ALIEF ISD 2025
BENEFITS GUIDE

SCAN ME

FFGA
Benefit Solutions Simplified

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

Employee Benefits Center

A guide to your benefits!

Alief ISD and FFGA are excited to provide you with a custom website filled with information about your benefits. Visit the Employee Benefits Center to see current benefit options for your employer as well as find claim forms, important phone numbers and enrollment information.

There's no need to register for site access. Simply type the URL below into your browser and you will be directed to your Employee Benefits Center.

Scan the QR code to learn more about the plans that are available this year!

https://ffbenefits.ffga.com/aliefisd

How to Enroll

Benefits Enrollment

On-Site Enrollment

When it's time to enroll in your benefits, your FFGA Account Representative will be on-site to assist you with making your elections. Visit your EBC for more information.

Online Enrollment

To begin online enrollment, visit https://www5.benefitsolver.com

Enroll Now

Login

To enroll online, log in to BenefitSolver at www5.benefitsolver.com and log in with your User Name and password for this benefit website. If this is your first-time logging into the site, click Register to get started. This site will request your social security number, date of birth (mm/dd/yyyy) and company key (alief), case sensitive. The site will ask you to create your Username (8 characters or longer) and Password (8 characters or longer) and have a combination of letters and numbers.

View Current Benefits

After logging in, you will arrive at the welcome screen. Your current benefits and premium deductions will be listed on this screen.

View/Add Dependents

Click next to view your dependents. It is very important to make sure the social security numbers and birth dates listed are correct. If you plan to add dependents, you will need to enter their legal name, social security numbers and birth dates.

Begin Elections

Click next again to begin making your benefit elections. Remember, no changes to your elections can be made during the plan year unless you have either a qualified mid-year change under Section 125 or a special enrollment event.

Benefit Eligibility & Coverage

Employee Coverage

Eligibility

Eligible employees must be actively at work on the plan effective date for new benefits to be effective.

New Employees

You have 31 days from your actively-at-work date to make benefit elections. Insurance coverage becomes effective on the first day of the month that follows a waiting period of 30 calendar days.

Existing Employees

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

Mid-year Benefit Changes

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

Qualifying Life Events Include:

- Changes in household, including marriage, divorce, legal separation, annulment, death of a spouse, birth, adoption, placement for adoption or death of a dependent child
- Loss of health coverage, attributable to your spouse's employment, losing existing health coverage including job-based, individual and student plans, losing eligibility for Medicare, Medicaid, or CHIP, turning 26 and losing coverage through a parent's plan

Declining Coverage

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

Section 125 Plans

Section 125 Plan Information & Rules

A Section 125 Plan provides a tax-saving way to pay for eligible medical or dependent care expenses. The funds are automatically deducted from your paycheck on a pre-tax basis.

Here's How It Works

A Section 125 Plan reduces your taxes and increases your spendable income by allowing you to deduct the cost of eligible benefits from your earnings before tax. Plus, the plan is available to you at no cost, and you're already eligible – all you must do is enroll.

Is It Right For Me?

The savings you may experience with a Section 125 Plan are outlined in the example below. For instance, you could potentially take home about $70 more each month if you participated in your employer's Section 125 Plan – that's a savings of $840 a year!

You cannot change your benefit elections for the plan year unless the benefits office receives notification in writing within 31 days of the status change. If the benefits office is not notified within 31 days of the status change, no benefit change can be made until the next annual open enrollment.

IRS specified changes in family status include:

- Change in legal married status
- Change in number of dependents
- Termination or commencement of employment
- Dependent satisfies or ceases to satisfy dependent eligibility requirements
- Change in residence or worksite that affects eligibility for coverage

Section 125 Plan Sample Paycheck		
	Without S125	With S125
Monthly Salary	$2,000	$2,000
Less Medical Deductions	-N/A	-$250
Tax Gross Income	$2,000	$1,750
Less Taxes (Fed/State at 20%)	-$400	-$350
Less Estimated FICA (7.65%)	-$153	-$133
Less Medical Deductions	-$250	-N/A
Take Home Pay	$1,197	$1,267
You could save $70 per month in taxes by paying for your benefits on a pre-tax basis!		

**The figures in the sample paycheck above are for illustrative purposes only.*

Medical Coverage

Blue Cross Blue Shield of Texas

Your medical plans are offered through BCBSTX. From in- and out-of-network options to comprehensive prescription drug coverage and special health and wellness programs. BCBSTX plans have been designed to flexibly meet the needs of nearly half a million public education employees.

Blue Cross Blue Shield of Texas | https://www.bcbstx.com | 1.888.697.0683

BLUE ESSENTIAL HMO

- Copays for doctor visits and generic prescriptions before you meet deductible
- Participants must select a primary care provider who will make referrals to specialists

BLUE CHOICE EPO

- Large provider network
- Copays for many services and drugs
- No out-of-network services
- No requirement for PCP or referrals

Pharmacy Benefits by CVS Health

When you enroll in a BCBSTX Plan, you automatically receive prescription drug coverage through CVS Health

- Copays for various drugs
- 3 month drug mail order program

BCBSTX Medical Premiums

Medical Semi-Monthly Premiums		
	Blue Essentials HMO *Group #394443-0001*	Blue Choice EPO *Group #394442-0001*
Employee Only	$42.00	$131.00
Employee + Spouse	$229.00	$454.00
Employee + Children	$188.00	$417.00
Employee + Family	$372.00	$751.00

For more information, please refer to the BCBSTX website

2025 Medical - Blue Cross Blue Shield

Blue Cross Blue Shield Semi-Monthly Rates		
Coverage Tier	Blue Essential HMO	Blue Choice EPO
Employee Only	$42.00	$131.00
Employee + Spouse	$229.00	$454.00
Employee + Child(ren)	$188.00	$417.00
Employee + Family	$372.00	$751.00

BENEFIT FEATURES	Blue Essential HMO *Grp # 394443-0001*	Blue Choice EPO Grp # 394442-0001
Annual Deductible Individual Family Out of Pocket Maximum Individual Family Coinsurance Lifetime Maximum	.... $1,500 $2,250 .... $3,750 $7,500 20% Unlimited	.... $4,500 $4,500 .... $6,000 $12,000 20% Unlimited
Preventive Services Immunizations, Routine Physicals, Well Child, Pap Smears, PSA Tests, plan lay Mammograms	100% Covered	100% Covered
Primary Care Physician Referrals to Specialist Physician Office Visit Primary Care Specialist Maternity OB Visits	Required Required $30 Copay $40 Copay $40 Copay Initial Visit Only/Then 100%	Not Required Not Required $30 Copay $40/$60 Copays $40/$60 Copay Initial Visit Only/Then 100%
Urgent Care Emergency Room Ambulance (Non-emergency use not covered)	$40 Copay $250 Copay & 20% after deductible 20% after deductible	$40 Copay $500 Copay & 20% after deductible 20% after deductible
Hospital Care Inpatient Inpatient Maternity Outpatient	 $300 Copay + 20% after deductible Same as Inpatient Cost 20% after deductible	 $500 Copay + 20% after deductible Same as Inpatient Cost 20% after deductible
Diagnostic Services Laboratory & X-Ray– copay Complex Imaging (CT, PET, MRI, MRA & Nuclear Medicine)	$40 Copay $150 Copay	$40 Copay 20% after deductible
Skilled Nursing Home Health Care Hospice Care—Inpatient —Outpatient	$300 Copay + 20% after deductible 20% after deductible $300 Copay + 20% after deductible 20% after deductible	$500 copay + 20% after deductible 20% after deductible $500 copay + 20% after deductible $40 Copay
Mental Health Inpatient Outpatient	$300 Copay + 20% after deductible $40 copay	$500 copay + 20% after deductible $40 Copay
Pharmacy Benefits by CVS Health Retail Mail Order (3 month)	Generic/Formulary/Non-Formulary $15/$40/$70 Copay $20/$60/$100 Copay	Generic/Formulary/Non-Formulary $15/$40/$70 Copay $20/$60/$100 Copay

Blue Essentials℠

with Kelsey-Seybold Doctors

Welcome to a better kind of care.

Kelsey-Seybold Clinic®

An overview for members

Blue Essentials℠

with Kelsey-Seybold Doctors

With a **Blue Essentials Plan *with Kelsey-Seybold Doctors***, you not only get great coverage and benefits, but you also have access to highly personalized care delivered by an exclusive network of 850+ Kelsey-Seybold doctors and specialists.

Your entire care team at Kelsey-Seybold is connected to each other through your electronic health record. Best of all, primary and specialty care, labs, imaging, and more are all in one place, giving you an easier, more convenient healthcare experience.

The Care You Need When You Need It

Your Care Team Is Connected

At Kelsey-Seybold, your doctors are connected to each other and to you. By working together, your care team provides the personalized care you need, plus a more streamlined healthcare experience.

No Referral Is Ever Needed To See a Kelsey-Seybold Specialist

- 850+ physicians and providers
- 65+ medical specialties
- 40+ locations and growing!

All in One Place

Discover the convenience of having primary and specialty care, on-site labs, diagnostic services, and more all in one location. Plus, Kelsey-Seybold's regional campus locations bring outpatient surgery and nationally accredited cancer care even closer to home.

Virtual Care 365 Days a Year

No matter where you are, Kelsey-Seybold care is there. Choose VideoVisitNOW (on-demand), schedule a Video Visit, or start an E-Visit online. Virtual care is available with Kelsey-Seybold providers day or night, 365 days a year.

After-Hours Nurse Hotline

Kelsey-Seybold registered nurses provide answers and reassurance to help you get the care you need after regular business hours and on weekends and holidays.

Access, Convenience, and Quality You Can Count On

With locations all across Greater Houston, you'll find a Kelsey-Seybold location close to where you live or work. Same-day and next-day primary care appointments are available.

Choosing a Kelsey-Seybold Primary Care Physician Gives You Access to ALL Kelsey-Seybold Doctors
Your designated Kelsey-Seybold primary care physician (PCP) gives you access to ALL Kelsey-Seybold doctors, including specialists. No referrals are ever required from your PCP to see Kelsey-Seybold specialists with expertise in 65+ medical specialties.

- To gain access to all doctors in the Kelsey-Seybold network, you must select a Kelsey-Seybold PCP. **kelsey-seybold.com/find**
- This does not limit your access. You can still see any physician at any clinic without a referral.

Access To Houston's Top Hospitals
Kelsey-Seybold has affiliations with world-class hospitals. This includes facilities with Texas Children's Hospital, St. Luke's Health, Memorial Hermann, Houston Methodist, The Woman's Hospital of Texas, and HCA Houston Healthcare.

Saturday Appointments
Saturday sick-care appointments are available at select locations from 9 a.m. to 2 p.m.*

Emergency Care
If you need emergency care, your plan includes nationwide coverage.**

Nationwide Urgent Care Centers
If you need urgent care, you have access to Blue Cross Blue Shield of Texas' nationwide, in-network urgent care centers.

Behavioral and Mental Health Resources
Your resources may include Blue Cross Blue Shield of Texas' behavioral and mental health network†, your primary care physician at Kelsey-Seybold, and/or your employer's EAP program.**

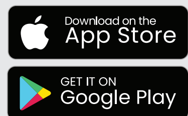
At Your Service

Your Kelsey Concierge is here to provide personalized help and answer your questions about the services you need – and more.

You Have a Secure Patient Portal

MyKelseyOnline (MKO) and your MyKelsey App keep you connected 24/7 with Kelsey-Seybold. You can schedule appointments, email your doctor's office, get most test results, and more! You can also schedule Virtual Care – Video Visits, on-demand VideoVisitNOW, and E-Visits.

Download the MyKelsey App!



Predictable Co-Pays

You can count on predictable co-pays, including labs and X-rays, for appointments with your providers.**

Doctors Who Understand You

Kelsey-Seybold features a culturally diverse team of doctors who speak 35+ different languages. To learn more about our doctors, visit **kelsey-seybold.com/find**.

Plan Details

For specific questions or details about your plan or coverage, please call the customer service number located on the back of your insurance card.

* Kelsey-Seybold Clinic days and hours may vary by location. Please visit kelsey-seybold.com for specific details.
** Benefits may vary by plan. Please refer to your carrier for specific plan details.
† No referral required.

Blue Essentials℠

with Kelsey-Seybold Doctors

Important Phone Numbers:

24/7 Appointment Scheduling: **713-442-0000**

After-Hours Nurse Hotline: **713-442-0000**

Your Kelsey Concierge: **713-442-8977**
Monday-Friday, 8 a.m. to 5 p.m.

MyKelseyOnline Help Line: **713-442-6565**
Sunday-Saturday, 7 a.m. to 9 p.m.

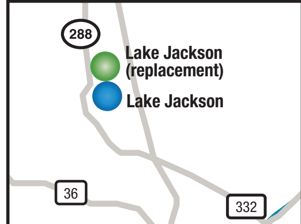
To view a list of our primary care physicians and their PCP ID numbers go to kelsey-seybold.com/find.

For a list of primary care physicians and frequently asked questions, scan this QR code.

Kelsey-Seybold Locations and Affiliated Hospitals

Map Legend

- Current Locations
- Future Locations 2024-2028
- Affiliated Hospitals



Conroe (replacement)
Conroe
West Woodlands
The Woodlands OB/GYN and Women's Health
The Woodlands
Second Woodlands
Springwoods Village Campus
Kingwood
Klein
The Vintage
Fairfield
Atascocita
North Houston Campus
Summer Creek
Lake Houston Campus
FM 1960
Towne Lake
Cypress
Northwest Campus
Copperwood Villages
West/NW Cancer Center
Rice Village
Sleep Center
Greater Heights
Upper Kirby
West Campus
West Grand Parkway
Memorial Villages Campus
River Oaks
North Channel
Baytown
West Katy
Memorial City
Downtown
Westchase
Tanglewood
Downtown at Esperson Tunnel
Eldridge
St. Luke's Medical Tower
Main Campus
Katy
Gulfgate
Stafford
Meyerland
West University
Aliana
Fort Bend Campus
Pasadena
Rosenberg
Missouri City
Pearland
Bay Area Campus
Sienna
Pearland Parkway
South Shore Harbour
League City

Hardy Toll Rd.
Beltway 8
Westpark Tollway
Fort Bend Toll Rd
Broadway St. / FM 518
Nasa Rd. 1

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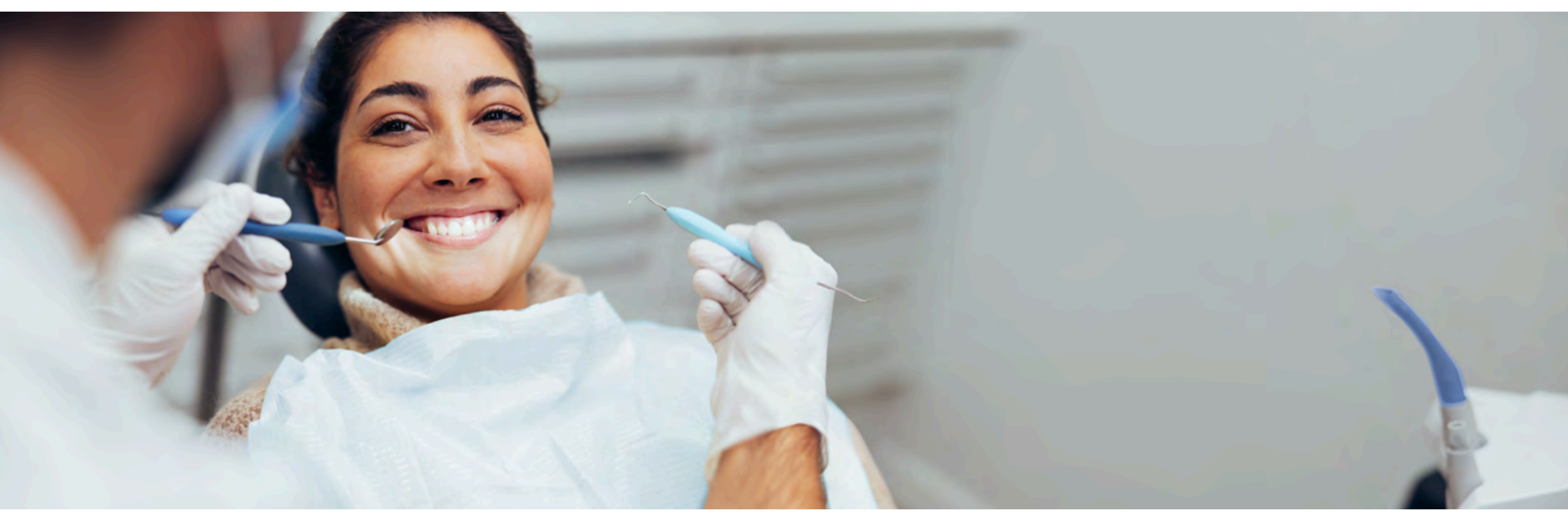
Dental Insurance

Plan Choices



Cigna | www.mycigna.com | 800-244-6224

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

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

Dental Semi-Monthly Premiums			
Coverage Tier	DHMO	PPO Low	PPO High
Employee Only	$5.53	$11.73	$19.02
Employee + Spouse	$10.49	$30.11	$48.84
Employee + Children	$11.04	$30.90	$50.12
Employee + Family	$17.13	$40.75	$66.11

Cigna P7XVO TX (DHMO) Sample Fee Schedule

Coverage Type	Fee	Coverage Type	Fee
Office Visit Fee	$5.00	Periodic Oral Evaluation	$0.00
X-rays (bitewings)	$0.00	Prophylaxis (cleaning)	$0.00
Amalgam Filling (one surface)	$0.00	Amalgam Filling (two surface)	$0.00
Root Canal (anterior)	$100.00	Crown: Resin based (anterior)	$45.00
Crown: Resin based (posterior, 1 surface)	$70.00	Removal of impacted tooth soft tissue	$65.00
Pre-treatment planning for Ortho (Child/Adult)	$125.00	Lifetime Orthodontia treatment (Child)	$1,608.00
Removal of Appliances, construction/placement of retainers (Adults Only)	$295.00	Lifetime Orthodontia treatment (Adult)	$2,592.00

Plan Option 2—Low Plan **NO ORTHODONTICS			Plan Option 3—High Plan		
Coverage Type	DPPO Network	Out of Network	Coverage Type	DPPO Network	Out of Network
Deductible	**In-Network**	**Out-of-Network**	**Deductible**	**In-Network**	**Out-of-Network**
Individual/Family	$50/ $150	$50/ $150	Individual/Family	$50/ $150	$50/ $150
Diagnostic/Preventative *No Deductible	100%	100%	Diagnostic/Preventative *No Deductible	100%	100%
Fillings/Simple Extractions *After Deductible	80%	80%	Fillings/Simple Extractions *After Deductible	80%	80%
Endodontics/Periodontics/ Oral Surgery *After Deductible	50%	50%	Endodontics/Periodontics/ Oral Surgery *After Deductible	80%	80%
Major Services *After Deductible	50%	50%	Major Services *After Deductible	50%	50%
Annual Maximum Benefit – Per Person	$1,800	$1,800	Annual Maximum Benefit – Per Person	$1,800	$1,800
ORTHODONTICS	$0	$0	ORTHODONTICS (Dep Children Only)	50%	50%
			Orthodontia Lifetime Maximum	$1,500	$1,500

Vision Insurance

VSP | www.vsp.com | 800-877-7195

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

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

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

Vision Insurance

VSP | www.vsp.com | 800-877-7195

VSP Vision Plan – Semi-Monthly Rates	
Coverage Tier	**Low Plan**
Employee Only	$2.49
Employee + Spouse	$4.98
Employee + Children	$5.85
Employee + Family	$8.95

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	
FRAME*	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart®/Sam's Club® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Tinted lenses • Scratch-resistant coating • UV protection • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $0 $0 $0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $25	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

Vision Insurance

VSP | www.vsp.com | 800-877-7195

VSP Vision Plan – Semi-Monthly Rates	
Coverage Tier	**High Plan**
Employee Only	$3.55
Employee + Spouse	$7.15
Employee + Children	$8.40
Employee + Family	$12.88

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	
FRAME*	• $250 featured frame brands allowance • $250 Visionworks frame allowance on any frame • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart®/Sam's Club® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Tinted lenses • Scratch-resistant coating • UV protection • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $0 $0 $0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $25	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to **vsp.com/framebrands** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

Check Out vsp.com

As a VSP® member, you have access to **vsp.com** and the VSP Vision Care App. Both offer easy navigation and a personalized dashboard, so you can get the benefit information you need, exactly when you need it.

Your VSP Dashboard

Once logged in, **My Dashboard** is your homepage. You'll find a quick view of your benefit information, access to your claim history, and you can print your Member ID Card, plus more.

Personalized Benefits Section

The **My Benefits** tab shows your benefits history and an explanation of how you and your dependents can use your benefits.

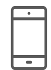
Special Offers and Savings

We put our members first by providing exclusive offers from VSP and leading industry brands, totaling more than $3,000 in savings. Log in to your VSP account and take advantage of these offers and save even more.

Improved Find a Doctor Page

The search capabilities are endless on the **Find a Doctor** page. View a map and use the drop-pin functionality to find the right VSP network practice location for you. You can also filter by business hours or appointment availability. Look for the orange **Premier Program** banner to find a VSP network eye doctor that will help you maximize your savings!

vsp vision care



VSP Vision Care App

Scan the QR code below to download the VSP Vision Care App from the **Apple App** or **Google Play Stores**. Get instant access to your benefit coverage, Member ID Card, Exclusive Member Extras, and more.

Create a vsp.com account to get the most out of your vision benefits.

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Employee Assistance Program

ComPsych | www.compsych.com | 800-557-1005

Life pulls us in many different directions. Between kids, personal relationships, extracurricular activities, and family time, it seems like we don't have enough time in a day to fit it all in. When life gets you stressed, call the employee assistance line provided by your employer. It offers 24/7 access to professionals who can help you successfully face emotional issues.

An employee assistance program, or EAP, is a free, voluntary program offered by your employer. With one phone call, you will have access to short-term counseling and confidential assessments whenever you have a personal or work-related problem.

Employee assistance programs address a wide range of issues including mental and emotional well-being, substance abuse and grief. Counselors are held to the highest ethical standard and are trained to keep your situation confidential. They work with you to determine the best way to address your needs and move you in a positive direction.

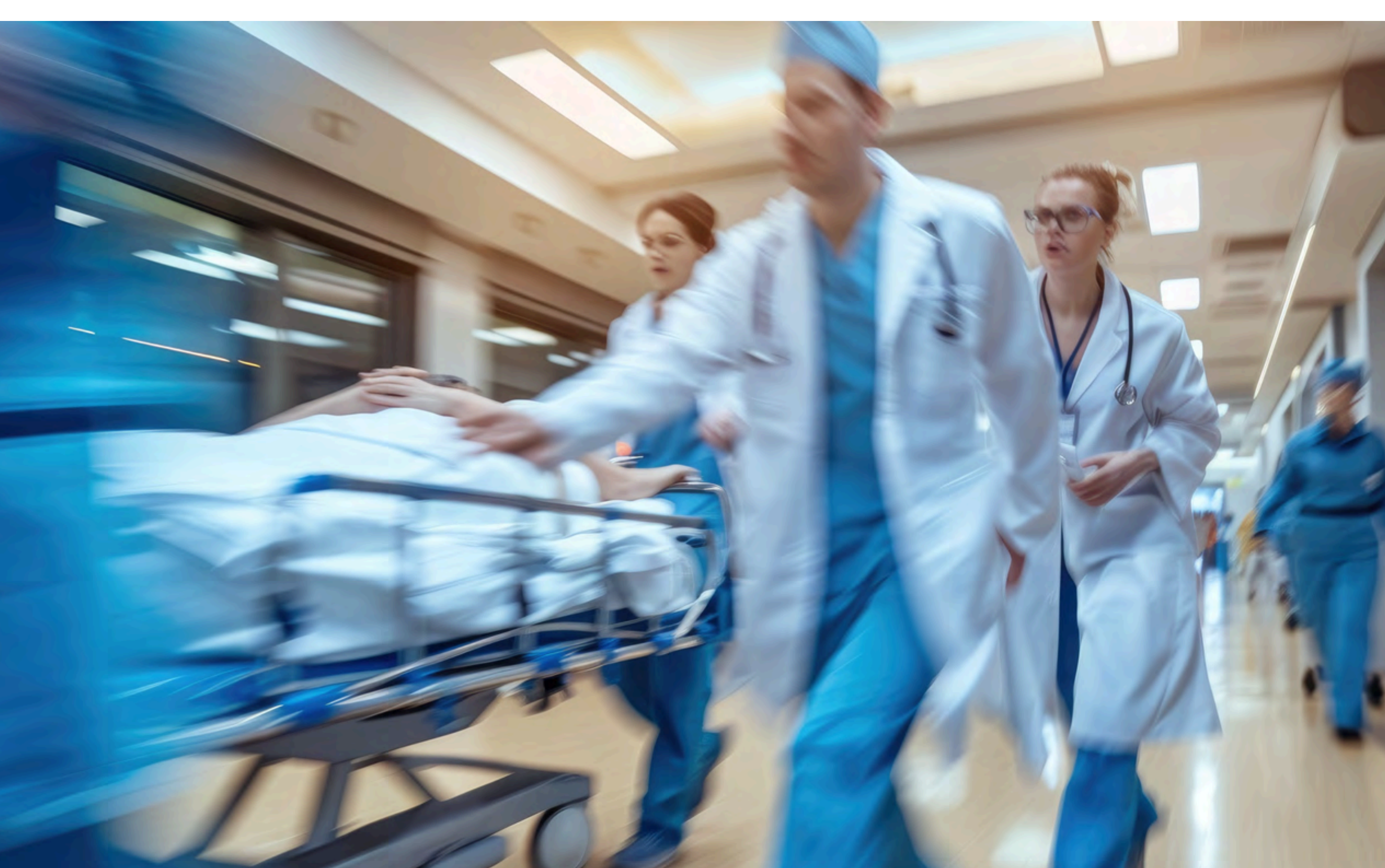
Accident Insurance

Aetna | www.aetna.com | 800-872-3862

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

Highlights Include:

- Guaranteed issue for all employees
- High and Low Plan to fit your budget and needs
- Helps pay high deductibles on medical expenses from an accident
- Coverage includes – but is not limited to – fractured bones, x-rays, diagnostic exams, third degree burns, hospital confinement



Covering your bases

Aetna Accident Plan

Be prepared for the unexpected
Accidents are just that — accidents. You can't plan for them. But, you can protect yourself financially as much as possible.

What is the Accident Plan?
The Aetna Accident Plan pays benefits when you get treatment for an accidental injury. The insurance plan pays for a long list of covered minor and serious injuries. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that might come with an accidental injury.

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

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

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or anything else you choose.

Easy to use
Online tools make it easy to manage your plan. File a claim in about 90 seconds or less if you have a covered injury or treatment. And, benefits get paid directly to you by check or direct deposit.

The Aetna Accident Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com

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"What ifs" are everywhere

2.6+ million children get seen in emergency departments for injuries related to sports and recreation each year[1]. An American has an accidental injury **every second[2]**.

Because you never know

Miguel* didn't expect to get rear-ended in the middle of rush hour on his drive home. But it happened, and now his back and his car need some work.

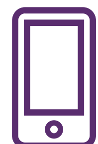
Luckily, he had the Aetna Accident Plan. He submitted his claim online and his benefits were deposited directly into his bank account.

He used some of the money to pay out-of-pocket medical costs. The rest went towards getting his car back into shape.

A Simplified Claims Experience™

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

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



[1]Sports and Recreation Safety Fact Sheet (2015). Safe Kids Worldwide. February 2015. Available at: safekids.org/sites/default/files/ documents/skw_sports_fact_sheet_feb_2015.pdf. Accessed April 18, 2018.
[2]National Safety Council. Injury Facts: The Source of Injury Stats. 2019. Available at https://www.nsc.org/membership/member-resources/injury-facts. Accessed January 28, 2019.
*This is a fictional example of how the plan could work.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

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

Policy forms issued in Oklahoma include: GR-96841, AL HPOL-VOL Acc 01, AL HCOC-VOL Acc 01
Policy forms issued in Missouri include: GR-96842 01, AL HPOL-VOL Acc 01, AL HCOC-VOL Acc 01.

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57.03.507.1 (02/21)

Alief Independent School District

802982

Aetna Off/On Job Accident Plan

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

Insurance plans are underwritten by Aetna Life Insurance Company.

The benefits in the table below will be paid when you receive covered treatment for a covered Accident. Unless otherwise indicated, all benefits and limitations are per covered person.

Note: Certain benefits are payable once per covered accident; while others are once per plan year. If a service or injury falls in more than one category, the plan will pay the greater of. Refer to the Certificate for more details.

Initial Care

Covered Benefit	Low	High
Ambulance		
Ground ambulance	$400	$400
Pays a benefit for when you are transported by a licensed professional ambulance company by a Ground ambulance to or from a hospital, or between medical facilities, where treatment for an accidental injury is received. Transportation to or from a hospital within 24 hours after an accidental injury.		
Air ambulance	$1,500	$1,500
Pays a benefit for when you are transported by a licensed professional ambulance company by an Air ambulance to or from a hospital, or between medical facilities, where treatment for an accidental injury is received. Transportation to or from a hospital within 48 hours after an accidental injury.		
Maximum trips per accident, air and ground combined	*1*	*1*

Covered Benefit	Low	High
Initial Treatment		
Emergency room/Hospital	$100	$150
Pays a benefit if an insured person requires initial examination and treatment in an emergency room as the result of an accidental injury. The initial examination and treatment must be received within 72 hours after the accidental injury.		
Physician's office/Urgent care facility	$100	$150
Pays a benefit if an insured person requires initial examination and treatment in a physician's office or urgent care center as the result of an accidental injury. The initial examination and treatment must be received within 72 hours after the accidental injury.		
Walk-in clinic/Telemedicine	$50	$50
Maximum visits per accident, combined for all places of service	*1*	*1*
Maximum visits per plan year, combined for all places of service	*3*	*3*
X-ray/Lab	$100 / $50	$150 / $50
Pays if an insured person receives an X-ray due to an accidental injury. The X-ray(s) must be prescribed by a physician and performed by a licensed facility within 30 days after the accidental injury.		
Medical imaging	$150	$225
Pays a benefit if an insured person receives a medical imaging test due to an accidental injury. Medical imaging tests include only the following: 1. Positron Emission Tomography (PET) 2. Computed Tomography Scan (CT) 3. Computed Axial Tomography (CAT) 4. Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI) 5. Electroencephalogram (EEG) The test must be ordered by a physician and performed in a medical facility on an outpatient basis within 180 days after the accidental injury.		

Follow-up Care

Covered Benefit	Low	High
Accident follow-up		
Emergency room/Hospital	$75	$150
Pay a benefit if an insured person receives follow-up treatment in a physician's office, urgent care center or emergency room for an accidental injury within one year of the accident.		
Physician's office/Urgent care facility	$75	$150
Pay a benefit if an insured person receives follow-up treatment in a physician's office, urgent care center or emergency room for an accidental injury within one year of the accident.		
Walk-in clinic/Telemedicine	$25	$25
Maximum visits per accident, combined for all places of service	*2*	*3*
Maximum visits per plan year, combined for all places of service	*6*	*9*
Appliances		
Major: Back brace, body jacket, knee scooter, wheelchair, motorized scooter or wheelchair	$100	$200
Minor: Brace, cane, crutches, walker, walking boot, other medical devices to aid in your physical movement	$50	$100
Chiropractic treatment and alternative therapy	$25	$35
Maximum visits per accident	*10*	*10*
Maximum visits per plan year	*30*	*30*
Pain management (epidural anesthesia)	$100	$200
Pays a benefit if an insured person receives epidural anesthesia as the result of an accidental injury. The epidural anesthesia must be administered within 60 days after the accidental injury.		
Prescription drugs	$10	$10
Prosthetic device/Artificial limb		
One limb	$500	$750
Multiple limbs	$1,000	$1,500
Maximum benefit per accident	*1*	*1*
Repair or replace	25%	25%
Maximum benefit per plan year	*1*	*1*
Therapy services - Speech, occupational, or physical therapy or cognitive rehabilitation	$15	$25
Maximum visits per accident	*10*	*10*

Hospital Care

Covered Benefit	Low	High
Hospital stay – admission (initial day)		
Non-ICU admission	$1,000	$1,500
Pays a benefit if an insured person is admitted into the hospital due to an accidental injury. We will not pay this benefit if you're admitted into an observation unit, treated in an emergency room or outpatient surgery. The stay must begin within 180 days after an accidental injury.		
ICU admission	$2,000	$3,000
Pays a benefit if an insured person is admitted directly to ICU due to an accidental injury. The stay must begin within 30 days after an accidental injury.		
Hospital stay – daily*		
Non-ICU daily	$200	$300
Pays a benefit if an insured person has a stay in a hospital due to an accidental injury.		
ICU daily	$400	$600
Pays a benefit if an insured person has a stay in an ICU due to an accidental injury. The stay must begin within 30 days after an accidental injury.		
Step down intensive care unit daily	$300	$400
Maximum days per accident (combined for all stays due to the same accident)	*365*	*365*
Rehabilitation unit stay – daily	$50	$100
Pays a benefit if an insured person is transferred to a rehabilitation unit immediately after a stay in a hospital due to an accidental injury.		
Maximum days per accident	*30*	*30*
Observation unit	$100	$100
Pays a benefit if an insured person requires services in an observation unit as the result of an accidental injury. The Hospital Stay Admission Benefit will not be payable if the Observation Unit Benefit is payable. Observation services must begin within 72 hours after the accidental injury.		

*** Important Note:** All Hospital stay – daily benefits begin on day two.

Surgical Care

Covered Benefit	Low	High
Blood/Plasma/Platelets	$300	$400
Pays a benefit if an insured person receives the transfusion of blood, plasma and/or platelets due to an accidental injury. The transfusion must take place within 90 days after the accidental injury		
Eye Injury		
Surgical repair	$300	$400
Removal of foreign object	$150	$200
Surgery (without repair)		
Arthroscopic or exploratory	$100	$150
Pays a benefit if an insured person undergoes exploratory or arthroscopic surgery, and no repair is done, within 60 days of the accidental injury.		
Surgery (with repair)		
Cranial, open abdominal or thoracic	$1,500	$2,000
Pays a benefit if an insured person undergoes cranial, open abdominal or thoracic surgery, and repair is done, within 72 hours of the accidental injury.		
Hernia	$200	$250
Pays a benefit if an insured person undergoes hernia surgery as the result of an accidental injury. A physician must diagnose the hernia within 30 days after the accidental injury; and perform surgery within 60 days after the accidental injury.		
Ruptured disc	$750	$1,000
Pays a benefit if an insured person sustains a ruptured disc in the spine as the result of an accidental injury. A physician must treat the ruptured disc within 60 days after the accidental injury; and repair it through surgery within one year after the accidental injury.		
Tendon/Ligament/Rotator cuff		
Single repair	$750	$1,000
Multiple repairs	$1,500	$2,000
Torn knee cartilage	$750	$1,500
Pays a benefit if an insured person sustains a torn knee cartilage (meniscus) as the result of an accidental injury. A physician must treat the torn knee cartilage within 60 days after the accidental injury; and repair it through surgery within 180 days after the accidental injury.		
Non-Specified		
Inpatient	$300	$500
Pays a benefit if an insured person is transferred to a rehabilitation unit immediately after a stay in a hospital due to an accidental injury.		
Outpatient	$300	$500
Maximum benefits per accident, combined for all Surgery (without repair) and Surgery (with repair) benefits	*2*	*2*

Transportation/Lodging Assistance

Covered Benefit	Low	High
Lodging	$200	$200
Pays for one motel/hotel room for a companion to accompany you for each day of a stay due to an accidental injury. Your stay must be more than 50 miles from your home.		
Maximum days per accident	*30*	*30*
Transportation	$300	$300
We will pay the Transportation Benefit shown in the Schedule of Benefits for an insured person who must travel from his or her residence more than 50 miles one way on physician's advice for treatment of a payable Accidental injury.		

Dislocations and Fractures

Covered Benefit	Low	High
Dislocations – Closed Reduction*		
Hip	$3,000	$6,000
Knee	$1,500	$3,000
Ankle – bone or bones of the foot (other than toes)	$750	$1,500
Collarbone (sternoclavicular)	$600	$1,200
Lower jaw	$600	$1,200
Shoulder (glenohumeral)	$600	$1,200
Elbow	$600	$1,200
Wrist	$600	$1,200
Bone or bones of the hand (other than fingers)	$600	$1,200
Collarbone (acromioclavicular and separation)	$150	$300
Rib	$150	$300
One toe or one finger	$150	$300
Partial dislocation	25%	25%
Maximum dislocations per accident	*3*	*3*

*Open reduction pays 2.0 times the closed reduction benefit value

Covered Benefit	Low	High
Fractures - Closed Reduction*		
Pays a benefit if an insured person sustains a fracture as the result of an accidental injury.		
A physician must diagnose the fracture within **90 days** after the accidental injury and correct it by **closed reduction**.		
Skull (except bones of the face or nose), depressed	$4,125	$8,250
Skull (except bones of the face or nose), non-depressed	$4,125	$8,250
Hip, thigh (femur)	$1,725	$3,450
Vertebrae, body of (excluding vertebral processes)	$1,125	$2,250
Pelvis (inc. ilium, ischium, pubis, acetabulum except coccyx)	$1,125	$2,250
Leg (tibia and/or fibula malleolus)	$1,125	$2,250
Bones of the face or nose (except mandible or maxilla)	$600	$1,200
Upper jaw, maxilla (except alveolar process)	$600	$1,200
Upper arm between elbow and shoulder (humerus)	$600	$1,200
Lower jaw, mandible (except alveolar process)	$600	$1,200
Collarbone (clavicle, sternum)	$600	$1,200
Shoulder blade (scapula)	$600	$1,200
Vertebral process	$600	$1,200
Forearm (radius and/or ulna)	$450	$900
Kneecap (patella)	$450	$900
Hand/foot (except fingers/toes)	$450	$900
Ankle/wrist	$450	$900
Rib	$225	$450
Coccyx	$225	$450
Finger, toe	$225	$450
Chip fracture	25%	25%
Maximum fractures per accident	*3*	*3*

*Open reduction pays 2.0 times the closed reduction benefit value

Accidental Death & Dismemberment and Paralysis Benefits

Covered Benefit	Low	High
Accidental death		
Pays a benefit if an insured person sustains an accidental injury which causes the insured person's death within 90 days after an accident.		
Employee	$25,000	$50,000
Covered dependent spouse	$12,500	$25,000
Covered dependent children	$12,500	$25,000
Accidental death common carrier		
Pays a benefit if an insured person sustains an accidental injury while the insured person is a fare paying passenger on a common carrier and the accidental injury causes the insured person's death within 90 days after an accident.		
Employee	$50,000	$100,000
Covered dependent spouse	$25,000	$50,000
Covered dependent children	$25,000	$50,000
Accidental dismemberment		
Pays a benefit if an insured person sustains one or more limbs due to an accidental injury as classified below and in the schedule of benefits. The loss must occur within 90 days after an accidental injury.		
Loss of arm	$5,000	$12,500
Loss of hand	$5,000	$12,500
Loss of leg	$5,000	$12,500
Loss of foot	$5,000	$12,500
Loss of sight	$5,000	$12,500
Loss of ability to speak	$10,000	$25,000
Loss of hearing	$5,000	$12,500
Maximum dismemberments per accident (non-finger, toe)	*2*	*2*
Loss of finger	$500	$1,250
Loss of toe	$500	$1,250
Maximum dismemberments per accident (finger, toe)	*4*	*4*
Home and vehicle alteration	$500	$1,000
Paralysis (complete, total and permanent loss)		
Pays a benefit if an insured person sustains paralysis as a result of an accidental injury. A physician must diagnose paralysis within 60 days after the accidental injury; and confirm the paralysis continued for a period of 90 consecutive days.		
Quadriplegia	$7,500	$15,000
Triplegia	$5,000	$7,500
Paraplegia	$5,000	$7,500
Hemiplegia	$5,000	$7,500
Diplegia	$5,000	$7,500
Monoplegia	$2,500	$5,000

Other Accidental Injuries

Covered Benefit	Low	High
Animal bite treatment		
Tetanus shot	$100	$100
Anti-venom shot	$200	$200
Rabies shot	$300	$300
Brain injury		
Concussion/Mild traumatic brain injury	$300	$500
Moderate/Severe traumatic brain injury	$1,250	$2,500
Burn		
Pays a benefit if an insured person receives a second degree burn or third degree burn as a result of an accidental injury. Treatment must be received by a physician within 72 hours after the accidental injury.		
Second degree burn, greater than 5% of total body surface	$500	$1,000
Third degree burn, less than 5% of total body surface	$1,000	$2,000
Third degree burn, 5-10% of total body surface	$5,000	$7,000
Third degree burn, greater than 10% of total body surface	$10,000	$20,000
Burn skin graft	50% of Burn	50% of Burn
Pays a benefit if an insured person receives a skin graft for a burn as a result of an accidental injury. Treatment must be received by a physician within 72 hours after the accidental injury.		
Coma/Persistent vegetative state (PVS)		
Coma (non-induced)	$7,500	$15,000
PVS	$7,500	$15,000
Coma (induced)	$250	$250
Maximum days per accident	*10*	*10*
Dental treatment		
Pays a benefit if an insured person sustains a broken tooth as the result of an accidental injury and the tooth is repaired by a dental crown and/or dental extraction. The dental services must begin within 60 days after the accidental injury.		
Maximum 1 per accident		
Extractions	$50	$75
Crown	$150	$225
Gunshot wound	$1,000	$1,500
Laceration		
Pays a benefit if an insured person receives a laceration as the result of an accidental injury. The laceration must be repaired by a physician within 72 hours after the accidental injury.		
Without stitches	$50	$50
With stitches, less than 7.5 centimeters	$75	$75
With stitches, 7.6 - 20.0 centimeters	$300	$300
With stitches, greater than 20.0 centimeters	$600	$600
Posttraumatic stress disorder (PTSD)	$500	$500
Maximum diagnoses per lifetime	*1*	*1*
Service dog	$1,500	$1,500
Maximum service dogs per your lifetime	*1*	*1*

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

Group accident insurance policy

The words which appear in **bold** type are defined in the *Glossary* section of the certificate.

The group accident insurance **policy** ("this **policy**") is by and between

Aetna Life Insurance Company
(**Aetna**, we, us, or our)

and

Alief ISD
(**Policyholder**)

Policy number:	802982
Policy issue date:	October 11, 2022
Policy effective date	January 1, 2023
Original effective date	January 1, 2023

This **policy** begins on the **policy** effective date at 12:01 a.m. at the **policyholder's** address. We must receive the **policyholder's** signed group application and the initial **premium** for it to take effect.

Term of this policy

The initial term is the 12 consecutive months period beginning on the **policy**, effective date. Subsequent terms are the 12 consecutive month period beginning with the renewal date.

Premium due dates

The **policy**, effective date and the 15th day of each succeeding calendar month.

This **policy** is a non-participating policy and does not share in the company's surplus.

This **policy** is governed by applicable federal law and the laws of the State of Texas.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT.

This is an accident-only plan. This plan provides limited benefits. It pays a fixed dollar benefits for covered benefits without regard to the provider's actual charges. The benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

PLEASE READ THIS POLICY CAREFULLY

Notice of 10-day right to examine this policy

The **policyholder** has 10 days from the date of delivery of this **policy** to examine it. If the **policyholder** is not satisfied for any reason, this **policy** may be returned within 10 days to us at our home office or to the writing agent. We will refund the **premium** paid and this **policy** will be void from its beginning.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS; COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS; COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

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This policy – entire contract

This **policy** consists of these documents:

- The **policyholder's** application
- This **policy**
- The certificate
- Any amendments and riders to this **policy** or the certificate

These documents are the entire contract between us and the **policyholder**.

Policyholder questions or comments

If the **policyholder** has questions or comments about this **policy**, the **policyholder** may contact their agent. If an agent was not used, the **policyholder** may contact us at: **Aetna**, P.O. Box 14079, Lexington, KY 40512. When contacting us, we will ask for the **policy** number. It is on the front page of this **policy**.

Eligible classes

All classes of **employees** defined in this **policy** are eligible. An **employee** is eligible only for the coverage shown in the certificate which applies to his or her class.

Premium

Premium – rates

The current **premium** rates for all of the benefits provided under this **policy** are on record with both us and the **policyholder**.

Premium Payments

Premiums will be paid in advance. They may be paid to Aetna Inc., PO Box 536919, Atlanta GA 30353-6919 or by agreed upon electronic means or to our authorized agent.

A **premium** is due to be paid on the 15th of each month, this is called the **premium** due date.

Grace Period

A grace period of 45 days after the **premium** due date will be allowed for the payment of each **premium**. During this time, this **policy** will remain in full force. If a past due **premium** is not paid by the end of the grace period, this **policy** will end as of the **premium** due date.

Premium rate changes

We have the right to change the **premium** rates by giving the **policyholder** at least 31 days advance written notice. The notice will include the date the change will take place.

Return of premiums

If this **policy** ends, we shall promptly return on a pro-rata basis the unearned **premium** paid, if any, and the **policyholder** shall promptly pay on a pro-rata basis the earned **premium**.

Unpaid premium

Any unpaid **premium** due under this **policy** may be recovered by us by offsetting against amounts otherwise payable under this **policy**.

Responsibility for conduct

Our agents and employees

We are responsible to the **policyholder** for what our agents and employees do.

We are not responsible to the **policyholder** for what is done by others that are not our agents or employees. We contract entities such as Third Party Administrators; these entities are what the law calls our independent contractors. That means we have a business relationship with them and they are not our agents or employees.

Some of our other responsibilities

We will prepare the certificate that is part of this **policy**. We will

- Provide it to the **policyholder** in electronic form
- Provide it to the **policyholder** in paper form when requested
- Administer the coverage stated in the certificate

We will protect the personal health information of **covered person** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process claims and otherwise help us administer this policy. For a copy of our Notice of Privacy Practices, call our toll-free number 1-800-872-3862 or log on to www.aetna.com.

This provision survives if this policy ends.

Some policyholder requirements and responsibilities

Distribution of the certificate

The **policyholder** will give the certificate attached to this **policy** to each **covered person**.

Information – access

The **policyholder** must make payroll and other records directly related to a person's coverage under this **policy** available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At the **policyholder's** office
- During regular business hours

This provision survives if this **policy** ends.

Information – eligibility

The **policyholder** must send us eligibility information we request to administer this **policy**. We may request the information monthly or as otherwise required. The **policyholder** will send us the information on our form, or through such other means, as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll the **policyholder's** eligible employees and their eligible dependents
- Enroll the **policyholder's** eligible employees
- Process the end of a **covered person's** coverage
- Process coverage changes
- Make family status changes

By sending the information to us, the **policyholder**:
- Represents that it is correct
- Acknowledges that we can and will rely on the information

The **policyholder** must:
- Maintain a reasonably complete record of the information the **policyholder** sends us for at least seven years, and until the final rights and duties under this **policy** have been resolved.
- Send us information that was sent us before, upon request.

We will not start covering a person under this **policy** until the **policyholder** sends us the information to enroll that person, if needed, to start their coverage. Subject to applicable federal and state laws and this **policy**, we will not stop covering a person until the **policyholder**:
- Sends us the notice to end coverage

The **policyholder** must notify us within 31 business days of the date in which:
- An **employee's** employment ceases, or
- An **employee's** dependent who is a **covered person** is no longer eligible

Notices – when coverage ends
The **policyholder** will tell **covered persons** in writing of their rights when coverage under this **policy** ends. In particular, the **policyholder** will tell all **covered persons** of their right to keep coverage pursuant to the *Portability* section in the certificate

The **policyholder's** duties and our rights within this provision survive if the **policy** ends.

Ending this policy

When the policyholder ends this policy
The **policyholder** may end this **policy** as to all or any class of its **employees**. We must be given written notice. The notice must state the end date. It must be a date after the notice. It shall not be effective during a period for which a **premium** has been paid to us for the coverage.

When we end this policy
We may end this **policy**:
- At any time after the initial term by giving the **policyholder** written notice at least 31 days in advance.
- If **premium** is not paid by the **policyholder** as detailed in the *Grace period* provision of this **policy**.

This **policy** will end at midnight at the **policyholder's** address.

Intentional deception
If we learn that the **policyholder** or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious effects on the **policyholder's** coverage. These serious effects include, but are not limited to:
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid
- Reduced benefits

We also may report fraud to law enforcement.

General provisions

Content and interpretation of this policy

Compliance with law

We interpret this **policy** so that it complies with applicable federal and state laws. The **policyholder** must do the same.

Applicable law means all federal and state laws that apply to the matters covered by this **policy**. Federal and state laws mean statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

If this **policy** omits or misstates any right or duty under applicable federal and state laws, the **policyholder** and we shall implement this **policy** as though the right or duty is stated correctly in this **policy**.

If any provision of this **policy** is invalid or illegal, the **policyholder** and we shall implement this policy as though the provision is not in this **policy**.

Changes to the group policy

This **policy** may be amended in writing to which we and the **policyholder** consent.

We may end some or all coverage under this **policy** by written notice, if we act as required by applicable federal and state laws.

If we change the **policy**, we will give the **policyholder** 90 days advance written notice. Changes to this **policy** do not require the **policyholder's** consent. All agreements made by us are signed by one of our authorized officers. Only an authorized officer of **Aetna** may change or waive any of the **policy** terms or make any agreement binding us.

Third parties rights

This **policy** does not give any rights or impose any duties on third parties except as specifically stated.

Administration of this policy

Aetna name, symbols, trademarks and service marks
We control the use of our name and of our symbols, trademarks and service marks. The **policyholder** may not use any of them in advertising or promotional materials or in any other way without our prior written consent. The **policyholder** must stop any use immediately upon our direction or when this **policy** ends.

Additional covered persons
Additional **covered persons** may be added to this **policy**, in accordance with this **policy's** provisions.

Necessary information
We must receive sufficient information to administer this **policy** and compute the **premium**. **We** have the right to inspect any of the **policyholder's** records as required to carry out the provisions of this **policy** at any time.

Claim determinations – ERISA claim fiduciary
We are a fiduciary for the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974. We have complete authority to review all denied claims for benefits under this **policy**. In exercising this fiduciary responsibility, we have authority to:
- Determine whether and to what extent **covered persons** are entitled to benefits
- Construe any disputed or doubtful terms under this **policy**. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:
- A **covered persons** claim history
- A **provider's** billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors
A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in **premium** if correction changes coverage.

We may correct, withdraw, or replace this **policy**, any certificate, and any other document issued with an error or issued in error.

Correcting mistakes
Any statement the **policyholder** or a **covered person** makes in a signed application for coverage is considered a representation and not a warranty.

If the **policyholder** or any **employee** make a mistake of fact, we may make a fair change in **premium**. If the misstatement affects the existence or amount of coverage, we will use the true facts to decide if coverage is or remains in effect and its amount.

Discrimination prohibited
The **policyholder** must:
- Not encourage or discourage enrollment in coverage by this **policy** because of health risks.
- Act so as not to discriminate unfairly between persons in like situations at the time of the action.

Incontestability

We will not use any **policyholder** statement to void this **policy** after it has been in force for 2 years from its effective date.

We will use only a statement in writing that the **policyholder** or a **covered person** makes, to do any of the following:

- Void coverage of the **covered person**
- Deny coverage of the **covered person**
- Deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Financial sanctions exclusions

No coverage based on United States (U.S.) trade sanctions:

If U.S. trade sanctions consider the **policyholder** or a beneficiary a blocked person; the plan cannot provide benefits to the **policyholder**. If the **policyholder** travels to a country sanctioned by the U.S., the plan in most cases cannot provide benefits to the **policyholder**. For more information on U.S. trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Cancer Insurance

Plan Options

American Fidelity | www.americanfidelity.com | 800-654-8489

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

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

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

Cancer Insurance		
Monthly Premium	**Basic**	**Enhanced Plus**
Individual	$15.80	$31.62
Family	$26.86	$53.80

AF™ Group Cancer Insurance

Focus on the fight.

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

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

Did You Know?

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

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

Plan Highlights

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

Cancer Insurance Benefits

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

Example cancer insurance benefits include:

Diagnostic and Prevention

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

Travel Expenses

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

Choose Your Coverage

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

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

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

Monthly Premium

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

The premium and amount of benefits provided vary depending upon the plan selected.

Plan Benefit Highlights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Benefit Highlights (cont.)

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

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

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

Donor Benefit Blood donor expenses are not covered.

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

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

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

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

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

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

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

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

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

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

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

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

Exclusions We will not pay benefits resulting from or caused by:
(a) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
(b) alcoholism or drug addiction;
(c) war or acts of war, declared or undeclared, while serving in the military or an auxiliary unit thereto;
(d) military service for any country at war;
(e) participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or
(f) participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.)

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

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

Marketed by:

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

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

COBRA

Inspira Financial (formerly Payflex) | www.inspirafinancial.com | 888-678-7835

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

COBRA Highlights

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

Critical Illness Insurance

Metlife | www.metlife.com | 800-438-6388

Prepare For the Unexpected

If you've heard of heart attacks, strokes, organ transplants or paralysis, then you're familiar with critical illness. It's likely you or someone you know has experienced one of these life-altering events. Often times, a critical illness has a powerful impact on people's lives, affecting their livelihood and finances.

A critical illness plan can help with the treatment costs of covered illnesses. Benefits are paid directly to you, unless otherwise assigned, giving you the choice of how to spend the money. Plus, there are plans available to provide coverage for you, your spouse and dependent children.

Prepare now for the unexpected with a critical illness insurance plan. The plan helps you focus on getting well rather than worrying about finances. Visit the Employee Benefits Center and view policy for more details.

Highlights include:

- Guaranteed issue every annual enrollment and new hires within 31 days
- Low and High plans available to meet your needs
- Plan pays lump-sum benefit amounts of $15,000 $30,000 and $50,000
- Wellness benefit pays you $50 or $100 for annual health screening test, depending on benefit amount
- Plan will pay up to 500% of the benefit for each person on the plan
- Covers Heart Attack, Stroke, Major Organ Transplant, Alzheimer's, Cancer, Kidney Failure, Skin Cancer (partial benefit), Coronary Artery by-pass, and many other partial benefit conditions.
- Covid19 covered at 25% if hospitalized for 5+ consecutive days

No Pre-existing conditions

Critical Illness and specified diseases coverage only
A pre-existing condition is any sickness or loss for which medical advice or treatment was received or recommended within 3 months prior to the effective date of coverage.

Actively at work

If you are not actively at work when coverage is scheduled to become effective, your coverage does not take effect until you complete your first day at work.

Critical Illness Insurance

Benefits that may help cover expenses that are not covered by your medical plan.

Alief Independent School District

Critical Illness Insurance Benefits

Eligible Individual	Benefit Amount	Requirements
Coverage Options		
Employee	**$15,000, $30,000, or $50,000**	Coverage is guaranteed provided you are actively at work. [1]
Spouse/Domestic Partner[2]	**100% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]
Dependent Child(ren)[3]	**100% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]

Benefit Payment

Your plan pays a lump-sum **Initial Benefit** upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump-sum **Recurrence Benefit**[4] for a subsequent verified diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit Amount** and is 500% of your Benefit Amount. This is the maximum aggregate amount that MetLife will pay per covered person per lifetime for the covered conditions.

Please refer to the table below for the percentage benefit payable for each Covered Condition.
Plan Design – "Covered Conditions"

Covered Conditions*	Initial Benefit	Recurrence Benefit
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit Amount
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit Amount
Cardiovascular Disease Category		
Coronary Artery Bypass Graft (CABG) - *where surgery involving either a median sternotomy or minimally invasive procedure is performed*	100% of Benefit Amount	100% of Initial Benefit Amount
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	None
Cleft Lip or Cleft Palate	100% of Benefit Amount	None
Cystic Fibrosis	100% of Benefit Amount	None
Diabetes (Type 1)	100% of Benefit Amount	None

Critical Illness Insurance

Down Syndrome	100% of Benefit Amount	None
Sickle Cell Anemia	100% of Benefit Amount	None
Spina Bifida	100% of Benefit Amount	None
Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or Sight	100% of Benefit Amount	None
Paralysis of 2 or More Limbs	100% of Benefit Amount	None
Heart Attack Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Sudden Cardiac Arrest	100% of Benefit Amount	None
Infectious Disease Category		
For a benefit to be payable, the covered person must have been treated for the disease in a hospital for [5] consecutive days.		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	None
COVID-19	25% of Benefit Amount	None
Diphtheria	25% of Benefit Amount	None
Encephalitis	25% of Benefit Amount	None
Legionnaire's Disease	25% of Benefit Amount	None
Malaria	25% of Benefit Amount	None
Necrotizing Fasciitis	25% of Benefit Amount	None
Osteomyelitis	25% of Benefit Amount	None
Rabies	25% of Benefit Amount	None
Tetanus	25% of Benefit Amount	None
Tuberculosis	25% of Benefit Amount	None
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant Category		
Major Organ Transplant *For bone marrow, heart, lung, pancreas, and liver*	100% of Benefit Amount	None
Progressive Disease Category		
Adrenal Hypofunction (Addison's Disease)	25% of Benefit Amount	None
ALS	25% of Benefit Amount	None
Alzheimer's Disease	100% of Benefit Amount	None
Huntington's Disease	25% of Benefit Amount	None
Multiple Sclerosis	25% of Benefit Amount	None
Muscular Dystrophy	25% of Benefit Amount	None
Parkinson's Disease (Advanced)	25% of Benefit Amount	None
Systemic Lupus Erythematosus (SLE)	25% of Benefit Amount	None
Systemic Sclerosis (Scleroderma)	25% of Benefit Amount	None
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit

* Notes Regarding Covered Conditions

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Critical Illness Insurance

MetLife will not pay a benefit for a Covered Condition that is diagnosed prior to the coverage effective date.

- Alzheimer's Disease – Please review the Outline of Coverage/Disclosure Document for specific information about Alzheimer's disease.
- Cancer – Please review the certificate for specific information about cancer benefits. In most states, not all types of cancer are covered.
- Coronary Artery Bypass Graft – In certain states, the Covered Condition is Coronary Artery Disease.
- Heart Attack – The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.
- Major Organ Transplant – In most states, we will not pay a Major Organ Transplant benefit if a covered person is placed on the organ transplant list prior to coverage taking effect and subsequently undergoes a transplant procedure for the same organ while coverage is in effect. Covered organs may vary by state; refer to the Certificate for details. In some states, the condition is Major Organ Failure.
- Stroke – In certain states, the Covered Condition is Severe Stroke.
- The following benefits are not available in all states. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for details.
    - Aortic Valve or Mitral Valve Repair or Replacement
    - Coma
    - Congenital Heart Disease (for which Surgery has been recommended for treatment)
    - Coronary Angioplasty
    - ICD
    - Loss of: Ability to Speak; Hearing; or Sight
    - Major Organ Transplant Donation
    - Pacemaker
    - Paralysis
    - Severe Burn

Health Screening Benefit MetLife will provide an annual benefit of $50 if employee elects $15,000, $100 if employee elects $30,000 or $50,000, per calendar year for taking one of the eligible screening/prevention measures. The Health Screening Benefit is not available in certain states. Please review your Disclosure Statement or Outline of Coverage/Disclosure Document for specific state variations and exclusions around this benefit.

Example of How Benefits are Paid

The example below illustrates an employee who elected a Benefit Amount of $15,000.

Illness – Covered Condition	Payment
Heart Attack — first verified diagnosis	Initial Benefit payment of $15,000 or 100%
Kidney Failure – first verified diagnosis, two years later	Initial Benefit payment of $15,000 or 100%
Heart Attack — second verified diagnosis, four years later	Recurrence Benefit payment of $15,000 or 100%

This example is for illustrative purposes only. The MetLife Group Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

Questions & Answers

Q. Who is eligible to enroll for this critical illness coverage?

A. You are eligible to enroll yourself and your eligible family members![5] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my critical illness coverage?

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

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

A. Yes, you can take your coverage with you.[6] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: *mybenefits.metlife.com*.

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Critical Illness Insurance

Insurance Rates

MetLife offers group rates and payment of premium through payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Monthly Premium per $1,000 of Coverage

Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse + Children
<30	$0.66	$1.56	$0.97	$1.84
30-39	$0.94	$2.48	$1.33	$2.76
40-49	$1.56	$4.48	$2.16	$4.76
50-59	$2.85	$7.20	$3.33	$7.47
60+	$5.53	$10.87	$5.03	$11.15

[1] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. MetLife will not pay a benefit for a Covered Condition that is diagnosed prior to the coverage effective date.
[2] Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.
[3] Dependent Child coverage varies by state. Please contact MetLife for more information.
[4] Review the Disclosure Document or Outline of Coverage/Disclosure Document for information on which Covered Condition may be eligible for a Recurrence Benefit. There may be a Benefit Suspension Period between recurrences of the same Covered Condition, as well as occurrences of different Covered Conditions. There may be a limitation on the number of Recurrence Benefits payable per Covered Condition. We will not pay a benefit for a Covered Condition that is subject to a Benefit Suspension Period. If a Recurrence Benefit is payable for a Cancer Covered Condition, we will not pay such benefit unless the Covered Person has not had symptoms of or been treated for the same cancer for which we paid a benefit during the Treatment Free Period.
[5] Eligible Family Members means all persons eligible for coverage as defined in the Certificate.
[6] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. There may be a Benefit Suspension Period between recurrences of the same Covered Condition or occurrences of different Covered Conditions. MetLife offers CII on both an Attained Age basis, where rates will increase when a Covered Person reaches a new age band, and an Issue Age basis, where rates will not increase due to age. Rates are subject to change. MetLife reserves the right to raise premium rates for Issue Age CII on a class-wide basis. A more detailed description of the benefits, limitations, and exclusions applicable to MetLife's CII product can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI, GPNP10-CI, GPNP14- CI, GPNP19-CI or contact MetLife for more information. Please contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.

MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses

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Disability Insurance

The Standard | www.standard.com | 800-368-1135

Why Do I Need Disability Insurance?

Have you ever wondered what would happen to your income if you had an accidental injury, sickness, or pregnancy? That is why you need disability coverage. It replaces a portion of income for the period of time you are unable to work due to those reasons. You are able to choose the monthly benefit amount, which is the amount of your income to replace, and the waiting period that you begin receiving payments after you have satisfied. It pays a monthly benefit amount so you may continue to pay for everyday living expenses. GUARANTEED ISSUE!

Highlights Include:

- Multiple Elimination Periods
- Based on your individual need, you can select amount of monthly salary to cover, up to 66 2/3% of current salary and multiple elimination periods (waiting periods).
- Hospital Waiver is included, if you choose a 30 day elimination period or less, if you are hospitalized as an inpatient for 24 hours or more, Standard Ins will waive the rest of your waiting period and start paying you immediately until the Doctor says you can return to work or up to age 65.
- Waiver of Premium Benefit after you have been receiving disability payments for 90 days.

Pre-existing condition limitations only apply on new levels of coverage elected or for any enhancements to the plan or your existing coverage. Pre-existing conditions will only not be covered until after 12 months of continuous coverage

The resources you need to meet life's challenges

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*SM, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

*EmployeeConnect*SM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston

LTD-EAPEE-FLI001_Z02

We partner with your employer to offer this service at no additional cost to you!

*EmployeeConnect*SM counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*SM

For more information about the program, visit GuidanceResources.com, download the GuidanceNowSM mobile app or call 888-628-4824.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

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Order code: LTD-EAPEE-FLI001

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*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  username: LFGSupport password: LFGSupport1
- Download the GuidanceNowSM mobile app
- Call 888-628-4824

Flexible Spending Accounts

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

Medical FSA

A Medical Flexible Spending Account (Medical FSA) is an IRS-approved program to help you save taxes and reimburse yourself for out-of-pocket medical expenses not covered under your medical plan. Your employer has chosen the $640 carryover option for your Medical FSA plan. This option allows you the opportunity to carry over up to $640 of unclaimed Medical FSA funds into the following plan year. Keep in mind that balances more than $640 will be forfeited under the use-it-or-lose-it rule.

Your maximum contribution amount for 2024 is $3,200.

Medical FSA Highlights	
	• Contributions are automatically deducted from your paycheck on a pre-tax basis, which helps reduce your taxable income and increase your spendable income. • Your full election will be available to you at the beginning of the plan year. • Be conservative – any money left in your account at the end of the plan year will be forfeited. • Use your benefits card to pay for qualified expenses upfront without spending money out of pocket. • Keep all receipts in case you need to substantiate a claim for tax purposes.

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

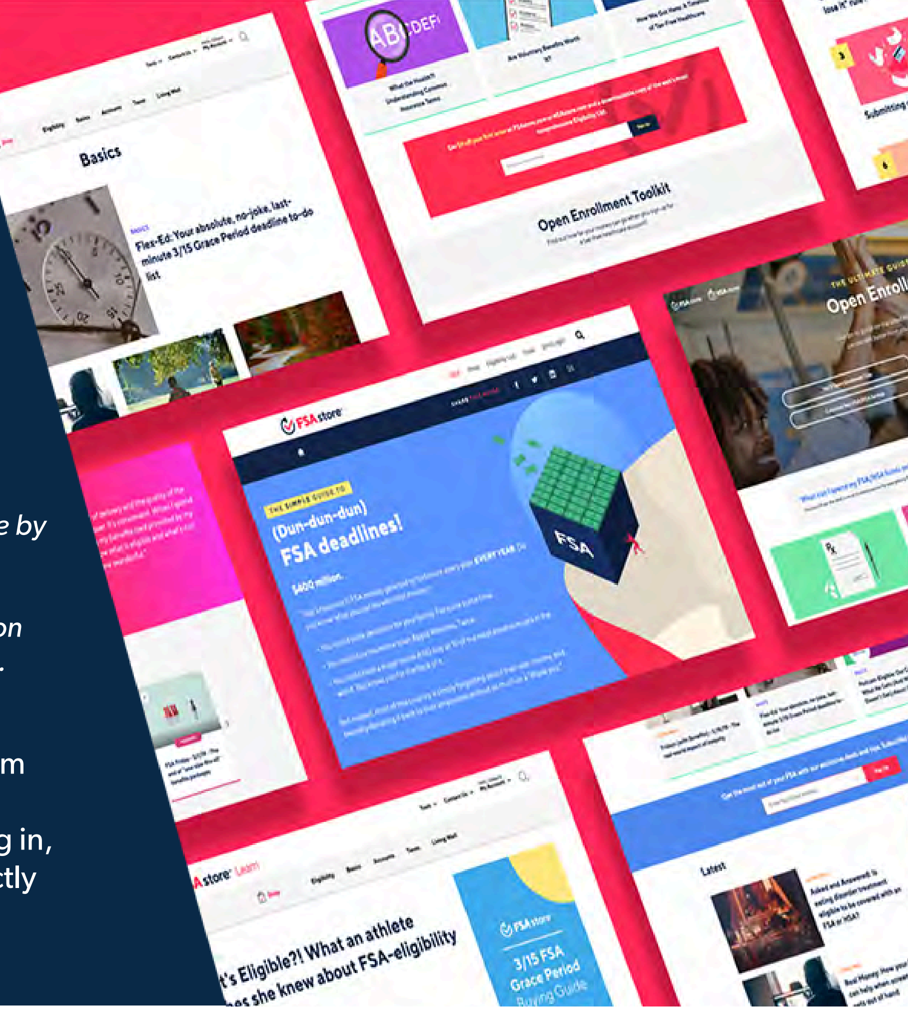
Dependent Care FSA

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

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

Dependent Care FSA Highlights	
	• Eligible dependents must be claimed as an exemption on your tax return. • Eligible dependents must be children under age 13 or an adult dependent incapable of self-care. • Funds become available as contributions are made to your account. • Keep all receipts in case you need to substantiate a claim for tax purposes. • Balances will be forfeited at the end of the runoff or grace period.

FSA Resources



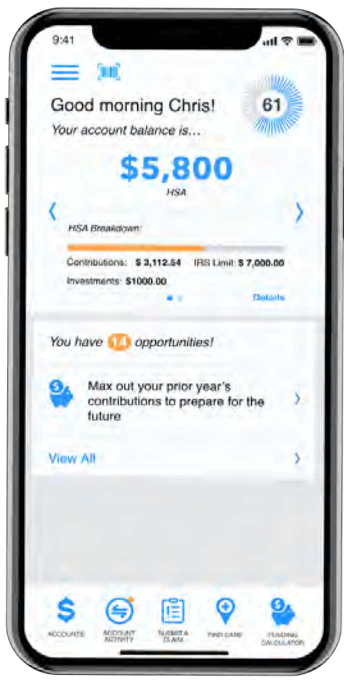
Benefits Card

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

The IRS requires validation of most transactions for FSAs. You must submit receipts for validation of expenses when requested. If you fail to substantiate by providing a receipt to FFGA within 60 days of the purchase or date of service your card will be suspended until the necessary receipt or explanation of benefits from your insurance provider is received.

View Your Account Details Online

Sign up to view your account balance, find claim forms and check claims status on our secure website. Log in at www.ffga.com. After you log in, you may sign up to have reimbursements directly deposited to your bank account.



FF Mobile Account App

With the FF Mobile Account App, you can submit claims, view account balance and history, check claims status, view alerts, upload receipts and documentation and more! The FF Mobile Account App is available for Apple® and Android™ devices on either the App Store or Google Play Store.

FSA Store

FFGA has partnered with the FSA Store to bring you an easy-to-use online store to better understand and manage your account. You can shop for eligible medical items like bandages and contact solution, browse for products and services using the Eligibility List and visit the Learning Center to find answers to commonly asked questions. Visit the store at http://www.ffga.com/individuals/#stores for more details and special deals.

Important Information About Your

Flexible Spending Account

Your First Financial Flexible Spending Account (FSA) now has an improved online experience for managing your FSA. Access to the new FF Flex Mobile App, Flex Portal, Text Alerts and much more today!

Enhancements:

- **FF Flex App** – Managing your FSA on-the-go is easier than ever with the *FF Flex Mobile App*. This powerful, intuitive mobile app gives you access to your accounts right from your Android or Apple mobile device. Securely check balances, request reimbursement, upload receipts and view transaction details .... *all from your smartphone or tablet.*
- **Flex Portal** – Our FSA Portal is a secure online site that you can access by logging into your account on *www.ffga.com*. Due to these enhancements, if you have previously set up an account you must re-register and create a new User ID and Password.

  Flex Portal and App Features:
  - *Access account information*
  - *View card details and profile information*
  - *Submit claims using an electronic claim form*
  - *View pending claims*
  - *Upload receipts and documentation*
  - *Receive alerts*
  - *Update direct deposit information*
  - *Register your phone to receive text alerts*
- **FFGA.com** – We have additional and helpful information available to you on our website. Visit *ffga.com* to find new claim forms, FF Flex mobile app users guide, flex portal guide, instructions for downloading the flex app and much more.
- **Claim Forms** – For expediting your claim process, please use the new forms available on *ffga.com*. The new claim forms have bar codes to ensure fast processing. For your convienence, we will still accept the old claim forms.
- **Direct Deposit** – **For quality control and security purposes, we did not transfer any of your direct deposit banking information.** As of September 15, 2015, we are transitioning to our new system. In order to continue receiving reimbursement by direct deposit you will need to reestablish your direct deposit information online or in the mobile app prior to September 15th.
- **Paperless** – We are excited to implement a paperless system. All claims will be scanned into our system. Once your claim is processed, the documentation will be attached to the transaction. All documentation entered or uploaded into the system will be viewable. We will no longer return copies of the submitted claim(s) or receipt(s) with denied claims.
- **Emailing Receipt Notifications** – With our new system we will email receipt notifications to the email address provided at time of enrollment. If you need to update your email or contact information please contact your employer.
- **FSA Store** - *www.ffga.com/fsaextras*
  First Financial has partnered with the FSA Store to bring you an easy to use online store to better understand and manage your Flexible Spending Account (FSA). Shop at the FSA Store for eligible items from bandages to wheel chairs and thousands of products in between, browse or search for eligible products and services using the FSA Eligibility List, and visit the FSA Learning Center to help find answers to questions you may have about your FSA.

Questions?

If you have questions about your account or any of our enhancements, please contact the First Financial Flex Department at 866-853-3539 or email us at flex@ffga.com.

FFGA-2023-0815

SECTION 125 FLEXIBLE BENEFITS PLAN

PARTICIPANT GUIDELINES FOR SPENDING ACCOUNTS

- Medical Expense Reimbursement
- Dependent Care Reimbursement

PREPARED BY:

First Financial Administrators, Inc.

For your Employer's Plan

Section 125 Flexible Spending Account

First Financial Administrators, Inc.

WE ARE COMMITTED

First Financial Administrators, Inc. is dedicated to providing excellent service to our customers and are delighted to serve as your cafeteria plan service provider. Our role is to process your requests for reimbursement according to the plan designed by your employer.

» There are two types of Flexible Spending Accounts (FSAs): The first is unreimbursed medical (URM) and the second is dependent day care (DDC).

» Your participation in an FSA program allows a portion of your salary to be redirected to provide reimbursement for these types of expenses on a tax-exempt basis.

» At the beginning of each plan year, you elect a specific dollar amount for each FSA you wish to participate.

» Participation in one or both FSAs can save you money by reducing your taxable income. This is because taxes will be calculated after the elected amount is deducted from your salary.

» If applicable, your taxable income will be reduced for Social Security purposes; therefore, there may be a corresponding reduction In Social Security benefits.

» Once you have elected your annual amount, you cannot change your election unless you experience a change in family status. See Election Irrevocability

» To ensure that you are aware of your account balance at all times, we send a new explanation of benefits with each claim that is paid. The explanation of benefits will provide you with information regarding your account balance, claims paid to date, and claims pending.

» We send monthly account balance statements when opted into electronic notifications.

FILING A CLAIM

Before submitting your claim, make sure you have had the service(s).

TO FILE YOUR CLAIM

1. Complete a claim form, and be sure to sign and date it.
2. Attach a legible receipt(s) from the service provided or an EOB (Explanation Of Benefits) showing:
   - » A description of the service or a list of supplies furnished.
   - » The charge(s) for each service.
   - » The date(s) of service.
   - » The name of the person(s) receiving the service.
   - » The amount you are responsible for.
3. For convenient direct deposit, you can visit www.ffga.com to set up this reimbursement method.

Or use your FFA Benefits Card

REQUESTING SERVICES *(Toll-free)*

For Inquires:	1-866-853-3539
For Claim Forms:	www.ffga.com
To Submit Claims by Fax:	1-800-298-7785

General IRS Rules & Information

The following rules apply to both URM and DDC FSAs

ELECTION IRREVOCABILITY

You may not make changes before the beginning of the next plan year unless there is a qualified change in status (as permitted by your plan) that affects Eligibility.

Qualified changes in status may include:

- » Change in employee's legal marital status
- » Change in number of tax dependents
- » Change in employment status that affects eligibility
- » Dependent satisfies or ceases to satisfy eligibility requirements
- » Change in residence that affects eligibility
- » Judgment, decree, or court order dictating provision of coverage
- » Entitlement of Medicare or Medicaid (URM only)
- » Change in cost of the benefit (DDC only)
  - *Addition or elimination of benefit option*
  - *Change in coverage of spouse or dependent under his/her employer's plan*
  - *Significant curtailment of coverage*

If a change in status occurs, you may make changes consistent with the qualifying event or as otherwise defined by your plan document. See your plan Sponsor for further details about making changes.

Dollar Limits

Unreimbursed Medical Account:

Your plan sponsor determines the maximum benefit that may be elected. The IRS maximum for 2024 is $3,200. Please see your employer for the maximum benefit amount allowed under your plan.

Dependent Daycare Account:

This reimbursement (when aggregated with all other dependent care reimbursements during the same calendar year) may not exceed the least of the following:

- » $5,000, or
- » $2,500, if married but filing separate tax returns

Use-it-or-lose-it-Rule

Money remaining in your FSA account(s) will not be returned to you at the end of the plan year. Any amount remaining after the end of the runoff or grace period, if your employer offers one, will be forfeited. Because of the use-it-or-lose-it rule, it is important for you to carefully estimate your out-of-pocket URM and DDC expenses for the upcoming plan year.

TERMINATION OF EMPLOYMENT

URM Account:

Your salary redirections will end; however, you may still file claims for dates of service that were incurred within your employment period. You have 90 days after termination to submit a claim.

DDC Account:

If you have not received reimbursement for all contributions made to your DDC account upon termination, you have 90 days after the end of the plan year to submit a claim.

COBRA

COBRA does not apply to DDC. However, it may apply to your URM account and allow you to continue participation in your URM, thus allowing you to receive reimbursement for medical expenses incurred after your employment termination if:

- » The plan sponsor is subject to COBRA, and
- » When you terminate employment and you have contributed more for URM than you have received in URM benefits.

Note: *Under COBRA you must elect coverage within 60 days and continue to submit contributions to your employer to continue coverage under your URM account for the current year.*

General IRS Rules & Information

UNREIMBURSED MEDICAL FSA

Almost every person has a number of necessary and predictable expenses that are not paid by their insurance plans. You can save money by putting that amount directly into your Unreimbursed Medical FSA. The FSA will help you pay for these predictable expenses with your pre-tax dollars.

ELIGIBLE EXPENSES

With the FSA, you can pay out-of-pocket health care expenses for yourself, your spouse and all of your eligibile dependents for health, dental, and vision care expenses. The services must be incurred while you are actively participating in the FSA plan. The eligible expenses may be reimbursed regardless of whether you, your spouse or dependents are covered by your employer's medical, dental, or health plan.

Expenses for medical care will be limited to expenses incurred primarily for the prevention or improvement of a physical or mental defect or illness. An expense that is merely beneficial to your general health is not an eligible expense. It must be an expense to treat an existing medical condition.

INELIGIBLE EXPENSES

Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations.

» **EXPENSES NOT YET INCURRED** - Expenses that have been paid, but not yet incurred (i.e. Prepayment of service), cannot be reimbursed until the service is rendered. Expenses don't necessarily have to be PAID, but merely incurred.

» **PREMIUMS FOR INSURANCE** - Premiums and payments to insurance policies are not eligible for reimbursement.

» **EXPENSES PAID BY ANOTHER PLAN OR THIRD PARTY** - Expenses that have already been paid by an insurance company or other reimbursement through your FSA plan.

» **EXPENSES INCURRED AFTER TERMINATION/SEPARATION FROM YOUR EMPLOYER** - If you are no longer participating in the FSA plan through your employer (termination, resignation, etc) any claims incurred after your participation ends are not eligible for reimbursement.

COMMON ELIGIBLE EXPENSES

- » Co-Payments
- » Co-Insurance
- » Deductibles
- » Over-the Counter Drugs
- » Dental Treatment
- » Orthodontia
- » Lab Fees
- » X-Rays
- » Vision Expenses
- » Lasik Surgery
- » Physical Therapy
- » Chiropractor Services
- » Acupuncture
- » Eye Contact Solution
- » Eye Drops

COMMON INELIGIBLE EXPENSES

- » Cosmetic Surgery
- » Teeth Whitening
- » Veneers
- » Botox
- » Non Prescribed Vitamins and Supplements
- » Toiletries
- » Medical Insurance Premiums
- » Health Club Membership Fees

General IRS Rules & Information

EXAMPLES OF ELIGIBLE MEDICAL CARE EXPENSES

The following lists are examples of the types of expenses that may or may not be reimbursed. These lists are not intended to be complete, as other expenses may also be eligible or ineligible under federal tax law or under employer's plan. To be eligible under an FSA URM account, the medical expense(s) must be incurred for medical care that is not reimbursed from any other source. Medical care means the drug or service is needed to treat a medical condition. First Financial Administrators, Inc. may request additional information from you to substantiate that an expense is for health care.

ELIGIBLE MEDICAL EXPENSES

- Acupuncture
- Alcohol and drug rehabilitation expenses
- Ambulance
- Anesthetist
- Artificial limbs and teeth
- Birth control pills
- Blood donor (expense)
- Chiropodist
- Chiropractor
- Christian Science Practitioners
- Certain corrective surgery
- Contact lens solution and cleaner
- Co-payment for health insurance
- Dental care and dentures
- Drugs and medical supplies
- Examinations
- Eye exam, eyeglasses, and contacts
- Gynecologist
- Hearing aids and batteries
- Home health care
- Hospital and skilled nursing facility expenses
- Laboratory fees
- Lip-reading lessons
- Midwife
- Nursing care
- Obstetrical expense
- Oculist
- Operations and related treatments
- Optometrist
- Orthodontist**
- Osteopath
- Outpatient clinic
- Over-the-Counter Medications
- Pediatrician
- Physician
- Podiatrist
- Practical nurse
- Prescription drugs
- Psychiatrist
- Psychologist
- Rental or purchase of medical equipment, including special equipment for use by handicapped persons
- Sanitarium
- Stop Smoking Programs and Drugs
- Support or corrective devices
- Surgery
- Therapy
- Transportation expenses
- Weight Loss for Obesity*
- X-ray

INELIGIBLE EXPENSES

- Dancing or swimming lessons
- Medications purchased outside US
- Expenses reimbursed under any health plan or other source
- Health Club Dues
- Face creams, moisturizers, etc.
- Hair removal treatments/waxes
- Vacation
- Cosmetic Surgery
- Teeth Whitening
- Vitamins taken for overall health
- OTC Medications not for Medical Care
- Toothpaste/Toothbrushes
- Mouth washes, oral anesthetics, etc.

* This service requires a letter of medical necessity with a diagnosis from the referring physician.
** Requires an active orthodontia contract be on file.

General IRS Rules & Information

The following rules apply to both URM and DDC FSAs

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars while you (and your spouse) are working, seeking employment, or attending school as a full-time student for at least 5 months during the year.

ELIGIBILITY REQUIREMENTS

Eligible dependents must be claimed as an exemption on your tax return. These dependents can include step-children, grandchildren, adopted children, or foster children. In a divorce situation, you must have custody of the child in order for the child to be considered an eligible dependent. Under IRS regulations, eligible dependents are further defined as: under the age of 13, and/or physically or mentally unable to care for themselves, such as a disabled spouse, disabled child, or elderly parents that live with you.

ELIGIBLE EXPENSES

Eligible dependent care expenses are those expenses you must pay for the care of a dependent so that you and your spouse can work. The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, the service cannot be provided by another child of yours under the age of 19, by your spouse, or by your dependents.

INELIGIBLE EXPENSES

Only those dependents care expenses that enable you and your spouse to work are eligible. Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations

» Educational Costs
» Weekends/Evening-out babysitting
» Transportation, books, clothing, food, activities, entertainment, and registration fees are ineligible if these expenses are shown separately on your bill

COMMON ELIGIBLE EXPENSES

» Day Camps
» Before/After School Care
» Babysitters/Day Care Centers
» Au Pair
» Nanny
» Nursery School

COMMON INELIGIBLE EXPENSES

» Registration Fees
» Care for child while not working
» Kindergarten
» Food/Activity expenses if separate from cost of care
» Care provided by anyone under age 19
» Books and Supplies
» Field Trips

Claims Information

THE REIMBURSEMENT PROCESS

REIMBURSEMENTS- The healthcare/medical FSAs are pre-funded; therefore, you are eligible to receive reimbursement up to your elected annual contribution from the beginning of your FSA plan year. The healthcare/medical FSA funds that are reimbursed to you will be recovered as your deductions are taken from your paycheck throughout the plan year. Dependent Care FSAs are NOT pre-funded; therefore, you will only receive reimbursement up to your year-to-date contributions from payroll deductions. The remainder of the reimbursement request is paid when additional funds are received from payroll deductions.

PAYMENT METHOD CHOICE- For Unreimbursed Medical expenses you may pay with your FFA Benefits Flex Card at the time you incur the expense, or pay the provider out-of-pocket and file a manual (paper) claim to receive a reimbursement. The FFA Benefits Flex Card is only available for Healthcare/Medical FSAs.

MANUAL CLAIMS-To obtain reimbursement from your FSA, you must complete a manual claim form and attach all itemized receipts from the service provider. Cancelled checks, bankcard/credit card receipts, and credit card statements are NOT acceptable forms of documentation. The receipt must come from the service provider or the Explanation of Benefits from your medical health carrier and must include the following information:

- Patient name
- Date of service incurred
- Provider / Merchant name
- Amount of your out-of-pocket charge incurred
- Type of service incurred
- Must include prescription number

REMEMBER-You must sign and date all claim forms.

> **FFGA recommends submitting an Explanation of Benefits (EOB) from your insurance company, if available.**

CLAIMS PROCESSING AND PAYMENTS

All claim reimbursements are handled with strict adherence to IRS adjudication and reporting regulations. Claims are processed daily, and our turn around time upon receipt is 3-5 business days and during peak periods (August-September and December-January) 5-10 business days. Your reimbursement check will be mailed to your home address on file. You may also elect to receive payment via direct deposit. You have a 2 ½ month grace period (employer permitting) to incur claims with an additional 2 weeks to file claims.

Online Service to View Account Information, visit www.ffga.com

FFA Benefits Flex Card

Medical reimbursement accounts only

BENEFITS FLEX CARD

The First Financial Administrators, Inc. Benefits Flex Card is available for Medical Reimbursement Flexible Spending Accounts. Cards can be issued to spouses and dependent children (ages 18 to 26) for no additional fee. The initial cards are free, but if a replacement card is issued, the cost is $10.00 per card and will be deducted from your account balance. Cards are good for three years from the issue date as long as you participate each consecutive plan year. Claims can also be submitted directly for reimbursement. If funds remain in your account after the end of the plan year, you may use the debit card during the 2½ month grace period (if your employer has elected to participate in the grace period option). The system will deduct all remaining funds from your old plan year and then deduct any balance from the new plan year, if you continue to participate. New cards (not replacement cards) are only activated with the upcoming plan year -- they are not activated to use money from the prior plan year.

The IRS requires validation of most transactions – you must submit receipts for verification of expenses when requested. If you fail to substantiate by providing a receipt to us within 60 days of purchase, your card will be suspended until the necessary receipt or explanation of benefits from your insurance provider is received.

Claim forms can be found on our website, www.ffga.com.

Copies can either be mailed to:
First Financial Administrators, Inc.
PO Box 161968
Altamonte Springs, FL 32716

or faxed to:
(800) 298-7785

WHERE TO USE YOUR DEBIT CARD FOR ELIGIBLE UNREIMBURSED MEDICAL EXPENSES:

- » Pharmacies – always use your debit card at the pharmacy counter only.
- » In-Store Pharmacies – If "merchant code" is programmed "pharmacy," the expense will be authorized. However, if the MasterCard transaction code is programmed "grocery/retail," ***the transaction may be denied. The debit card may not work, and the expense may be declined in some grocery/discount stores.***
- » Physician Offices
- » Specialist Physician Offices
- » Dental Offices
- » Over-the-counter Drugs, including Feminine Hygiene Products
- » Vision Care Providers
- » Medical Facilities
- » Medical Clinics
- » Hospitals, including Emergency Rooms

(Your FFA Benefits Flex Card cannot be used past your termination date. If you have available funds in your account, a manual claim will be required.)

First Financial Administrators, Inc. can provide you with a list of eligible expenses associated with your Medical Reimbursement Flexible Spending Account. This card is a signature debit card and does not require a PIN for use. Transactions must always be submitted as "credit." Participants may review Flexible Spending Account balances online at www.ffga.com.

CALL (866) 853-FLEX FOR MORE INFORMATION.

Medical Reimbursement Claim Form

First Financial Administrators, Inc.

EMPLOYEE INFORMATION (Please Print)

EMPLOYER	FIRST NAME		MI	LAST NAME
ADDRESS	CITY	STATE		ZIP
PHONE (Between Hours of 8am-5pm)	SSN	EMAIL ADDRESS		

MEDICAL REIMBURSEMENT EXPENSE CLAIMS

			SELECT ONE		
DATE OF SERVICE	TYPE OF SERVICE (CO-PAY, RX, OTC, ORTHO, ETC.)	NAME OF PATIENT	REQUEST FOR REIMB	USED BENEFIT CARD	AMOUNT OF EXPENSE
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			☐	☐	$
			TOTAL AMOUNT REQUESTED		$

EMPLOYEE SIGNATURE (REQUIRED)

I certify that all expenses listed above are eligible for reimbursement under Section Code 213(d) and in accordance with my Plan and were incurred during a period while I was covered by my employers plan. These expenses have not and are not reimbursable under any other health plan.

The undersigned participant agrees that if the medical provider charges more than the insurance contractual amount and the discount is later refunded after the claim has been processed, these monies are owed back to the plan via personal payment or the provider may issue a credit back to the benefits card.

Note: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for insufficient funds. Please contact your financial institution to verify deposit.

EMPLOYEE SIGNATURE:____ DATE:

F-MFSA-0122

See page 2 for claim filing guidelines.

CONTACT US TODAY:

PO Box 161968, Altamonte Springs, FL 32716| Online: *www.ffga.com* | Phone: 866-853-FLEX

Fax number: 800-298-7785 | Tech Support: techsupport@ffga.com

Flex Receipts and Documents only: First_Financial_Receipts@Alegeus.com

First Financial Administrators, Inc.
PO Box 161968, Altamonte Springs, FL 32716
Phone: 866-853-3539 · Fax: 800-298-7785

SUBMISSION GUIDELINES

Please follow these guidelines to ensure that your claims are reimbursed quickly. Failure to attach the proper documentation may result in claim denial.

Acceptable Documentation:

- Itemized receipt that shows the date of service, type of service received, provider name, patient name, amounts paid by the insurance, and amount owed.
- Explanation of Benefits (EOB) from insurance company
- Pharmacy receipt or statement that includes the RX number and name of the drug
- Detailed cash register receipt listing of all eligible over -the-counter items only

Unacceptable Documentation:

- Canceled checks
- Debit card or credit card receipts
- Balance forward or previous balance statements
- Paid on account statements
- Pre-payments for future services.
- Services incurred outside the plan year.

Orthodontia:

You must submit an orthodontic contract showing treatment start and end dates, the amount of the initial payment and the number of and amount of monthly payments.

Mail Claim Forms to:

First Financial Group of America
FSA Department
PO Box 161968
Altamonte Springs, FL 32716

Fax Claim Forms to:

800-298-7785

Email Claim Forms to:

First_Financial_Receipts@Alegeus.com

Fill out a claim form online:

www.ffga.com

Complete your claim form online and upload documentation on our secure participant portal by logging into www.ffga.com.

FF Mobile Account App:

File a claim form on your mobile device using the FF Mobile Account App. Available for download on the App Store or Google Play Store for Apple and Android devices.

