Guardian®

**ARANSAS PASS INDEPENDENT SCHOOL DISTRICT**
ALL ELIGIBLE EMPLOYEES
Group Number: 00561972

**Customer Service (888) 600-1600**
Monday to Friday | 8am to 8:30pm ET

# Welcome to
# Workplace benefits

## Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

## Your coverage options

| | |
|---|---|
| **Cancer insurance** | Financial support after a cancer diagnosis |

## Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.



This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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**Watch our video**
How cancer insurance can ease the financial burden of a cancer diagnosis.

# Cancer insurance

If you're diagnosed with cancer, the last thing you need to think about is the cost. Cancer insurance helps ease the financial burden.

Every year, more and more people are diagnosed with cancer. Unfortunately, in addition to bearing the physical and emotional toll of this disease, patients are often saddled with added financial expenses.

## Who is it for?

Cancer insurance is for people who want added financial protection, in addition to their regular health insurance. It comes into play if you are diagnosed with cancer—providing additional financial support to help keep the focus on your cancer treatment and recovery.

## What does it cover?

Cancer insurance benefits can help you handle medical plan deductibles, co-pays and other out-of-pocket costs by providing benefits when you receive radiation or chemotherapy treatment, or are hospitalized for surgery to treat cancer. These benefits can be used for non-medical expenses such as transportation to treatment facilities, and even everyday living expenses like groceries, rent, and mortgage payments.

## Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. The unexpected out-of-pocket expenses of cancer recovery, including transportation, co-pays, and deductibles, can add up fast. What's more, some of the costs you may incur during recovery are non-medical, such as covering a mortgage, childcare, and household expenses. Cancer insurance can help you pay for all of them.

Plus, cancer insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

## Extra support

Sarah's diagnosed with kidney cancer after a screening test and decides to undergo kidney removal surgery.

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Average surgical expense: **$25,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Sarah's still responsible for 20%: **$4,700**

Total out-of-pocket amount for Sarah (deductible + coinsurance): **$6,200**

Sarah has Guardian's Cancer Advantage policy, which pays her **$2,500** as an initial diagnosis benefit and **$2,100** for a 7-day hospital stay.

This gives her a total of **$4,600** to help cover a portion of her out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

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# Your cancer coverage

| | CANCER | |
|---|---|---|
| **COVERAGE - DETAILS** | **Option 1: Advantage Plan** | **Option 2: Premier Plan** |
| **INITIAL DIAGNOSIS BENEFIT -** Paid when you are diagnosed with internal invasive cancer for the first time while insured under this Plan. | | |
| **Benefit Amount(s)** | Employee $2,500<br>Spouse $2,500<br>Child $2,500 | Employee $5,000<br>Spouse $5,000<br>Child $5,000 |
| **Benefit Waiting Period -** A specified period of time after your effective date during which the Initial Diagnosis benefits will not be payable. | 30 Days | 30 Days |
| **CANCER SCREENING** | | |
| **Benefit Amount** | $50; $50 for Follow-Up screening | $100; $100 for Follow-Up screening |
| **RADIATION THERAPY OR CHEMOTHERAPY** | | |
| **Benefit** | Schedule amounts up to a $10,000 benefit year maximum. | Schedule amounts up to a $15,000 benefit year maximum. |
| **Pre-Existing Conditions Limitation:** A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. | 3 months prior/ 6 months treatment free/ 12 months after. | 3 months prior/ 6 months treatment free/ 12 months after. |
| **Portability:** Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70. | Included | Included |
| **Child(ren) Age Limits** | Children age birth to 26 years | Children age birth to 26 years |

| **FEATURES** | | |
|---|---|---|
| Air Ambulance | $1,500/trip, limit 2 trips per hospital confinement | $2,000/trip, limit 2 trips per hospital confinement |
| Alternative Care | No Benefit | $50/visit up to 20 visits |
| Ambulance | $200/trip, limit 2 trips per hospital confinement | $250/trip, limit 2 trips per hospital confinement |
| Anesthesia | 25% of surgery benefit | 25% of surgery benefit |
| Anti-Nausea | $50/day up to $150 per month | $50/day up to $250 per month |
| Attending Physician | $25/day while hospital confined. Limit 75 visits. | $25/day while hospital confined. Limit 75 visits. |
| Blood/Plasma/Platelets | $100/day up to $5,000 per year | $200/day up to $10,000 per year |
| Bone Marrow/Stem Cell | Bone Marrow: $7,500<br>Stem Cell: $1,500<br>50% benefit for 2nd transplant.<br>$1,000 benefit if a donor | Bone Marrow: $10,000<br>Stem Cell: $2,500<br>50% benefit for 2nd transplant.<br>$1,500 benefit if a donor |
| Experimental Treatment | $100/day up to $1,000/month | $200/day up to $2,400/month |
| Extended Care Facility/Skilled Nursing care | $100/day up to 90 days per year | $150/day up to 90 days per year |
| Government or Charity Hospital | $300 per day in lieu of all other benefits | $400 per day in lieu of all other benefits |

