Drug addiction therapy
- Fertility enhancement (including in-vitro fertilization)
- Guide dog (or other service animal)
- Gynecologist
- Hearing aids and batteries
- Hospital bills
- **Insurance premiums[5]**
- Laboratory fees
- Lactation expenses
- Lodging (away from home for outpatient care)
- Nursing home
- Nursing services
- Obstetrician
- Osteopath
- Oxygen
- Pregnancy test kit
- Podiatrist
- Prescription drugs and medicines (over-the-counter drugs are not IRS-qualified medical expenses unless prescribed by a doctor)
- Prenatal care & postnatal treatments
- Psychiatrist
- Psychologist
- Smoking cessation programs
- Special education tutoring
- Surgery
- Telephone or TV equipment to assist the hearing or vision impaired
- Therapy or counseling
- Medical transportation expenses
- Transplants
- Vaccines
- Vasectomy
- Vision care (including eyeglasses, contact lenses, lasik surgery)
- Weight loss programs (for a specific disease diagnosed by a physician – such as obesity, hypertension, or heart disease)
- Wheelchairs
- X-rays

[1] Investment accounts are not FDIC insured, may lose value and are not a deposit or other obligation of, or guarantee by the bank. Investment losses which are replaced are subject to the annual contribution limits of the HSA.

[2] HSA funds contributed in excess of these limits are subject to penalty and tax unless the excess and earnings are withdrawn prior to the due date, including any extensions for filing Federal Tax returns. Accountholders should consult with a qualified tax advisor in connection with excess contribution removal. The Internal Revenue Service requires HSA Bank to report withdrawals that are considered refunds of excess contributions. In order for the withdrawal to be accurately reported, accountholders may not withdraw the excess directly. Instead, an excess contribution refund must be requested from HSA Bank and an Excess Contribution Removal Form completed.

[3] Federal tax savings are available regardless of your state. State tax laws may vary. HSA Bank does not provide tax or legal advice. Please consult with a qualified tax or legal professional for tax related questions.

[4] This list is not comprehensive. It is provided to you with the understanding that HSA Bank is not engaged in rendering tax advice. The information provided is not intended to be used to avoid Federal tax penalties. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses". Publications can be ordered directly from the IRS by calling 1-800-TAXFORM. If tax advice is required, you should seek the services of a professional.

[5] Insurance premiums only qualify as an IRS-qualified medical expense: while continuing coverage under COBRA; for qualified long-term care coverage; coverage while receiving unemployment compensation; for any healthcare coverage for those over age 65 including Medicare (except Medicare supplemental coverage).

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

hsabank own your health®

How to use your HSA

It's easy to manage your Health Savings Account (HSA) online.

Access real-time account balances, transaction history and statements, as well as track your expenses online. Sign up for online banking today.

Mobile App* – Use your iOS (iPhone, iPod Touch, iPad) or Android-powered device to check available balances in your account and view HSA transaction details, save and store receipts using your device's camera, receive account balances and configurable alerts via text message, and access customer service contact information.

myHealth Portfolio℠ – Use this tool to track your healthcare expenses, submit and retain receipts and claims from multiple insurance and financial account providers. Also view expenses by provider, description, and more.

How to deposit funds into your HSA.

To maximize HSA tax and savings benefits, begin funding your account as soon as you can. HSA Bank offers several convenient methods for making contributions to your HSA.

Payroll Deductions – If your employer offers this option, HSA Bank will facilitate recurring pre-tax payroll deductions. Contact your employer to complete the appropriate paperwork.

Online Transfers – On HSA Bank's member website, you can transfer funds from an external bank account, such as a personal checking or savings account, to your HSA.

Check – Mail your personal check and completed Contribution Form to:

HSA Bank, PO Box 939, Sheboygan, WI 53082

How to pay for healthcare expenses from your HSA.**

Whether you want to reimburse yourself for an IRS-Qualified medical expense paid out-of-pocket or you want to pay directly from your HSA, HSA Bank offers multiple options for accessing your funds. NOTE: all transactions are limited to your available cash balance.

Health Benefits Debit Card – Your HSA Bank Health Benefits Debit Card provides access to your HSA funds at point-of-sale with signature or PIN and at ATMs for withdrawals. The daily debit card limit for the Health Benefits Debit Card is $5,000 at merchants dedicated to healthcare (e.g. a doctor's office or hospital) and $3,500 at merchants that are not healthcare specific but offer eligible medical products and/or services (e.g. a department or grocery store). The number of debit card transactions allowed per day is limited and varies based on how the card is used or types of transactions processed. These limits exist as a safeguard against fraudulent activity. Transaction fees may apply when used with a PIN.†

Checks – A book of 50 checks can be ordered upon request for an additional fee.† You can use these checks to pay providers or reimburse yourself for expenses already incurred. There is no daily limit on dollar amounts.

Online Transfers – On HSA Bank's Member Website or mobile app, you can reimburse yourself for out-of-pocket expenses by making a one-time or reoccurring online transfer from your HSA to your personal checking or savings account. There is a daily limit of $2,500.

Online Bill Pay – Use this feature to pay medical providers directly from your HSA. There is no daily limit.

HSA Bank's Health Benefits Debit Card can be used for point-of-sale transactions in two ways, signature or PIN. For signature, swipe card, press credit on the keypad, and sign the receipt. To pay using a PIN (fee per PIN transaction may apply†), swipe your card, select debit on the keypad, and enter your PIN. To withdraw HSA funds from an ATM (fee per ATM withdrawal may apply†), be sure to select the "checking" option (not savings) when asked the type of account you are withdrawing from. HSA Bank limits point-of-sale debit card transactions to medical merchants. As a mechanism for fraud protection, HSA Bank has set daily limits on debit card transactions. These limits are listed in your Deposit Account Agreement and Disclosures Booklet. Debit card transactions are also limited to your current balance.

*The HSA Bank Mobile App is free to download. However, you should check with your wireless provider for any associated fees for accessing the internet from your device.

**You can pay for a wide range of IRS-qualified medical expenses with your HSA, including many that aren't typically covered by health insurance plans. This includes deductibles, co-insurance, prescriptions, dental and vision care, and more. For a complete list of IRS-qualified medical expenses, visit irs.gov or hsabank.com/IRSQualifiedExpenses.

†For applicable fees, see your HSA Bank Interest and Fee Schedule or Explanation of HSA Bank Fee Changes document.

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

hsabank own your health®

HSA Frequently Asked Questions

What is a Health Savings Account (HSA)?

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

Who can get an HSA?

Any eligible individual that:

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

How much can I contribute annually to an HSA?

2019 IRS Maximum Allowable Contribution Limits

- Individual: $3,500
- Family: $7,000

2020 IRS Maximum Allowable Contribution Limits

- Individual: $3,550
- Family: $7,100

Catch-Up Contributions

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

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

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

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

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

Who can make contributions?

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

HSA Frequently Asked Questions

Are there income restrictions?

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

What are the advantages of an HSA?

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

Is an HSA compatible with an HRA/FSA?

Yes, this is permitted if the combination is:

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

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

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

The funds are portable and go with you.

Can I withdraw the money for non-medical expenses?

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

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

hsabank own your health®

HSA_FAQ_060419

HOSPITAL INDEMNITY

ABOUT THIS BENEFIT:

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

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

LEARN MORE

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

GROUP VOLUNTARY HOSPITAL INDEMNITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

A 4-day stay in the hospital could cost around $10,000.[1]

Advanced Financial School Block

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

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

To learn more about Hospital Indemnity insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

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

PLAN INFORMATION		PLAN 2
Coverage Type		On and off-job (24 hour)
Covered Events		Illness and injury
HSA Compatible?		Yes
BENEFITS		
HOSPITAL CARE[2]		**PLAN 2**
First Day Hospital Confinement	Up to 1 day per year	$1,500
Daily Hospital Confinement (Day 2+)	Up to 30 days per year	$100
Daily ICU Confinement (Day 1+)	Up to 30 days per year	$200
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM2] – Administrative & clinical support following serious illness or injury		Included

ASKED & ANSWERED

IS THIS COVERAGE HSA COMPATIBLE?

If you (or any dependent(s)) currently participate in a Health Saving Account (HSA) or if you plan to do so in the future, you should be aware that the IRS limits the types of supplemental insurance you may have in addition to a HSA, while still maintaining the tax-exempt status of the HSA.

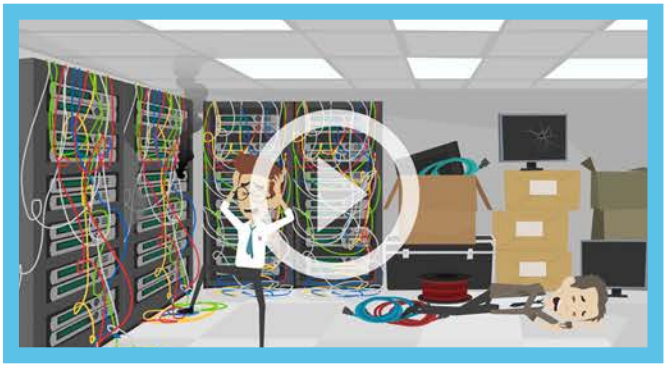
This plan design was designed to be compatible with Health Savings Accounts (HSAs). However, if you have or plan to open an HSA, please consult your tax and legal advisors to determine which supplemental benefits may be purchased by employees with an HSA.

IDENTITY THEFT PROTECTION

ABOUT THIS BENEFIT:

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

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



LEARN MORE

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

LifeLock™ with Norton™ | Benefit Plans

Your Employee Benefit Can Help Protect Your Identity and Devices.

Everyday we put our information at risk on the internet.

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

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

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

No one can prevent all identity theft or all cybercrime.

Benefit Pricing - Monthly Rates

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

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

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

844-698-8640

Norton LifeLock

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

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

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

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

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

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

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

[Δ] English only.

No one can prevent all identity theft or cybercrime.

LifeLock and Norton by Symantec are now Norton LifeLock.

GPPM8782

INDIVIDUAL LIFE

ABOUT THIS BENEFIT:

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

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

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

WOW!

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

- You own it
- You can take it with you when you change jobs or retire
- You pay for it through convenient payroll deductions: no checks to write or links to click
- You can cover your spouse, children and grandchildren, too[1]
- You can get a living benefit if you become terminally ill[2]
- It's Affordable
- You can qualify by answering just 3 questions - no exam or needles

1. 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.
2. Conditions apply.

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

19M004-C 1003 (exp0321)

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

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

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

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

3 QUICK QUESTIONS

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

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

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

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

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

19M016-C 1092 (exp0321)

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

TELEHEALTH

ABOUT THIS BENEFIT:

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

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

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

LEARN MORE

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

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

Quality Care When You Need It Most

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

WHY CHOOSE 1.800MD?

SAVES MONEY

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

CONVENIENCE AND QUALITY CARE

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

SUPPORT

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

CUTTING EDGE TECHNOLOGY

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

SAVE MONEY AND TIME!

HOW DOES IT WORK?

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

1. ACTIVATE ACCOUNT

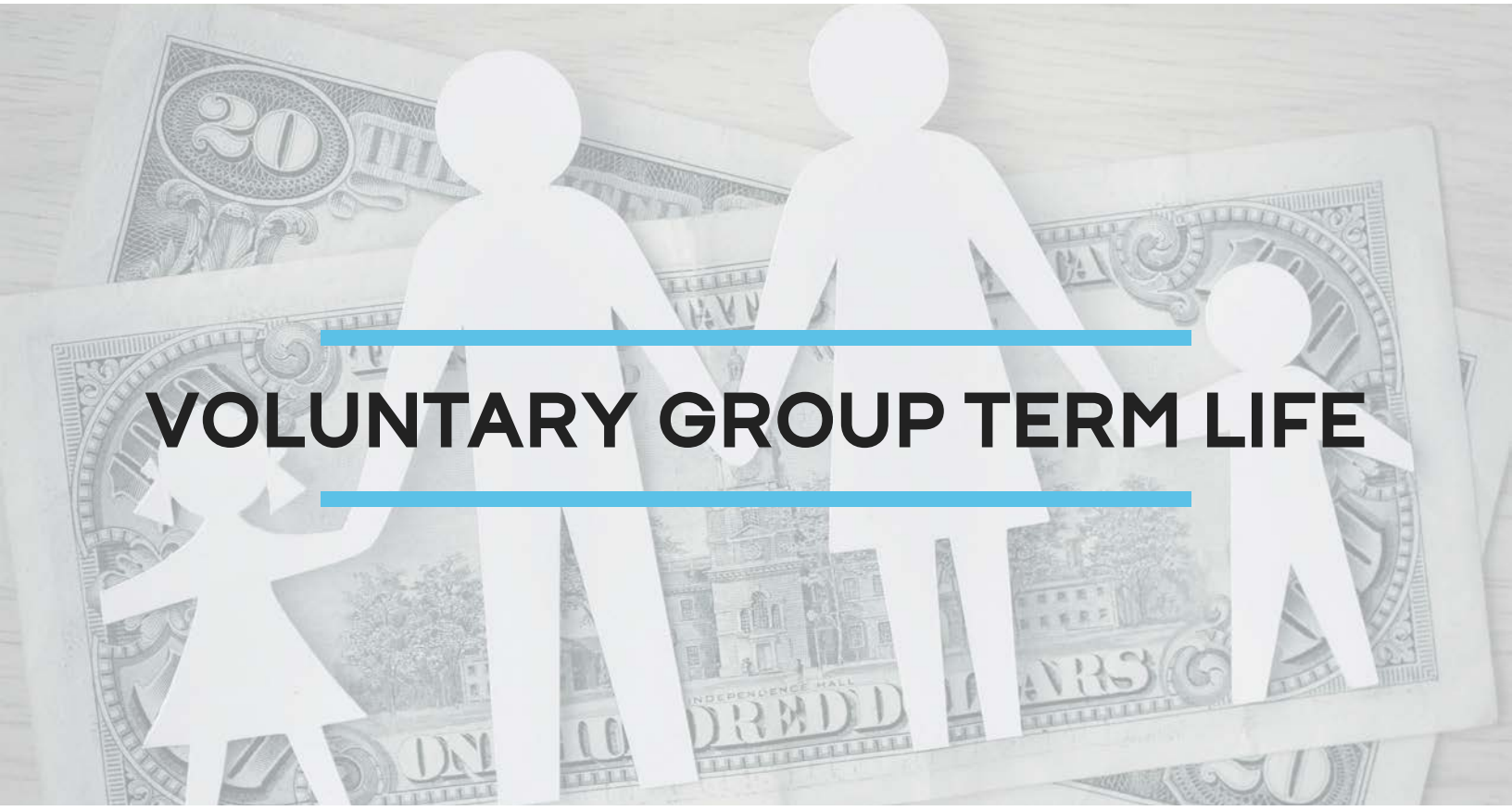
Activate your account online at **www.1800md.com** or by calling **1.800.530.8666**. Once activated, you will need to setup your member profile and complete your electronic health record.

2. REQUEST A CONSULT

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

3. RECEIVE CARE

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

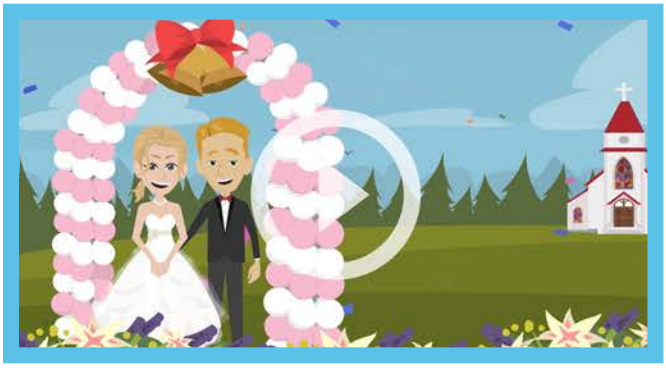


VOLUNTARY GROUP TERM LIFE

ABOUT THIS BENEFIT:

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

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



LEARN MORE

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

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

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

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

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

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

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

EN-1773 (8-17) FOR EMPLOYEES

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

Monthly Payroll Deduction

EMPLOYEE*

Life/AD&D

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

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

SPOUSE**

Life/AD&D

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

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

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CHILD(REN)

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

NOTE: FINAL RATES MAY VARY SLIGHTLY DUE TO ROUNDING.

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

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

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

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

VISION INSURANCE

ABOUT THIS BENEFIT:

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

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

LEARN MORE

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

Eyetopia 120/145 Standard
TAFG School Block Summary of Benefits

Eyetopia Benefits	
Eyetopia provides two vision benefits each eligibility period. You may have the opportunity to maximize your Eyetopia benefits by coordinating benefits with your Health Insurance coverage.	
Benefit One [2] (choose either one of the following 2 options every 12 months):	**Co-pay**[1]
1. Refractive Exam. One routine Vision Exam.	$10.00
2. $45 allowance towards a medical eye exam copay or other services or materials. [2]	None
Benefit Two (choose only one of the following Vision Correction Options): Eyetopia provides you with 3 material options every 12 months.[3]	
1a. Prescription Lenses (Not using Eyetopia Optics) [4] Standard Prescription Lenses – covered 100% ♦ Non-coated CR-39 plastic single vision, bifocal, trifocal. Progressive no-line lenses (PAL) are covered up to $120.00.	**Co-pay**[1] $20.00
♦ Polycarbonate upgrade [6] ♦ Basic Anti-Reflective Coating (Ultraviolet Protection & Scratch Resistant Coating) ♦ Mid-Level Anti-Reflective Coating ♦ Premium Anti-Reflective Coating	$35.00 $25.00 $65.00 $130.00
1b. Prescription Lenses from Eyetopia Optics [4,5] ♦ Eyetopia Optics Standard single vision or bifocal flat top 28 lenses with a mid-level Anti-Reflective Coating.[5]	$20
♦ Eyetopia Optics polycarbonate material and a mid-level AR Coating upgrade for child dependents (under age 26). ♦ Eyetopia Optics non-prescription anti-fatigue lenses. ♦ Eyetopia Optics high definition PAL or free form SV in CR-39 with a mid-level anti-reflective coating. [5] ♦ Eyetopia Optics premium blue light blocking, high definition PAL or SV in CR-39 with mid-level AR coating.[5] ♦ Eyetopia Optics photochromatic or polarized lenses	None None $65.00 $105.00 $90.00
♦ Medically necessary spectacles for Aniseikonia or Amblyopia - $400.00 lens allowance.	None
Additional upgrade for lenses from any lab source; Tint (Solid and Gradient)	$12.00
♦ **Frame:** The member may select any frame on display. Eyetopia provides an allowance of $120.00 to be applied toward the frame selected. The member pays any amount exceeding the $120.00 allowance.	None
2. Contact Lens Option: [7] Eyetopia provides a $145.00 allowance to be applied toward prescription contact lenses. This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.	$20.00
♦ Medically necessary contact lenses - $145.00 evaluation allowance and $400.00 contact lens allowance.[8]	None
3. Refractive Surgery Option. [9] You may select refractive surgery instead of spectacles or contact lenses during each plan period. Eyetopia provides a $350.00 per eye with contracted surgeons or a $75.00 per eye allowance with non-contracted surgeons toward the fees for refractive surgery care, for the following procedures: LASIK, PRK, ICL or RLE. The member pays any amount exceeding the per eye allowance.	None

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

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

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

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

5 Members can upgrade from standard non-coated lens to an Eyetopia Optics premium coated lenses at no charge. They can upgrade to an Eyetopia Optics high definition PAL or high definition single vision in CR-39 plastic for an additional $65.00. A $105.00 co-pay applies to premium blue light resistance lenses.

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

7 The Participating Provider must pre-authorize medical necessity.

8 Non-covered Items and Exclusions – Facility fees, medications and enhancements or treatments related to complications. Access to surgeons must come by referral from a Primary Eye Care Provider who provides pre and post-op care and counseling.