Visit www.ffga.com for more information about Flexible Spending Accounts.

Reimbursement Itemization

Continued

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT
		SUB-TOTAL THIS PAGE	$0.00

MEDICAL REIMBURSEMENT SUBMISSION GUIDELINES:

ACCEPTABLE DOCUMENTATION to accompany the reimbursement voucher:

1. Professional bill or receipt that includes:
   - » Provider of service
   - » Type of service rendered
   - » Original date of service
   - » Charges for the service
2. Insurance company Explanation of Benefits
3. Pharmacy statement that includes Rx number and name of the prescription

DAYCARE SUBMISSION GUIDELINES:

ACCEPTABLE DOCUMENTATION to accompany the reimbursement voucher:

1. Vouchers for Dependent Care signed by the Provider. Voucher must also be completed with the Provider's tax identification number or Social Security number and dates of service, Or...
2. Voucher with receipt from Provider, including Provider name, Provider signature, dates of service, amount for service, and tax identification/social security number.

I.R.S Regulations prevent us from reimbursing dependent care yearly contracts. Monthly submissions are required.

UNACCEPTABLE DOCUMENTATION

1. Cancelled checks / Credit card receipts
2. Bill or receipt that only shows a balance forward or previous balance
3. Cash register receipt

Note: *It is important to note that the date of service, not the date of payment, must fall within the dates of the plan year for which you are enrolled.*

GAP Insurance

American Fidelity | www.americanfidelity.com | 800-654-8489

You may think major medical insurance is enough to cover your needs, but the reality is that many plans may only cover a portion of your overall expenses. It's important to protect yourself in the event of a sudden hospitalization.

A Hospital GAP Insurance plan pays benefits directly to you and is designed to help cover the gap between what your traditional medical plan will cover and the out-of-pocket expenses you will pay. The plan may include benefits you can use to help pay for inpatient hospital stays and surgeries, doctor's office treatments and diagnostic testing costs.

With Hospital GAP Insurance, you can have peace of mind knowing that unexpected medical expenses will less of a financial burden for you and your family members.

Highlights Include:

- **Inpatient Benefits:** Covers inpatient hospital stay, inpatient surgery, physician expenses from inpatient stay and lab expenses from an inpatient stay
- **Outpatient Benefits:** Covers treatment in a hospital emergency room, outpatient surgery, treatment in a hospital, free- standing outpatient surgery center and outpatient diagnostic testing
- **Physician Office Visit Benefits:** This benefit provides a reimbursement amount for physician visits for up to five visits.

AMERICAN FIDELITY ASSURANCE COMPANY

Inpatient Benefit • Outpatient Benefit • Benefits Paid Directly to You • Learn More »

Hospital GAP PLAN Choice® Insurance

This is a supplemental limited benefit medical expense insurance policy. This product is inappropriate for people who are eligible for Medicaid coverage. *This brochure highlights important features of the policy. Please refer to your certificate for complete details.*

How Would You Cover Your Out-of-Pocket Costs??

CONSIDER THE FACTS

Hospital costs average $2,447 per person per day.[1]

American Fidelity's Hospital GAP PLAN Choice® Insurance provides coverage for you and your family to help with your share of unforeseen medical expenses.

[1] *AHRQ Healthcare Cost and Utilization Project, National Inpatient Sample as of November 10, 2017.*

Rising health care costs can be a financial concern. ***When faced with a hospital expense, how would you manage to pay your share, including the deductible and co-pays?*** Hospital GAP PLAN Choice® Insurance can help!

American Fidelity Assurance Company's Hospital GAP PLAN Choice® Insurance is a supplemental, limited benefit medical expense policy that is designed to help pay the deductible and co-insurance when you or a family member are confined in the hospital.

See How the Plan Works!

Let's assume your major medical plan deductible is $1,500 and your co-insurance is 80/20 with a total out-of-pocket maximum of $2,500. Our hypothetical example is based on a $2,000 Inpatient Benefit and $800 for our Outpatient Benefit.

Example: Hospital Stay and Surgery, totaling $10,000

Inpatient Benefit Payment Example*	Without Hospital GAP PLAN Choice® Insurance Coverage	WITH Hospital GAP PLAN Choice® Insurance Coverage
Deductible:	$1,500	$1,500
Coinsurance:	$1,000	$1,000
Total Out-of-Pocket:	$2,500	$2,500
Hospital GAP PLAN Choice® Insurance:	$0	$2,000
Your Out-of-Pocket Cost:	**$2,500**	**$500**

Example: One week of radiation, totaling $10,000

Outpatient Benefit Payment Example*	Without Hospital GAP PLAN Choice® Insurance Coverage	WITH Hospital GAP PLAN Choice® Insurance Coverage
Deductible:	$1,500	$1,500
Coinsurance:	$1,000	$1,000
Total Out-of-Pocket:	$2,500	$2,500
Hospital GAP PLAN Choice® Insurance:	$0	$800
Your Out-of-Pocket Cost:	**$2,500**	**$1,700**

**These are hypothetical examples and are for illustrative purposes only.*

INPATIENT HOSPITAL BENEFIT

What it Covers:

- Inpatient hospital stays
- Inpatient surgery
- Physician expenses from inpatient stay
- Lab expenses from inpatient stay

How it Pays:

The Inpatient Hospital Benefit pays the difference between the actual hospital expenses you incur as an inpatient and the amount your primary medical plan covers.

Your Maximum Reimbursement:

Benefit amounts available range from $1,000 to $7,500 per confinement for qualified out-of-pocket expenses for injury or sickness. Your reimbursement can not exceed the benefit amount you initially select under this plan.

How Long of a Hospital Stay is Required?

A hospital stay of 18 consecutive hours or over is considered an Inpatient Benefit. Anything under 18 hours is considered an Outpatient Benefit (see below).

OUTPATIENT BENEFIT

What it Covers:

- Treatment in a hospital emergency room
- Outpatient surgery
- Treatment in a hospital
- Free standing outpatient surgery center
- Outpatient diagnostic testing

Repeat visits for the same or related conditions will be subject to a single maximum outpatient benefit. After 90 consecutive days without a related condition, a new maximum outpatient benefit will apply.

How it Pays:

The Outpatient Benefit pays the difference between the actual outpatient expenses incurred and the amount paid by your primary medical plan.

Your Maximum Reimbursement:

- The plan covers qualified out-of-pocket expenses for injury or sickness (depending upon the plan selected) up to a maximum outpatient benefit of:
- $400, $800 or $1,200 for outpatient surgery or treatment performed in a Hospital or a Free-Standing Outpatient Surgery Center;
- $100, $200 or $300 for outpatient diagnostic testing procedure performed in a hospital or a Free-Standing Magnetic Resonance Imaging (MRI) Facility.; or
- $50, $100 or $150 for outpatient treatment in a Hospital Emergency Room, without the covered person subsequently being considered an inpatient.

PHYSICIAN OFFICE VISIT BENEFIT

What it Covers:

Qualified visits are for outpatient treatment due to sickness, or outpatient emergency care for an injury. The covered person must be covered by a primary medical plan, when such charges are incurred at a Hospital outpatient clinic, free-standing emergency care clinic, or Physician's office.

How it Pays:

The Physician Outpatient Treatment Benefit provides reimbursements for physician visits at $25.00 per visit, for up to five visits ($125.00) per family per calendar year for out-of-pocket covered charges. See your certificate for benefit amounts

ADDITIONAL PLAN INFORMATION

Effective Date of Coverage:

This plan will take effect on the application's requested effective date, or on an adjusted effective date as assigned by American Fidelity upon application approval, whichever is later, if:

- underwriting rules are met;
- such person is on active employment;
- such person is covered under a Major Medical Plan; and
- premium has been paid.

Important Plan Details:

- Benefits are paid directly to you and you are responsible for paying the providers.
- The policy does not cover 100% of out-of pocket costs.
- This is not Major Medical Coverage.
- This coverage cannot be used with a Health Savings Account.
- Actual expense means after any discounts or reductions take place as negotiated between the primary medical carrier and the service provider.

Coverage Available For:

- Employee
- Spouse, and/or
- Children

Plan Eligibility:

To be eligible for this coverage, you must be an active permanent full-time employee:

- Working 18 hours or more per week.
- Covered under another Major Medical Plan.
- Under the age of 70 (This limit does not apply if you work for an employer employing 20 or more employees on a typical work day in the preceding calendar year).

Hospital:

The term "Hospital" shall not include an institution, or part thereof, used by you as:

- a place for rehabilitation;
- a place for rest or for the aged;
- a nursing or convalescent home;
- a long-term nursing unit or geriatrics ward; or
- an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Benefits excluded or not covered:

Only charges approved by the group major medical carrier or the comprehensive carrier maybe considered under this plan. If this plan is Employer Paid, the pre-existing condition exclusion will not apply. For a list of all exclusions, please refer to your certificate.

Exclusions include:

- suicide or any attempt, thereat, while sane or insane);
- any intentionally self-inflicted injury or sickness;
- rest care or rehabilitative care and treatment;
- routine newborn care during the initial hospital confinement period, including routine nursery charges;
- voluntary abortion except, with respect to you or your covered dependent spouse, where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion;
- pregnancy of a dependent child;
- participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- commission of a felony;
- participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
- air travel, except:
  - as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - as a passenger for transportation only and not as a pilot or crew member;
- intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
- alcoholism or drug use, unless such drugs were taken on the advice of a physician and taken as prescribed;
- sex changes;
- elective surgery, including complications of elective surgery;
- experimental treatment, drugs, or surgery;
- pre-existing conditions, unless the covered person has satisfied the 12-month pre-existing condition exclusion period; ***"Pre-Existing Condition"*** means a disease, Injury, Sickness, or physical condition for which the Covered Person: had treatment; incurred expense; took medication; or received a diagnosis or advice from a Physician, during the 12 month period of time immediately before the Covered Person's Effective Date of coverage. The term "Pre-Existing Condition" will also include conditions which are related to such disease, Injury, Sickness or physical condition. See rate insert for applicability.
- performance of military, naval, or air force service of any country;
- injury or sickness arising out of and in the course of any occupation for compensation, wage or profit (This does not apply to those sole proprietors or partners not covered by Workers' Compensation.);
- dental or routine vision services, unless:
  - resulting from an Injury occurring while the covered person's coverage is in force and if performed within 12 months of the date of such Injury; or
  - due to congenital disease or anomaly of a covered newborn child;
- routine examinations, such as health exams, periodic check-ups, or routine physicals;
- air or ground ambulance; or
- any expense for which benefits are not payable under the covered person's other medical plan.

The Hospital GAP PLAN Choice® Insurance policy may exclude expenses that are covered under the underlying major medical plan. In those instances, there may be out-of-pocket expenses that are not covered under Hospital GAP PLAN Choice® Insurance. Coverage will continue as long as the group policy remains in force, the premiums are paid and the insured remains eligible for coverage under the policy. Your coverage will end when you no longer qualify as an Insured, you retire, you are not on Active Service, or your coverage under Another Medical Plan ends. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

View and print your policies plus file a claim at americanfidelity.com.

American Fidelity's Online Service Center provides you convenient, secure 24/7 access to manage your account or file a claim. All you need is the EOB (Explanation of Benefits) and itemized bill from your major medical provider!

This policy is endorsed/sponsored by an association or issued through a trust in which the employer is a member, is intended to be covered by ERISA, and will be administered and enforced in accordance with ERISA. If you reside in a state other than your employer's state of domicile, where required by law, policy provisions and benefits may vary.

Marked by:

Underwritten and administered by:

AMERICAN FIDELITY
a different opinion

800-654-8489 • americanfidelity.com

Identity Theft Protection

iLock360 | www.ilock360.com | 855-287-8888

Millions of Americans report having their identity stolen each year. People are online and mobile more than any time in history, so it's no surprise that identity theft is on the rise. And it goes far beyond simply having your credit card number stolen. While credit card fraud is one of the highest reported types of identity theft, it also includes bank, loan, phone and tax-related fraud.

Identity theft insurance won't prevent your identity from being stolen. But it will be there to alert you if any suspicious activity is noticed under your name. The plan includes credit bureau monitoring, social security number usage and lost wallet protection. Accounts are monitored daily so you can rest easy knowing your identity is being protected even while you sleep. The sooner you can take action to close your accounts, the quicker you can recover your identity.

It takes years to establish a good reputation with credit lenders and employers. Make sure it remains yours by taking advantage of the identity theft insurance offered through your employer.

Highlights Include:

- All employees eligible for Identity Theft Protection coverage
- Monitors your identity 24/7/365
- Personal email address required to sign up for this program

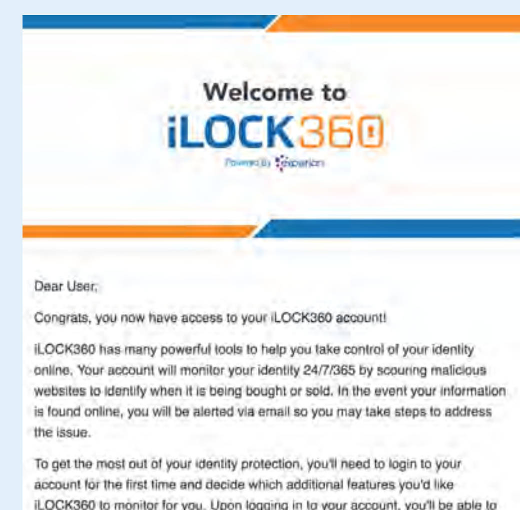
Activation guide

Welcome email

All iLOCK360 subscribers receive a Welcome Email on the first day of service.

This email explains how to access your iLOCK360 account and utilize the features included with your plan.

If you experience issues accessing your account, or you do not receive the Welcome Email, please contact iLOCK360: (855) 287-8888



Welcome to
iLOCK360

Dear User,

Congrats, you now have access to your iLOCK360 account!

iLOCK360 has many powerful tools to help you take control of your identity online. Your account will monitor your identity 24/7/365 by scouring malicious websites to identify when it is being bought or sold. In the event your information is found online, you will be alerted via email so you may take steps to address the issue.

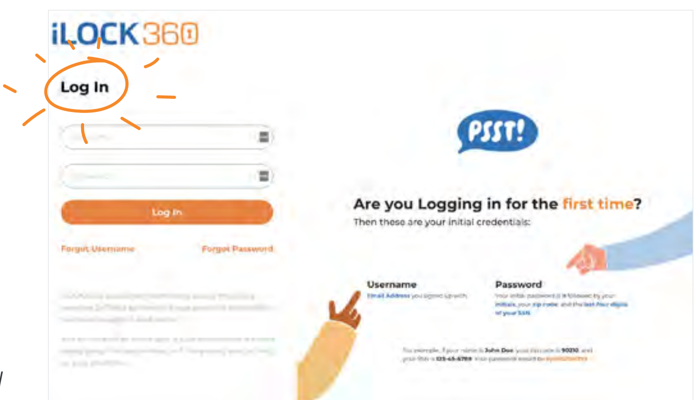
To get the most out of your identity protection, you'll need to login to your account for the first time and decide which additional features you'd like iLOCK360 to monitor for you. Upon logging in to your account, you'll be able to

Setting up your iLOCK360 account

1. Visit www.iLOCK360.com

2. Click "Log In"

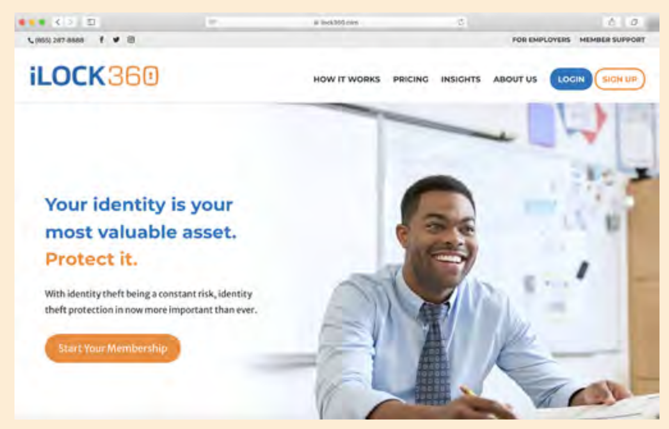
PLEASE NOTE: This information is also shared in the Welcome Email that is sent to you on the first day of service.



Initial login credentials

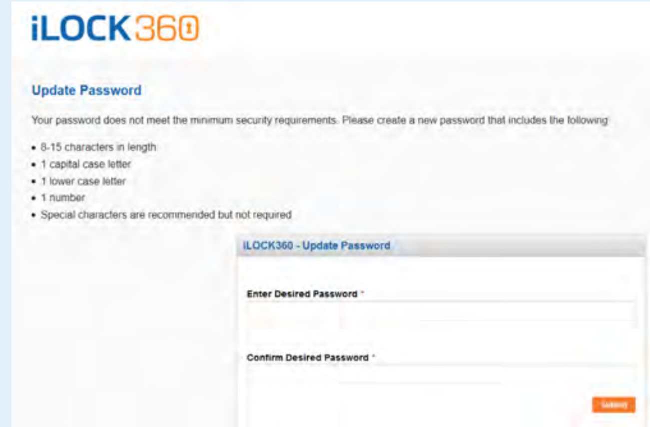
To access your iLOCK360 account for the first time you will use:

- **Username**: The email address you used to sign up for iLOCK360.
- **Password**: Your initial password is # followed by your first initial and then your second initial, followed by your zip code (provided during enrollment) and then lastly the last four digits of your Social Security Number.



Create an account password

- Once you login to your account for the first time, you will be prompted to create a password.
- We recommend you choose a password that is not used for any other accounts and is unique to you.



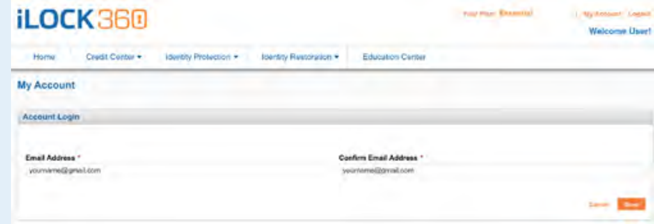
What is Knowledge Based Authentication?

These are questions that are derived from a composite of information pulled from commercially available data sources such as credit reporting agencies and public records.