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# Your cancer coverage

| FEATURES (Cont.) | Option 1: Advantage Plan | Option 2: Premier Plan |
|---|---|---|
| Home Health Care | $50/visit up to 30 visits per year | $100/visit up to 30 visits per year |
| Hormone Therapy | $25/treatment up to 12 treatments per year | $50/treatment up to 12 treatments per year |
| Hospice | $50/day up to 100 days/lifetime | $100/day up to 100 days/lifetime |
| Hospital Confinement | $300/day for first 30 days; $600/day for 31st day thereafter per confinement | $400/day for first 30 days; $800/day for 31st day thereafter per confinement |
| ICU Confinement | $400/day for first 30 days; $600/day for 31st day thereafter per confinement | $600/day for first 30 days; $800/day for 31st day thereafter per confinement |
| Immunotherapy | $500 per month, $2,500 lifetime max | $500 per month, $2500 lifetime max |
| Inpatient Special Nursing | $100/day up to 30 days per year | $150/day up to 30 days per year |
| Medical Imaging | $100/image up to 2 per year | $200/image up to 2 per year |
| Outpatient and family member lodging - Lodging must be more than 50 miles from your home. | $75/day, up to 90 days per year | $100/day, up to 90 days per year |
| Outpatient or Ambulatory Surgical Center | $250/day, 3 days per procedure | $350/day, 3 days per procedure |
| Physical or Speech Therapy | $25/visit up to 4 visits per month, $400 lifetime max | $50/visit up to 4 visits per month, $1,000 lifetime max |
| Prosthetic | Surgically Implanted: $2,000/device, $4,000 lifetime max<br>Non-Surgically: $200/device, $400 lifetime max | Surgically Implanted: $3,000/device, $6,000 lifetime max<br>Non-Surgically: $300/device, $600 lifetime max |
| Reconstructive Surgery | Breast TRAM Flap $2,000<br>Breast reconstruction $500<br>Breast Symmetry $250<br>Facial reconstruction $500 | Breast TRAM $3,000<br>Breast reconstruction $700<br>Breast Symmetry $350<br>Facial reconstruction $700 |
| Reproductive Benefit | No Benefit | $1,500 egg harvesting, $500 egg or sperm storage, $2,000 lifetime max |
| Second Surgical Opinion | $200/surgery procedure | $300/surgery procedure |
| Skin Cancer | Biopsy Only: $100<br>Reconstructive Surgery: $250<br>Excision of a skin cancer: $375<br>Excision of a skin cancer with flap or graft: $600 | Biopsy Only: $100<br>Reconstructive Surgery: $250<br>Excision of a skin cancer: $375<br>Excision of a skin cancer with flap or graft: $600 |
| Surgical Benefit | Schedule amount up to $4,125 | Schedule amount up to $5,500 |
| Transportation/Companion Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive treatment for internal cancer. | $0.50/mile up to $1,000 per round trip/equal benefit for companion | $0.50/mile up to $1,500 per round trip/equal benefit for companion |
| Waiver of Premium - If you become disabled due to cancer that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled. | Included | Included |

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# Your cancer coverage

## UNDERSTANDING YOUR BENEFITS :

- **Alternative Care** – Benefit is paid for palliative care (bio-feedback or hypnosis) or lifestyle benefits such as visits to an accredited practitioner for smoking cessation, yoga, meditation, relaxation techniques and nutritional counseling.
- **Cancer** – Cancer means you have been diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. Cancer includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodyplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered cancer. Cancer must be diagnosed while insured under the Guardian cancer plan.
- **Experimental Treatment** – Benefits will be paid for experimental treatment prescribed by a doctor for the purpose of destroying or changing abnormal tissue. All treatment must be NCI listed as viable experimental treatment for Internal Cancer.