Exclusions & Limitations

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

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

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

Find us on Facebook.com/eyetopiavision

Member:	$10.00
Member + 1:	$17.00
Member + Ch:	$20.00
Family:	$24.00

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

Eyetopia 150/250 Gold
TAFG School Block Summary of Benefits

Eyetopia Benefits	
Eyetopia provides two vision benefits each eligibility period. You may have the opportunity to maximize your Eyetopia benefits by coordinating benefits with your Health Insurance coverage.	
BENEFIT ONE [2] (choose either one of the following 2 options every 12 months):	**Co-pay**[1]
1. Refractive Exam. One routine vision exam.	$5.00
2. $65 allowance toward medical eye exam co-pay or other services or materials. [2]	None
BENEFIT TWO (choose only 1 of the following Vision Correction Options) Eyetopia provides you with 3 options for correcting your vision every 12 months. [3]	
1a. Prescription Lenses (Not using Eyetopia Optics) [3, 4] Single vision, bifocal or trifocal lenses in polycarbonate, Trivex®, 1.60 or 1.67 index plastic that also include a basic anti-reflective coating are covered 100%. Progressive no-line lenses (PAL) are covered up to $120.00.	**Co-pay**[1] None
• Mid-Level Anti-Reflective Coating - $45.00 allowance	None
• Premium Anti-Reflective Coating - $60.00 allowance	None
1b. Prescription Lenses from Eyetopia Optics [3, 4] Bi-focal, Tri-focal, high definition single vision or Progressive (no line) lenses in polycarbonate, Trivex®, 1.60 or 1.67 index plastic with a mid-level[5] anti-reflective coating are covered 100%.	None
• Eyetopia Optics non-prescription anti-fatigue, anti-reflective lenses.	None
• Eyetopia Optics premium blue light blocking, high definition with premium anti-reflective coating.	$50.00
• Eyetopia Optics photochromatic or polarized lenses.	$90.00
• Medically necessary spectacles for Aniseikonia or Amblyopia - $400.00 lens allowance.	None
Additional upgrade for lenses from any lab source: Tint (Solid and Gradient)	$12.00
♦ **Frame**: The member may select any frame on display. Eyetopia provides an allowance of $150.00 to be applied toward the frame selected. The member pays any amount exceeding the $150.00 allowance.	None
2. Contact Lens Option Eyetopia provides a $250.00 allowance to be applied toward prescription contact lenses. ♦ This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.[6]	None
♦ Medically necessary contact lenses - $250.00 evaluation allowance and $400.00 contact lens allowance.[7]	None
3. Refractive Surgery Option. [8] You may select refractive surgery instead of spectacles or contact lenses during each plan period. Eyetopia provides a $500.00 per eye with contracted surgeons or a $125.00 per eye allowance with non-contracted surgeons toward the fees for refractive surgery care, for the following procedures: LASIK, PRK, ICL or RLE. The member pays any amount exceeding the per eye allowance.	None

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

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

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

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

[5] The charge for a premium anti-reflective coating is a $65 co-pay plus the difference of the retail price of the mid-range anti-reflective coating and the premium coating.

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

[7] Total maximum benefit allowance is $650.00. The Participating Provider must pre-authorize medical necessity.

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

Exclusions & Limitations

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

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

Find us on facebook.com/eyetopiavision

Member:	$20.00
Member + 1:	$37.00
Member + Ch.	$44.00
Family:	$52.00

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

GLOSSARY OF TERMS

ACCIDENT
an unexpected event or circumstance without deliberate intent.

ACCIDENTAL DEATH & DISMEMBERMENT
an insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

BENEFICIARY
an individual who may become eligible to receive payment due to will, life insurance policy, retirement plan, annuity, trust, or other contract.

CALENDAR YEAR DEDUCTIBLE
in health insurance, the amount that must be paid by the insured during a calendar year before the insurer becomes responsible for further loss costs.

CLAIM
a request made by the insured for insurer remittance of payment due to loss incurred and covered under the policy agreement.

COINSURANCE
A clause contained in most property insurance policies to encourage policy holders to carry a reasonable amount of insurance. If the insured fails to maintain the amount specified in the clause (Usually at least 80%), the insured shares a higher proportion of the loss. In medical insurance a percentage of each claim that the insured will bear.

COORDINATION OF BENEFITS
provision to eliminate over insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan.

COPAY
a cost sharing mechanism in group insurance plans where the insured pays a specified dollar amount of incurred medical expenses and the insurer pays the remainder.

DEDUCTIBLE
Portion of the insured loss (in dollars) paid by the policy holder.

DENTAL INSURANCE
policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

DISABILITY INCOME
policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.

EFFECTIVE DATE
date at which an insurance policy goes into force.

FACE AMOUNT
the value of a policy to be provided upon maturity date or death.

GLOSSARY OF TERMS

HEALTH INSURANCE
a generic term applying to all types of insurance indemnifying or reimbursing for losses caused by bodily injury or illness including related medical expenses.

HEALTH MAINTENANCE ORGANIZATION (HMO)
a medical group plan that provides physician, hospital, and clinical services to participating members in exchange for a periodic flat fee.

HOSPITAL INDEMNITY COVERAGE
coverage that provides a pre-determined, fixed benefit or daily indemnity for contingencies based on a stay at a hospital or intensive care facility.

INCONTESTABILITY PROVISION
a life insurance and annuity provision limiting the time within which the insurer has the legal right to void the contract on grounds of material misrepresentation in the policy application.

INSURED
party(ies) covered by an insurance policy.

INSURER
an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state.

LAPSE
termination of a policy due to failure to pay the required premium.

LIVING BENEFITS RIDER
a rider attached to a life insurance policy providing long term care for the terminally ill.

LONG-TERM CARE
policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community based care, or any combination. The policy does not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated heath benefit-type products.

LONG-TERM DISABILITY INSURANCE
policy providing monthly income payments for insureds who become disabled for an extensive length of time, typically two years or longer.

MAJOR MEDICAL
a hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered.

MANAGED CARE
system of health care delivery that attempts to influence the utilization, quality, and cost of services provided.

GLOSSARY OF TERMS

PERMANENT LIFE INSURANCE
policy that remains active for the life of the insured.

PET INSURANCE PLANS
veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

POLICY
a written contract ratifying the legality of an insurance agreement.

POLICY PERIOD
time period during which insurance coverage is in effect.

POLICY RESERVE
the amount of money allocated specifically for the fulfillment of policy obligations by a life insurance company; reserves are in place to safeguard that the company is able to pay all future claims.

ORGANIZATION (PPO)
arrangement, insured or uninsured, where contracts are established by Health Plan Companies (typically, commercial insurers, and, in some circumstances, by self-insured employers) with health care providers. The Health Plans involved will often designate these contracted providers as "preferred" and will provide an incentive, usually in the form of lower deductibles or co-payments, to encourage covered individuals to use these providers. Members are allowed benefits for non-participating provider services on an indemnity basis with significant copayments and providers are often, but not always, paid on a discounted fee for service basis.

PREMIUM
Money charged for the insurance coverage reflecting expectation of loss.

PROVISIONS
contingencies outlined in an insurance policy.

RATE
value of insured losses expressed as a cost per unit of insurance.

RIDER
an amendment to a policy agreement.

SHORT-TERM DISABILITY
a company standard defining a period of time employees are eligible for short-term disability coverage, typically for 2 years or less.

SPECIFIED DISEASE COVERAGE
coverage that provides primarily pre-determined benefits for expenses of the care of cancer and/or other specified diseases.

TERM
period of time for which policy is in effect.

TERM INSURANCE
life insurance payable only if death of insured occurs within a specified time, such as 5 or 10 years, or before a specified age.

GLOSSARY OF TERMS

UNIVERSAL LIFE INSURANCE
adjustable life insurance under which premiums and coverage are adjustable, company expenses are not specifically disclosed to the insured but a financial report is provided to policyholders annually.

VARIABLE ANNUITY
an annuity contract under which the premium payments are used to purchase stock and the value of each unit is relative to the value of the investment portfolio.

VARIABLE LIFE INSURANCE
life insurance whose face value and/or duration varies depending upon the value of underlying securities.

VARIABLE UNIVERSAL LIFE
combines the flexible premium features of universal life with the component of variable life in which excess credited to the cash value of the account depends on investment results of separate accounts. The policyholder selects the accounts into which the premium payments are to be made.

VISION
limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.

WHOLE LIFE INSURANCE
life insurance that may be kept in force for the duration of a person's life and pays a benefit upon the person's death. Premiums are made for same time period.

Source:

Commissioners, March 2020

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