Identity verification process

- You **must complete** the Identity Verification Process in order to authenticate your account.
- iLOCK360 will ensure you are who you say you are by using an industry- standard procedure called "Knowledge Based Authentication."
- As a security precaution, you will be locked out of your account if any answer you provide is incorrect. If an account lockout occurs, you will need to contact iLOCK360 at (855) 287-8888

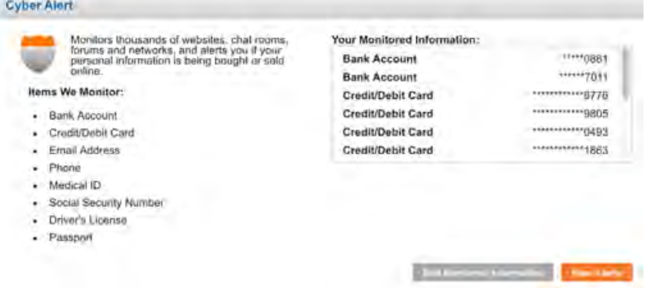
Preferred email address



- Your iLOCK360 account alerts and notifications will be sent to the email address you provided during your enrollment.

- Take a moment to consider which email address is best for you to receive your alerts in a timely fashion.

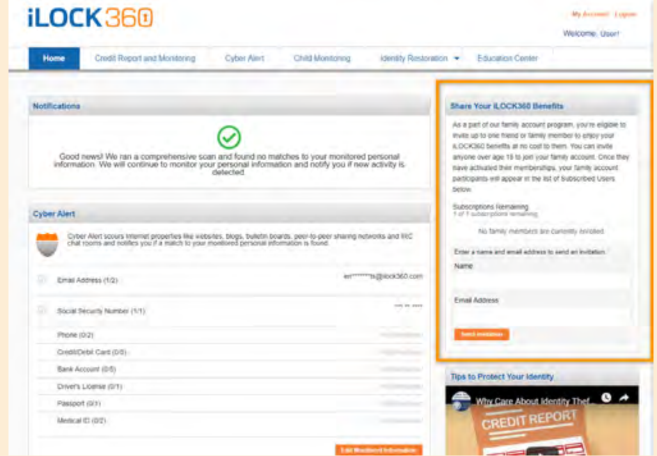
Update monitored information



- Take a moment to review all of the features included with your iLOCK360 plan.

- While logged into your account, add any additional information you want iLOCK360 to monitor.

How to setup a spouse account



- If you elected iLOCK360 coverage that includes your Spouse, you can send your Spouse an email invitation to setup their own account.

- Please note: Your Spouse will need to sign up using their own unique email address. iLOCK360 requires each login to use a unique email address.

We have officially launched our app

Download it on your phone today!

Here's how to get started:

Step 1

Go to the App Store on your device.

Step 2

Type iLOCK360 in the search bar.

Step 3

Once you click on the first option, you will see this screen. Press the GET button to download the application.

Step 4

Once the app is downloaded on your device, open it and use the same credentials you use on our website portal to sign in.

More account information

Adult subscribers

- All adult individuals will use their own Social Security Number, Date of Birth and email address in order to register their own account, not the Primary Employee's details.
- If you signed up for coverage that includes your Spouse, and can send them an invitation to setup their iLOCK360 account while you're logged into your own iLOCK360 account (see page 9 for details).

Minor dependents

- Minor dependents (under18) will be considered "activated" once their guardian whose plan they are under logs in and completes the Identity Verification Process. The child does not need to individually complete this process.
- Minor dependents do not have a "dashboard" due to COPPA laws, but will receive alerts at their parent's email address.
- The account holder (i.e. parent/guardian) can be assisted with Minor dependent alerts over the phone.
- When a Minor turns 18, they will no longer be eligible for coverage under this benefit enrollment election due to COPPA laws. They can contact iLOCK360 at (855) 287-8888 to create their own account.

iLOCK360

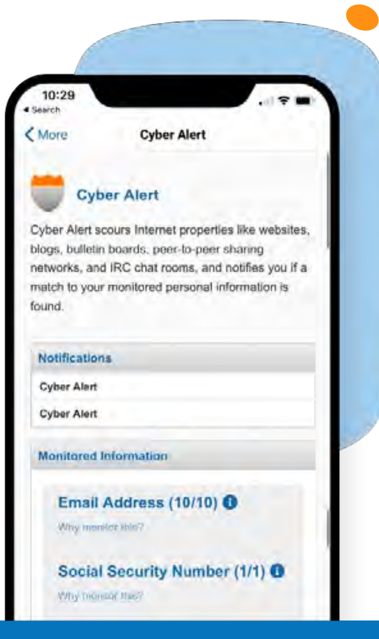
Your identity is your most valuable asset. Is yours protected?

39 seconds is how often cyber-attacks to occur

25% of kids are projected to be affected by identity theft before turning 18

17% increase in data breaches 2022 to 2023

Identity theft is the **fastest growing crime.** With iLOCK360, you can rest easier knowing you have experienced professionals in your corner restoring your identity. Your identity is more than simply reviewing your credit card charges. That's why we offer a comprehensive monitoring service of online activity, financial affairs, and immediate resolution.



Defend

Your personal information is monitored 24 / 7 / 365

Protect

Alerts inform you of potential threats for immediate action

Restore

iLOCK360 does the work to restore your identity

Sign up during enrollment

For educator pricing

Coverage plan	Plus	Premium
Employee	$8	$15
Employee + Spouse	$15	$22
Employee + Children	$13	$20
Employee + Family	$20	$27

Please note: A valid email address is required for enrollment in iLOCK360. All iLOCK360 alerts and/or notifications are sent via email. Consider utilizing an email address that you check regularly. • Account activation & setup of monitored elements is required upon the start of your new benefit plan year.

Learn more about the protections that iLOCK360 offers:

Plan features	Service description	Plus	Premium
Identity theft resolution services			
Full-Service Identity Theft Restoration & Lost Wallet Protection MOST VALUABLE SERVICE. Dependable help that's just a phone call away!	If your identity is compromised, a U.S.-based certified Identity Theft Restoration Specialist will work with you and on your behalf to restore your good name, so that you can get on with your life. All restoration activities can be completed for you, and your case will be managed until your identity is fully restored. Even pre-existing conditions can be dealt with. Restoration Specialists offer robust case knowledge in both credit and non-credit fraud situations and can help you with closing accounts, re-ordering cards, placing a fraud alert with each of the three credit bureaus, and removing fraudulent activity from your credit report.	✔ adults ✔ Children to age 18	✔ adults ✔ Children to age 18
$1M Identity Theft Insurance	If you incur expenses associated with your identity theft recovery, you will be covered up to $1M reimbursement ($0 deductible). Covered costs include: • Lost wages or income • Attorney and legal fees • Expenses incurred for refiling of loans, grants and other lines of credit • Costs of childcare and/or elderly care incurred as a result of identity restoration	✔ adults	✔ adults
Comprehensive identity monitoring			
CyberAlert™ monitors: • one Social Security Number • two Phone Numbers • two Email Addresses • five Credit/Debit Cards • two Medical ID Numbers • five Bank Accounts • one Drivers License Number • one Passport	We scour Internet properties, including the Dark Web, as well as hacker websites, blogs, bulletin boards, peer-to-peer sharing networks and chat rooms to identify the illegal trading and selling of your personal information.	✔ adults ✔ Children to age 18	✔ adults ✔ Children to age 18
Change of Address Monitoring	A thief may try to establish "your" new identity by changing your address. Receive an alert if your mail is redirected through the USPS National Change of Address (NCOA) Registry.	✔ adults	✔ adults
Court/Criminal Records Monitoring	Tracks municipal court systems and notifies you if a crime has been committed under your name and date of birth.	✔ adults	✔ adults
Sex Offender Alerts	Keep your family safe with awareness of where registered sex offenders live in your immediate area. You'll also be notified when a new one moves to your area. As well as notifying you if someone registers as a sex offender in your name.	✔ adults	✔ adults
Payday Loan Monitoring	Often times, these types of loans don't show up on your credit report until they have gone through collections which will be damaging to your credit report. High-interest, easy-to-obtain payday loans can negatively impact your credit score. We alert you if a non-credit loan been opened using your identity at a payday or quick cash loan provider.	✔ adults	✔ adults
Social Security Number Trace	Provides you with a report of all names and/or aliases as well as current and reported addresses associated with your Social Security number. If there are findings that you don't recognize, this could be a sign of possible identity theft.	✔ adults ✔ Children to age 18	✔ adults ✔ Children to age 18
Credit monitoring services			
Daily Monitoring of Experian Credit Bureau	Provides credit protection with monitoring from Experian. Provides you with notifications for changes in a credit report such as loan data, inquiries, new accounts, judgments, liens and more.	✔ adults	✔ adults
Daily Monitoring of Three Credit Bureaus	Provides higher-level credit protection with monitoring from all three credit bureaus: Experian, Equifax & TransUnion. Receive notifications for changes in your credit report such as loan data, inquiries, new accounts, judgments, liens and more.		✔ adults
VantageScoreTracker	Receive a monthly report that helps you understand how your credit score has trended over time and what is impacting it with credit score insight.		✔ adults

✔ adults ✔ Children to age 18 ✔ adults ✔ Children to age 18

Legal Plan

Metlaw | www.legalplans.com | 800-821-6400

Have you ever found yourself in need of legal advice, but aren't sure where to go? A voluntary group legal plan helps fill that need. It provides you with access to professional lawyers at a low monthly rate. For just a few dollars a month, you can consult with a lawyer about having your will prepared, reviewing documents, contesting a traffic ticket, lawsuits, divorce and so much more. Expert legal advice is available at your fingertips.

Highlights Include:

- Family Law, Estate Law, Civil Lawsuits, Vehicle Law, Real Estate Law, Money Matters and Elder Care issues
- Benefits of the preparation of Living Trusts, Living Wills, Powers of Attorney and Will
- Preparation/ Review of Affidavits, Deeds, Demand Letters, Document Reviews, Mortgages and Promissory Notes
- Adoption and Legitimization, Guardianship, Name Change, Prenuptial Agreement, protection from Domestic Violence, Juvenile Court of Defense, Debt Collection defense and Tax Audit Representation
- Letter preparation, a checklist and an online library of all necessary recovery forms and documents to resolve and restore your name are also available

Product Overview

Alief Independent School District

Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Legal experts on your side, whenever you need them

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly premium of **$16.50** conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorneys online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[2]

How to use the plan

1. Find an attorney

Create an account at **legalplans.com** to see your coverages, select an attorney and get a case number for your legal matter. Or, give us a call at **800.821.6400** for assistance.

2. Make an appointment

Call the attorney you select, provide your case number and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Helping you navigate life's planned and unplanned events.

For **$16.50 a month**, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter. And, for non-covered matters that are not otherwise excluded, your plan provides four hours of network attorney time and services per year.[3]

Money Matters	• Debt Collection Defense • Identity Management Services[4]	• Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy	• Promissory Notes • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary or Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance	• Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets[5] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

To learn more about your coverages and see our attorney network, create an account at **legalplans.com** or call **800.821.6400** Monday – Friday 8:00 am to 8:00 pm (ET).

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

1. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.
2. Digital notary and signing is not available in all states.
3. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents, annually.
4. This benefit provides the Participant with access to LifeStages Identity Management Service provided by Cyberscout, LLC. Cyberscout is not a corporate affiliate of MetLife Legal Plans.
5. Does not cover DUI.

Group legal plans provided by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. MetLife® is a registered trademark of MetLife Services and Solutions, LLC, New York, NY. [MLP4]

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Life & AD&D Insurance

Lincoln Financial | www.lincolnfinancial.com | 877-275-5462

Group Optional Life

Group life insurance allows you to purchase affordable life insurance on yourself, spouse and dependent children. This is term insurance, available as long as you are employed by district. Employees enrolling in the coverage after the first 30 days of their employment will be subject to insurability and must complete a health questionnaire prior to coverage being issued. Alief ISD provides each eligible employee with Basic Term Life and Accidental Death and Dismemberment (AD&D) at no cost to the employee.

Basic Life / AD&D Insurance

Alief ISD automatically provides Basic Life and AD&D insurance for you through Lincoln Financial.

- Administrators receive $60,000
- Professionals receive $25,000
- All others receive $15,000

Basic Life & AD&D Highlights

- Offers protection in the event you should die due to either natural causes or an accident.
- Benefits will be paid to the beneficiaries declared on your application.
- Covers a specific term for a predetermined benefit amount.
- Coverage would cease should employment end. However, you may be able to convert your plan to an individual policy within a certain number of days within you leaving employment.

Life Insurance

Lincoln Financial | www.lincolnfinancial.com | 877-275-5462

All basic, optional, and dependent spouse insurance reduces to 35% at age 65, 50% at age 70, and 15% and 15% at age 75

- Guaranteed issue for employees 18 years to 69 years: $300,000
- Max benefit for employees 70+: $50,000

Optional Life Monthly Rates per $1,000	
Age	**Rate**
15-29	0.040
30-34	0.048
35-39	0.056
40-44	0.080
45-49	0.120
50-54	0.184
55-59	0.344
60-64	0.504
65-69	0.808
70-74	1.584
75+	1.648

Dependent Life Rates		
Level	**Monthly Rate**	**Semi-Monthly Rate**
Option A: Spouse $5,000 / Child(ren) $2,000	$0.80	$0.40
Option B: Spouse $10,000 / Child(ren) $5,000	$1.66	$0.83
Option C: Spouse $20,000 / Child(ren) $10,000	$3.30	$1.65
Option D: Spouse $30,000 / Child(ren) $10,000	$4.96	$2.48

Full-Time Employees, excluding Superintendents of Alief Independent School District

Benefits At-A-Glance

Voluntary Term Life Insurance

The Lincoln Term Life Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Features group rates for Alief Independent School District employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$300,000
Maximum coverage amount	5 times your annual salary ($500,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Spouse / Domestic Partner	
Newly hired employee guaranteed coverage amount	$30,000
Coverage Options	$5,000, $10,000, $20,000, or $30,000
Dependent Children	
Day 1 to age 26 guaranteed coverage amount	$10,000
Coverage Options	$2,000, $5,000, or $10,000

What your benefits cover

Employee Coverage

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $300,000 without providing evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($500,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- Your coverage amount will reduce by 35% when you reach age 65; an additional 15% of the original amount when you reach age 70; and an additional 15% of the original amount when you reach age 75.

Spouse / Domestic Partner Coverage - You can secure term life insurance for your spouse / domestic partner if you select coverage for yourself.

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 100% of your coverage amount ($30,000 maximum) for your spouse / domestic partner without providing evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($250,000 maximum) for your spouse / domestic partner with evidence of insurability.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $2,000, $5,000, or $10,000

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included

Benefit Exclusions

Like any insurance, this term life insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

A complete list of benefit exclusions is included in the policy. State variations apply.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. *TravelConnect®* travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

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Monthly Voluntary Life Insurance Premium Calculate Your Premium.

Group Life Rates for You

Employee Age Range	Life Premium Rate
0 - 24	$.040
25 - 29	$.040
30 - 34	$.048
35 - 39	$.056
40 - 44	$.080
45 - 49	$.120
50 - 54	$.184
55 - 59	$.344
60 - 64	$.504
65 - 69	$.808
70 - 74	$1.584
75 +	$1.648

Group Life Rates for Your Dependents

Option	Spouse Amount	Child Amount	Combined Cost per Unit
A	$5,000	$2,000	$.080
B	$10,000	$5,000	$1.66
C	$20,000	$10,000	$3.30
D	$30,000	$10,000	$4.96

One affordable monthly premium covers all of your eligible dependent children.

Note: To be eligible for coverage, a spouse or dependent child cannot be confined on the date the increase or addition is to take effect, it will take effect when the confinement ends.

Calculate Your Monthly Cost

Use the appropriate rate provided in the tables above to calculate your cost based on the amount of coverage you select. The following example calculates the monthly cost for a 36-year-old employee who would like to purchase $100,000 in employee voluntary term life insurance coverage.

Calculation Example		Example	You
Step 1	Using the table above, enter the rate that corresponds with your age.	$0.056	
Step 2	Enter the desired coverage amount in dollars.	$100,000	
Step 3	Enter the desired coverage amount in increments of $1,000. *To calculate, divide the coverage amount by $1,000.*	100	
Step 4	Calculate the monthly cost. *Multiply Step 1 by Step 3.*	$5.60	

Note: Rates are subject to change and can vary over time.

Please see prior page for product information.

Medicare & Age 65

FFMS | https://www.ffga.com/medicare-solutions | 800-523-8422

Questions to Consider Before Retiring

- Do I ***plan*** to Retire?
- Am I ***eligible*** to Enroll?
- ***When*** can I enroll?
- Do I really ***want*** to enroll?
- ***Should*** I enroll now or wait?
- What happens if I ***don't*** enroll when I'm eligible?

Robert Dawson
FFMS Coordinator
Cell: 281-889-9382

Whether or not you intend to retire yet, these questions and more may occur as you approach age 65.

Planning for your future is important, and you don't have to do it alone.

Let the experts at First Financial assist you through this process.

Texas Life
Permanent Life

Texas Life | www.texaslife.com | 800-283-9233

Texas Life Insurance - Permanent, Portable Life Insurance

The peace of mind voluntary, permanent life insurance provides is unmatched. It is a solid companion to your group life insurance plan. Texas Life provides life insurance that you can keep for a lifetime. The plan is easy to purchase, pay for, and keep through the convenience of payroll deduction. Coverage is affordable and dependable. Plus, Texas Life has over a century of experience protecting families and giving the peace of mind only permanent life insurance can provide.

This coverage does not reduce at 65, 70, or 75. Dependent children, once added are covered thru age 120.

Texas Life - Permanent Life Highlights

- You own the policy, even if you change jobs or retire.
- The policy remains in force until you die or up to age 121 if you pay the necessary premium on time.
- It is a permanent, universal life policy which means you can rest easy knowing your loved ones will be well taken care of when you're gone.

MONTHLY NON-TOBACCO PREMIUMS
EMPLOYEE & SPOUSE *with Accidental Death & Chronic Illness Riders*

TEXASLIFE INSURANCE COMPANY

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

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

Non-Tobacco

CHILDREN AND GRANDCHILDREN (NON-TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

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

Indicates Spouse Coverage Available

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

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

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

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

ACCIDENTAL DEATH BENEFIT RIDER EXCEPTIONS TO COVERAGE

The following exceptions to coverage apply to these states: AK, AL, AR, AZ, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY

a) war or any act attributable to war, whether or not the Insured is in military service;
b) participating or engaging in a riot;
c) suicide or any attempt to commit suicide, while sane or insane;
d) bodily or mental infirmity or illness or disease of any kind;
e) participation in an illegal occupation or activity;
f) any cause, if death occurred while the Insured is incarcerated;
g) an accident caused or contributed to by intoxication as defined by the jurisdiction in which death occurred;
h) taking of any poison, drug, or sedative, unless such drug or sedative was taken as prescribed for occurred;
i) asphyxiation from inhalation of gas, except the accidental inhalation of gas in the course of Insured's employment;
j) operating or riding in, or descending from any kind of aircraft if the Insured is a pilot, officer, or member of the crew of the aircraft, or is giving or receiving any kind of training or instruction, or has any duties aboard the aircraft or duties requiring descent therefrom.

In SD, this provision does not cover death which results from any of the following causes:

a) war or any act attributable to war, whether or not the insured is in military service;
b) suicide or any attempt to commit suicide, while sane;
c) bodily illnesses or disease of any kind;
d) committing a felony
e) operating in, or descending from any kind of aircraft if the Insured is a pilot, officer, or member of the crew of the aircraft, or is giving or receiving any kid of training or instruction, or has any duties aboard the aircraft or duties requiring descent therefrom.

In FL and ND, this provision does not cover death which results from any of the following causes:

a) an accidental bodily injury occurring, outside the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, Panama Canal Zone, the Republic of Panama, and Canada, while in the military service for any country at war;
b) war or any act attributable to war, whether or not the Insured is in military service;
c) participating or engaging in a riot;
d) suicide or any attempt to commit suicide, while sane or insane;
e) bodily or mental infirmity or illness or disease of any kind
f) committing or attempting to commit a felony;
g) taking of any poison, drug, or sedative, unless such drug or sedative was taken as prescribed for the Insured by a physician;
h) asphyxiation from inhalation of gas, except the accidental inhalation of gas in the course of the Insured's employment;
i) operating or riding in, or descending from any kind of aircraft if the Insured is a pilot, officer, or member of the crew of the aircraft, or is giving or receiving any kind of training or instruction, or has any duties aboard the aircraft or duties requiring descent therefrom.

MONTHLY TOBACCO PREMIUMS
EMPLOYEE & SPOUSE *with Accidental Death & Chronic Illness Riders*

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

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

Tobacco

CHILDREN AND GRANDCHILDREN (TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

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

Indicates Spouse Coverage Available

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

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

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

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

LIFE INSURANCE HIGHLIGHTS

For the employee

PURELIFE-PLUS

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

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

- **High Death Benefit.** Written on a minimal cash-value Universal Life frame, PURELIFE-PLUS features one of the highest death benefits per payroll-deducted dollar offered at the worksite.[1]
- **Refund of Premium.** Unique in the workplace, PURELIFE-PLUS offers you a refund of 10 years' premium, should you surrender the contract if initial specified premium paid for ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Due to Terminal Illness Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a $150 ($100 in Florida) administrative fee. Included with your contract at no additional cost, this valuable living benefit helps give you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.) (Form ICC07-ULABR-07 or Form Series ULABR-07)*
- **Accelerated Death Benefit for Chronic Illness Rider.** Optional on employee contracts at an additional cost, this rider will be triggered by the loss of two out of six Activities of Daily Living[2] or severe cognitive impairment for a period of 90 days. It pays the insured up to 92% of the death benefit minus a small administrative fee, should the insured decide to exercise it. This valuable living benefit can help offset the cost of either in-home care or care in a resident facility. *(Conditions apply; see the following pages for additional details. Form Series CA-ULABR-CI-18)*

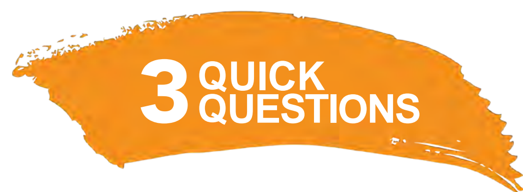
The agent/agency offering this coverage is not affiliated with Texas Life other than to market its products. Claims payments are the responsibility of Texas Life Insurance Company.

Additional Features

- **Minimal Cash Value.** Designed to provide a high death benefit at a reasonable premium, PURE**LIFE**-PLUS helps provide peace of mind for you and your beneficiaries while freeing investment dollars to be directed toward such tax-favored retirement plans as 403(b), 457 and 401(k).

- **Long Guarantees.** Enjoy the assurance of a contract that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).[3]

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



You can qualify by answering just 3 questions[5] – 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?

Important Note: Texas Life does not offer legal or financial advice. Contact an attorney and a financial advisor in your state for legal and financial information on wills, estates and trusts.

PureLife-plus is a Flexible Premium Adjustable Life Insurance to Age 121. As with most life insurance products, Texas Life contracts and riders contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative or see the Purelife-plus brochure for costs and complete details. Contract Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO.

[1] Voluntary Whole and Universal Life Products, Eastbridge Consulting Group, March 2022
[2] Six Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that: (1) places the Insured in jeopardy of harming him/herself or others and, therefore, the Insured requires Substantial Supervision by another individual; and (2) is measured by clinical evidence and standardized tests which reliably measure impairment in; (a) short or long-term memory; (b) orientation to people, places or time; and (c) deductive or abstract reasoning.
[3] As long as you pay the necessary premium. Guarantees are subject to product terms, limitations, exclusions, and the insurer's claims paying ability and financial strength. 45 years average for all ages based on our actuarial review.
[4] Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
[5] Issuance of coverage will depend on the answer to these questions.

LIFE INSURANCE HIGHLIGHTS

For the employee

PURELIFE-PLUS

You can take it with you when you change jobs or retire, as long as premiums are paid

You can cover your spouse, children and grandchildren, too[1]

You pay for it through convenient payroll deductions: No checks to write or links to click

You can get a living benefit if you become terminally ill[2]

You can qualify by answering just 3 questions - no exam or needles (see inside for more details)

You can get cash to cover living expenses if you become chronically ill[3]

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. Accelerated Death Benefit Due to Terminal Illness Rider Form ICC07-ULABR-07 or Form Series ULABR-07
3 Chronic Illness Rider included in the life contract for employees and their spouses at an additional cost. Conditions apply. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15

23M023-C FFGA 1021 (exp0425)
Not for use in CA.

The agent/agency offering this proposal is not affiliated with Texas Life other than to market its products. Claims payments are the responsibility of Texas Life Insurance Company.

ADDITIONAL POLICY BENEFITS

Accelerated Death Benefit Due to Chronic Illness Rider

Included with the life contract for employees and their spouses at an additional cost, this valuable living benefit can help offset the unplanned expense of care should the insured be faced with a qualifying disabling chronic illness or severe cognitive impairment.

Here's how it works:

- If you're no longer able to perform any two of the six Activities of Daily Living or if you suffer severe cognitive impairment, you can receive a living benefit.[4]
  - Example: You own a $100,000 Texas Life insurance policy with the Chronic Illness rider. A medical professional certifies that you can no longer perform two of the six Activities of Daily Living or have suffered serious cognitive impairment. You can apply for a lump sum of $92,000 minus a $150 processing fee.[5]
- The money is yours to do with as you choose: you do not have to go to a nursing home, convalescent center or receive home health care to receive the cash.
- The cost to add this valuable living benefit to your life insurance policy is minimal – just 10% of the policy's base premium.

A death benefit for your family,
or a living benefit should you need it.

PureLife-plus is a Flexible Premium Adjustable Life Insurance to Age 121. As with most life insurance products, Texas Life contracts and r in force. Please contact a Texas Life representative or see the PureLife-plus brochure for costs and complete details. Form ICC18-PRFN state but New York.

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

5 The Accelerated Death Benefit Rider for Chronic Illness pays 92% of the insurance proceeds less a $150 administration fee ($100 in FL) in lieu of the benefit payable at death. Any outstanding loans will reduce the cash value and death benefit. Contract form series ULABR-CI-15 or ICC15-ULABR-CI-15. Payment of this rider terminates the contract and any obligations under other riders, endorsements and supplemental benefits as if the insured had died.

Accidental Death Benefit Rider

Included in the contract at the option of your employer, the Accidental Death Benefit Rider covers all employees and spouses between the ages of 17-59.[6] This rider costs $0.08 per thousand of face amount per month and pays the insured's beneficiary double the death benefit[7] if the insured dies within 180 days of an accident from injuries incurred in that accident (90 days in FL, ND, and SD)[8]. The benefit is payable through the insured's age 65. Maximum in-force limits and exclusions apply. See the complete list of exceptions to coverage on the following page.

According to the Centers for Disease Control, accidents continue to be a leading cause of death in the U.S.[9]

You can qualify by answering just 3 questions[10] – 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?

ts and riders contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them
NG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO. Texas Life is licensed to do business in the District of Columbia and every

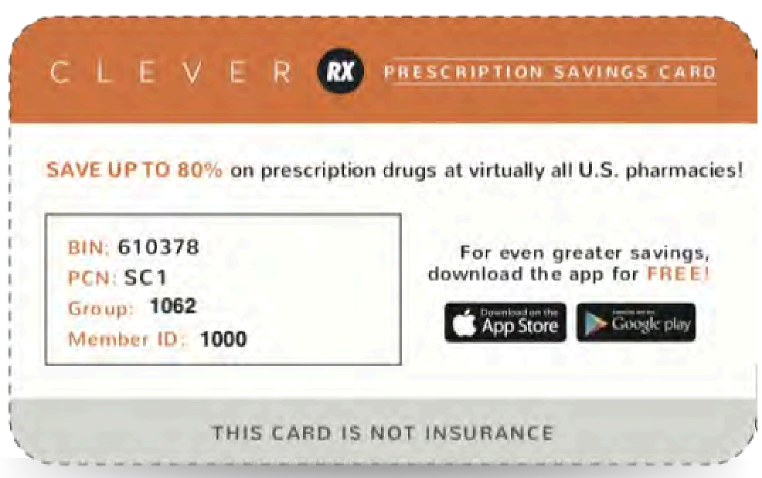
6 Available to children at issue age 17-26, and grandchildren ages 17-18.
7 The accidental death benefit is paid in addition to and for the same amount as the contract's death benefit.
8 Rider details may vary by state. Conditions apply. See contract for complete coverage description. Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07.
9 Mortality in the United States, 2020. HCHS Data Brief, No. 427, December 2021.
10 Issuance of coverage will depend on answers to these questions.

Prescription Drug Card

Clever RX | https://partner.cleverrx.com/ffga | 800-873-1195

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

Use Clever RX every time you pay for a medication for instant savings!



Download the app or visit the site to price a drug: https://partner.cleverrx.com/ffga.

Clever RX Highlights

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

TeleHealth

RediMD | www.redimd.com | 866-989-2873, option 3

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

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

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

- Registration is a one-time process and can be done without having to schedule an appointment
- *Code to register = aliefisd*

Alief offers Tele-Medicine!

TO USE REDIMD AS A FIRST-TIME USER

1 REGISTER.*

- Click "register"
- Select "register " or "First Time User"
- Enter code listed bottom of page and click "next"
- Follow registration directions, enter your e-mail and create a password
- Complete profiles and registration directions.

2 SCHEDULE.

- Make appointment
- Select provider, date, and time
- No copay or payment required.

3 CONSULT.

- Take vitals. Or put 1 in each box if vitals are not taken.
- Consult with your provider (see options below)

*Registration is a one-time process and can be done without having to schedule an appointment.

TO USE REDIMD AS A RETURN USER

1 LOG IN.

From any internet connected computer or smart phone .

- Log in at www.redimd.com
- Enter your e-mail and password

2 SCHEDULE.

- Make appointment
- Select provider, date, and time
- No copay or payment required.

3 CONSULT.

- Take vitals or put 1 in each box if vitals are not taken.
- Consult with your provider (see options below)

CONSULT WITH YOUR REDIMD PROVIDER

AT YOUR WORKPLACE or HOME Computer: To see a provider for your online consult

- Go to the RediMD clinic at your workplace or home computer for the online consult 10 minutes before your appointment time
- Have your photo ID available
- Go to www.redimd.com, log in to your account and go to your appointment (You can follow the hardcopy instructions located by the computer.)
- Take your blood pressure, pulse and temperature and enter your vital readings as prompted, and follow the directions, or put 1 in each box if vitals are not taken.
- The provider will appear at the appointment time to consult with you about the medical information you provided and give you a diagnosis and recommend treatment.

On a smart phone: To see the provider for your online consult

- Go to your smart phone app store and download skype (free). Set up an account.
- 10 minutes before your appointment time, go to www.redimd.com, log in to your account and go to your appointment
- Have your photo ID available.
- Put 1 in each box if the vitals: blood pressure, pulse, etc are not taken and follow the directions.
- Press the skype button and the provider will appear at the appointment time to consult with you about the medical information you provided and give you a diagnosis and recommend treatment.

BY PHONE: To speak with provider (Note: you must be an established patient with RediMD to consult by phone.)

- After hours when the clinic is closed or when a computer or smart phone is not available.
- Call our after hours line **281-633-0148.**

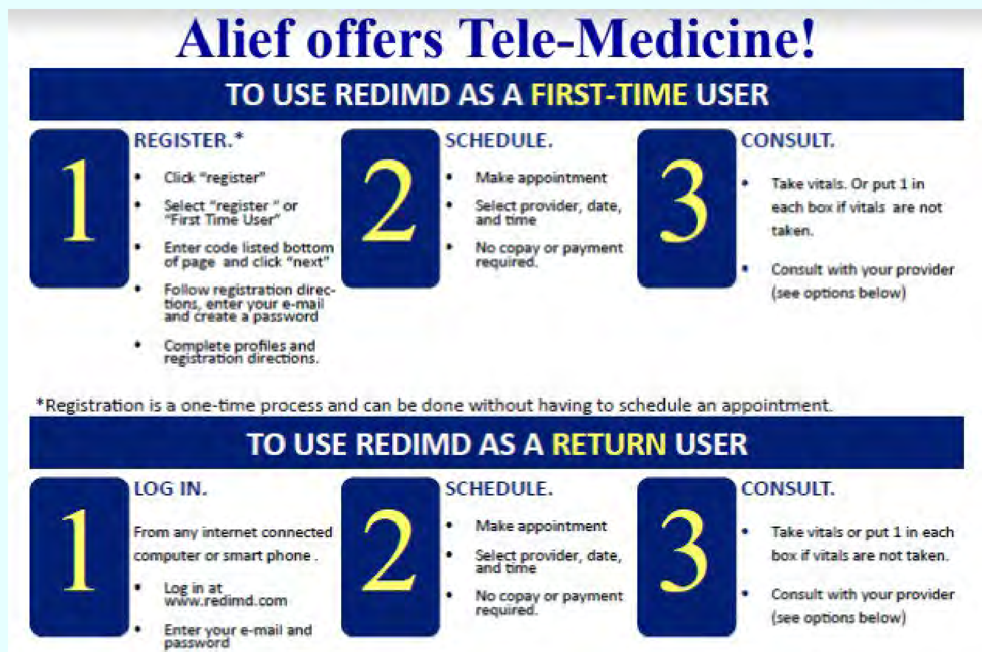
For help, call RediMD at 866-989-CURE, option 3

Code to register = aliefisd

Out-of Network Services for College Students

If you have a student currently out of the current network in college, here are some options to utilize while on our insurance plans.

RediMD - registration code "aliefisd" $0 copay



Alief ISD Employee Health & Wellness Center Clinic

Virtual visits are available, $0 copay for employees and dependents on the plan.

Alief ISD Employee Health & Wellness Center

Primary Care

12000 Richmond Ave, Suite 220, Houston, TX 77082

2.04 miles Get Directions

(713) 814-2720 | (713) 814-2725 Fax

Mon	8:00 AM - 5:00 PM
Tue	8:00 AM - 6:00 PM
Wed	8:00 AM - 5:00 PM
Thu	8:00 AM - 6:00 PM
Fri	8:00 AM - 5:00 PM
Sat	8:00 AM - 1:00 PM

Question call ext. 29150 or benefits@aliefisd.net

403(b) Retirement Plans

TCG | www.tcgservices.com | 800-943-9179

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

How a 403(b) Works

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

Benefits

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

Contribution Limits
2024
$23,000
Participants aged 50 and older at any time during the calendar year are permitted to contribute an additional $7,500.

All investing involves risk. Past performance is not a guarantee of future returns.

457(b) Retirement Plans

Retirement Manager | www.myretirementmanager.com | 866-294-7950

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

Benefits

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

Contribution Limits
2024
$23,000
Participants aged 50 and older at any time during the calendar year are permitted to contribute an additional $7,500.

All investing involves risk. Past performance is not a guarantee of future returns.

Contact Information

Product	Carrier	Website	Phone
Medical	BCBSTX	www.bcbstx.com	888-697-0683
Dental	Cigna	www.mycigna.com	800-244-6224
Vision	VSP	www.vsp.com	800-877-7195
Employee Assistance	ComPsych	www.compsych.com	800-557-1005
Accident	AETNA	www.aetna.com	800-872-3862
Cancer	American Fidelity	www.americanfidelity.com	800-654-8489
Cobra	Inspira Financial	www.inspirafinancial.com	888-678-7835
Critical Illness	MetLife	www.metlife.com	800-438-6388
Disability	The Standard	www.standard.com	800-368-1135
FSA	FFGA	www.ffga.com	866-853-3539
GAP	American Fidelity	www.americanfidelity.com	800-654-8489
Identity Theft	iLock360	www.ilock360.com	855-287-8888
Legal	MetLaw	www.legalplans.com	800-821-6400
Life Insurance	Lincoln Financial	www.lincolnfinancial.com	877-275-5462
Medicare	FFMS	www.ffga.com/medicare-solutions.com	800-523-8422
Permanent Life Insurance	Texas Life	www.texaslife.com	800-283-9233

Contact Information

Product	Carrier	Website	Phone
Prescription Drug Card	CLEVER RX	partner.cleverrx/ffga.com	800-873-1195
Telehealth	RediMD	www.redimd.com	866-989-2873, option 3
403(b)	TCG	www.tcgservices.com	800-943-9179
457(b)	Retirment Manager	www.myretirementmanager.com	866-294-7950