## LIMITATIONS AND EXCLUSIONS:

### A SUMMARY OF CANCER LIMITATIONS AND EXCLUSIONS:

Conditional Issue underwriting is required on those enrolling outside of the initial enrollment period or annual open enrollment period.

This plan will not pay benefits for: Services or treatment not included in the Features. Services or treatment provided by a family member. Services or treatment rendered for hospital confinement outside the United States. Any cancer diagnosed solely outside of the United States. Services or treatment provided primarily for cosmetic purposes. Services or treatment for premalignant conditions. Services or treatment for conditions with malignant potential. Services or treatment for non-cancer sicknesses.

Cancer caused by, contributed to by, or resulting from: participating in a felony, riot or insurrection; intentionally causing a self-inflicted injury; committing or attempting to commit suicide while sane or insane; a covered person's mental or emotional disorder, alcoholism or drug addiction; engaging in any illegal activity; or serving in the armed forces or any auxiliary unit of the armed forces of any country.

*If Cancer insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.*

Contract # GP-1-CAN-IC-12

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# Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

## Important information

### Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

### No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

**Please print clearly and mark carefully.**

| Employer/Planholder Name: ARANSAS PASS INDEPENDENT SCHOOL DISTRICT | Group Plan Number: 00561972 | Benefits Effective:_____ |
|---|---|---|

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer/Planholder)

| **About You:** | Employer/Planholder Provided Identification: | Social Security Number | |
|---|---|---|---|
| Full Legal Name-First, MI, Last Name:<br>What is the name you go by? (optional) | _____ | ___ ___ ___ - ___ ___ - ___ ___ ___ ___<br>Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage. | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

Gender Identity: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home ( ____ ) ____ - ____
❑ Work ( ____ ) ____ - ____
❑ Mobile ( ____ ) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Date a child is subject to a legal suit of adoption: ____-____-_____

**About Your Job:** Job Title:

| Work Status:<br>❑ Active ❑ Retired ❑ COBRA/State Continuation<br>Hours worked per week: _____ | Date of full time hire: _____ - _____ - _____ | Annual Salary: $_____ |
|---|---|---|

**About Your Family:** Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

| Spouse<br>Address/City/State/Zip:<br>Phone: ( ) - | Gender Identity:<br>❑ M ❑ F | Social Security Number<br>_____ - _____ - _____<br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | |
|---|---|---|---|



DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
*DATE FORM PUBLISHED: Jun 13, 2025*

| | | | | |
|---|---|---|---|---|
| Child/Dependent 1:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | ❑ Add ❑ Drop | Gender Identity:<br>❑ M ❑ F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check as applicable)<br>❑ Student (post high school) ❑ Disabled<br>❑ Non standard dependent |
| Child/Dependent 2:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | ❑ Add ❑ Drop | Gender Identity:<br>❑ M ❑ F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check as applicable)<br>❑ Student (post high school) ❑ Disabled<br>❑ Non standard dependent |
| Child/Dependent 3:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | ❑ Add ❑ Drop | Gender Identity:<br>❑ M ❑ F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check as applicable)<br>❑ Student (post high school) ❑ Disabled<br>❑ Non standard dependent |
| Child/Dependent 4:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | ❑ Add ❑ Drop | Gender Identity:<br>❑ M ❑ F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check as applicable)<br>❑ Student (post high school) ❑ Disabled<br>❑ Non standard dependent |

## Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

## Coverage Being Dropped:

❑ Basic Term Life

❑ Voluntary Term Life

❑ Cancer ❑ Employee/Member ❑ Spouse ❑ Child(ren)

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

## Cancer Coverage

**You must be enrolled to cover your dependents. Check only one box.**

| Your Semi-monthly premium | Employee/Member Only | Employee/Member & Spouse | Employee/Member & Dependent/Child(ren) | Employee/Member, Spouse & Dependent/Child(ren) |
|---|---|---|---|---|
| Option 1: Advantage Plan | ❑ | ❑ | ❑ | ❑ |
| Option 2: Premier Plan | ❑ | ❑ | ❑ | ❑ |

❑ I do not want this coverage.

## Signature

- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.

Guardian Group Plan Number: 00561972 Please print employee name:

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____

## Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER