Rapoport Academy 2024-2025

BENEFITS GUIDE

SCAN ME

https://ffbenefits.ffga.com/rapoportacademy

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Rapoport Academy Benefits Office
www.rapoportacademy.org
254-754-8000

Contents

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!

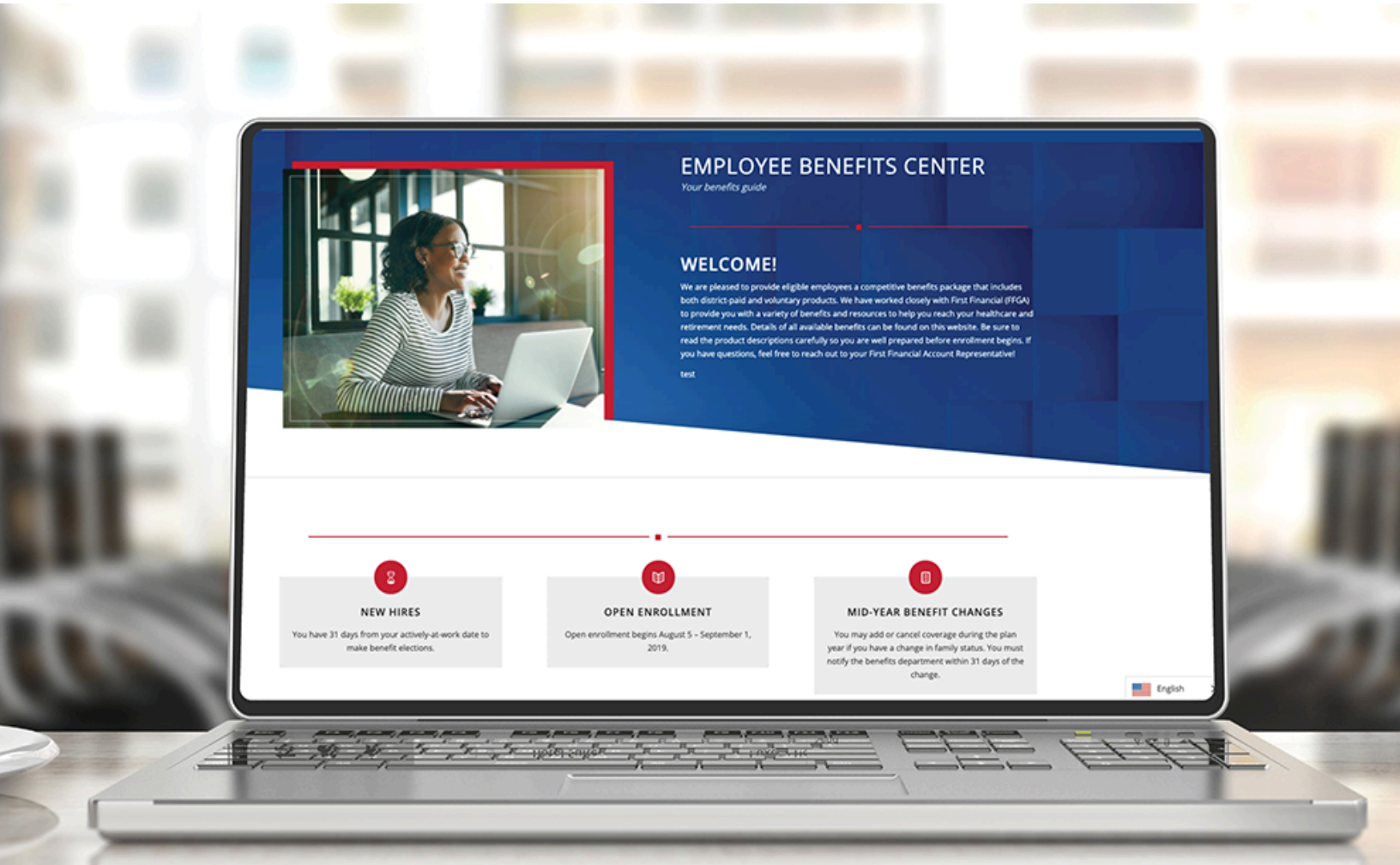
Rapoport Academy and FFGA are excited to provide you with a custom website filled with information about your benefits. Visit the Employee Benefits Center to see current benefit options for your employer as well as find claim forms, important phone numbers and enrollment information.

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 ME!

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

https://ffbenefits.ffga.com/rapoportacademy



How to Enroll

Benefits Enrollment

Online Enrollment

To begin online enrollment, visit https://ffga.benselect.com/Enroll/login.aspx.

Enroll Now

Login

- Login: Your Employee ID or Social Security Number (no dashes)
- PIN (first login only): The last four digits of your Social Security Number and the last two digits of the year you were born (six digits total)
- New PIN: The first time you log in you will be required to change to a new PIN. Please note your new PIN because you will use the new PIN from that point forward.

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

TRS-ActiveCare

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

Blue Cross Blue Shield of Texas | https://www.bcbstx.com/trsactivecare/ | 1.866.355.5999

TRS-ActiveCare Primary

- Copays for doctor visits and generic prescriptions before you meet deductible
- Statewide Network
- Participants must select a primary care provider who will make referrals to specialists
- No out-of-network coverage
- Employee will receive two (2) ID cards (BCBS & Express Scripts)

TRS-ActiveCare HD

- Must meet deductible before plan pays for non-preventive care
- In-network and out-of-network benefits – separate out-of-network deductible/out-of-pocket maximum Nationwide network
- Deductible applies to medical and pharmacy
- No requirement for PCP or referrals
- Compatible with health savings account (HSA)
- Employee will receive two (2) ID cards (BCBS & Express Scripts)

TRS-ActiveCare Primary +

- Copays for many services and drugs
- Statewide Network
- Participants must select a primary care provider who will make referrals to specialists
- No out-of-network coverage
- Employee will receive 2 ID cards (BCBS & Express Scripts)

TRS-ActiveCare 2 - Closed to New Enrollees

- Copays for many drugs and services
- Nationwide network with out-of-network coverage
- Employee will receive two (2) ID cards (BCBS & Express Scripts)

TRS-ActiveCare Plan Prescription Benefits

Express Scripts | https://info.express-scripts.com/trsactivecare | 1.844.367.6108
When you enroll in a BCBSTX Plan, you automatically receive prescription drug coverage through Express Scripts which gives you access to a large, national network of retail pharmacies.

TRS ActiveCare Medical Premiums

Medical Semi-Monthly Premiums				
	Primary	Primary+	HD	AC2
Employee Only	$146.00	$223.00	$159.00	$713.00
Employee + Spouse	$905.00	$1060	$940.00	$2102.00
Employee + Children	$459.00	$590.00	$481.00	$1207
Employee + Family	$1217.00	$1426.00	$1261.00	$2541

Semi-Monthly Premiums shown above include the Employer contribution of $300.00

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

2024-25 TRS-ActiveCare Plan Highlights Sept. 1, 2024 – Aug. 31, 2025

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your Employer Contribution
= Your Premium

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

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

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

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

Primary Plans & Mental Health

- Both Primary and Primary+ offer $0 virtual mental health visits with any in-network provider.

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

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

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
Employee Only	$446	$300.00	$146.00	$523	$300.00	$223.00	$459	$300.00	$159.00
Employee and Spouse	$1,205	$300.00	$905.00	$1,360	$300.00	$1060.00	$1,240	$300.00	$940.00
Employee and Children	$759	$300.00	$459.00	$890	$300.00	$590.00	$781	$300.00	$481.00
Employee and Family	$1,517	$300.00	$1217.00	$1,726	$300.00	$1426.00	$1,561	$300.00	$1261.00

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network Coverage Only	In-Network	Out-of-Network
Individual/Family Deductible	$2,500/$5,000	$1,200/$2,400	$3,200/$6,400	$6,400/$12,800
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
Individual/Family Maximum Out of Pocket	$8,050/$16,100	$6,900/$13,800	$8,050/$16,100	$20,250/$40,500
Network	Statewide Network	Statewide Network	Nationwide Network	
PCP Required	Yes	Yes	No	

Doctor Visits				
Primary Care	$30 copay	$15 copay	You pay 30% after deductible	You pay 50% after deductible
Specialist	$70 copay	$70 copay	You pay 30% after deductible	You pay 50% after deductible

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

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

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

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

Total Premium	Employer Contribution	Your Premium
$1,013	$300.00	$713.00
$2,402	$300.00	$2102.00
$1,507	$300.00	$1207.00
$2,841	$300.00	$2541.00

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

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

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

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

Compare Prices for Common Medical Services

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

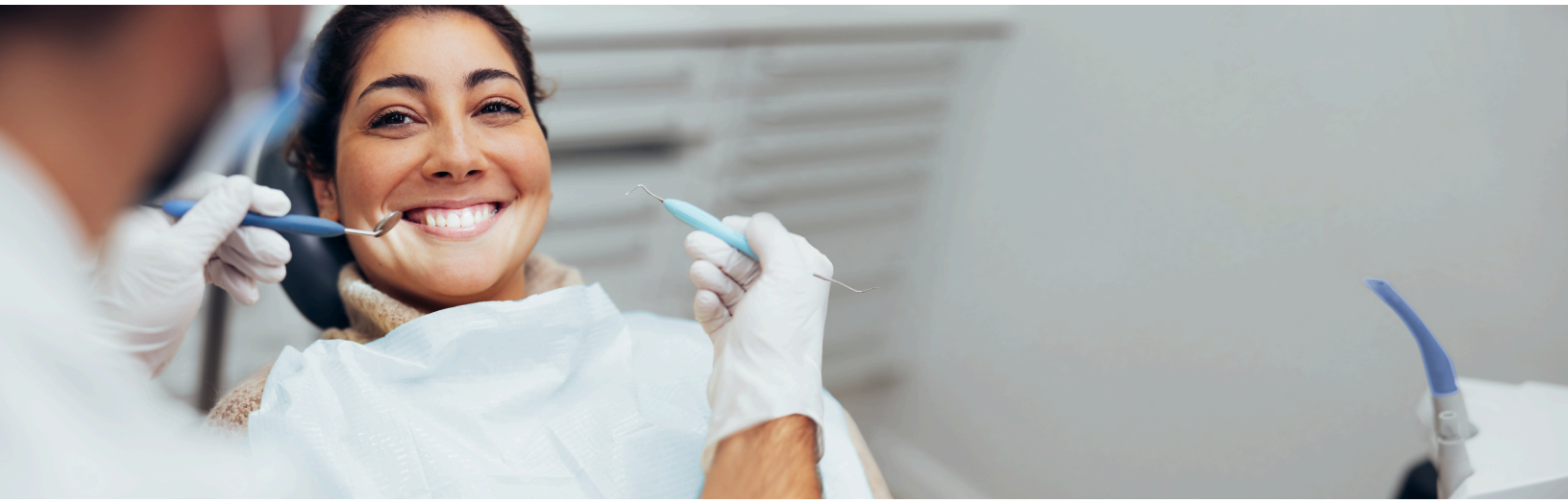
Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs**	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay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

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

www.trs.texas.gov

Revised 04/30/24

Dental Insurance



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 Monthly Premiums	
Employee Only	$33.32
Employee + Spouse	$63.96
Employee + Children	$79.80
Employee + Family	$122.04

Cigna Dental Benefit Summary
ESC Region 12 Cooperative
Plan Effective Date: 09/01/2023

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental Choice Plan				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Policy Year Benefits Maximum Applies to: Class I, II & III expenses	$1,250		$1,250	
Policy Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations; Prophylaxis: routine cleanings; X-rays: routine; X-rays: non-routine; Fluoride Application; Sealants: per tooth; Space Maintainers: non-orthodontic; Emergency Care to Relieve Pain (Note: This service is administrated at the in network coinsurance level.)	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings (Includes composite (white/tooth-colored) fillings on molars.); Endodontics: minor and major; Periodontics: minor and major; Oral Surgery: minor and major; Anesthesia: general and IV sedation; Repairs: bridges, crowns and inlays; Repairs: dentures; Denture Relines, Rebases and Adjustments	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays; Prosthesis Over Implant; Crowns: prefabricated stainless steel / resin; Crowns: permanent cast and porcelain; Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19; Lifetime Benefits Maximum: $1,000	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider allowed amounts in the geographic area The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Policy Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Policy Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.

Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IV services for12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to composite (white/tooth-colored) fillings on molars.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per policy year.
X-rays (routine)	Bitewings: 2 per policy year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per policy year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per policy year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Adjustments, Rebases and Relines	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit Exclusions:

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

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontics: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

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

Vision Insurance

Superior Vision | www.supervision.com | 800-507-3800

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 Monthly Premium	
Employee Only	$5.27
Employee + Family	$13.43

SuperiorVision®

Vision plan benefits for ESC Region 12

Copays	
Exam[1]	$10
Eyewear[2]	$25

Monthly premiums	
Emp. only	$5.27
Emp. + family	$13.43

Services/frequency	
Exam	12 months
Frame	12 months
Lenses	12 months
Contact lenses	12 months

(Based on date of service)

Benefits through Superior Select Southwest network

	In-network	Out-of-network
Exam	Covered in full	Up to $35 retail
Frames	$130 retail allowance	Up to $70 retail
Lenses (standard) per pair		
Single vision	Covered in full	Up to $25 retail
Bifocal	Covered in full	Up to $40 retail
Trifocal	Covered in full	Up to $45 retail
Progressive	See description[3]	Up to $45 retail
Contact lenses[4]	$130 retail allowance	Up to $80 retail
Medically necessary contact lenses	Covered in full	Up to $150 retail
LASIK vision correction[5]	$200 allowance	

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] Eye exam copay is a single payment due to the provider at the time of service

[2] Eyewear copay applies to eyeglass lenses / frame and contact lenses. Eyewear copay is a single payment that applies to the entire purchase of eyeglasses (frame and lenses)

[3] Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

[4] Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

[5] Lasik Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations

Discount features

superiorvision.com

(800) 507-3800

Discounts on covered materials[6]

These discounts apply to the glasses and contacts that are covered under the vision benefits.

Frames:	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contact	10% off amount over allowance

Lens type*	Member out-of-pocket[6]
Scratch coat	$15
Ultraviolet coat	$12
Tints, solid	$15
Tints, gradient	$18
Polycarbonate	$40
Blue light filtering	$15
Digital single vision	$30
Progressive lenses	
Standard/Premium/Ultra/Ultimate	$55 / $110 / $150 / $225
Anti-reflective coating	
Standard/Premium/Ultra/Ultimate	$50 / $70 / $85 / $120
Polarized lenses	$75
Plastic photochromic lenses	$80
High Index (1.67 / 1.74)	$80 / $120

* The above table highlights some of the most popular lens type and is not a complete listing. This table outlines member out-of-pocket costs[5] and are not available for premium/upgraded options unless otherwise noted.

Discounts on non-covered exam, services and materials[6]

Exams, frames, and prescription lenses:	30% off retail
Contacts, miscellaneous options:	20% off retail
Disposable contact lenses:	10% off retail
Retinal imaging:	$39 maximum out-of-pocket

Laser vision correction (LASIK)[6]

Laser vision correction (LASIK) is a procedure that can reduce or eliminate your dependency on glasses or contact lenses. This corrective service is available to you and your eligible dependents at a special discount (20-50%) with your Superior Vision plan. Contact QualSight LASIK at (877) 201-3602 for more information.

Hearing discounts[6]

A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Superior Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

[6]Not all providers participate in Superior Vision Discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all Superior Vision providers/all locations.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

Flexible Spending Accounts

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

Medical FSA

FSA 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.

Health Savings Account

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

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

Health Savings Account Highlights

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

Who Can Participate in an HSA?

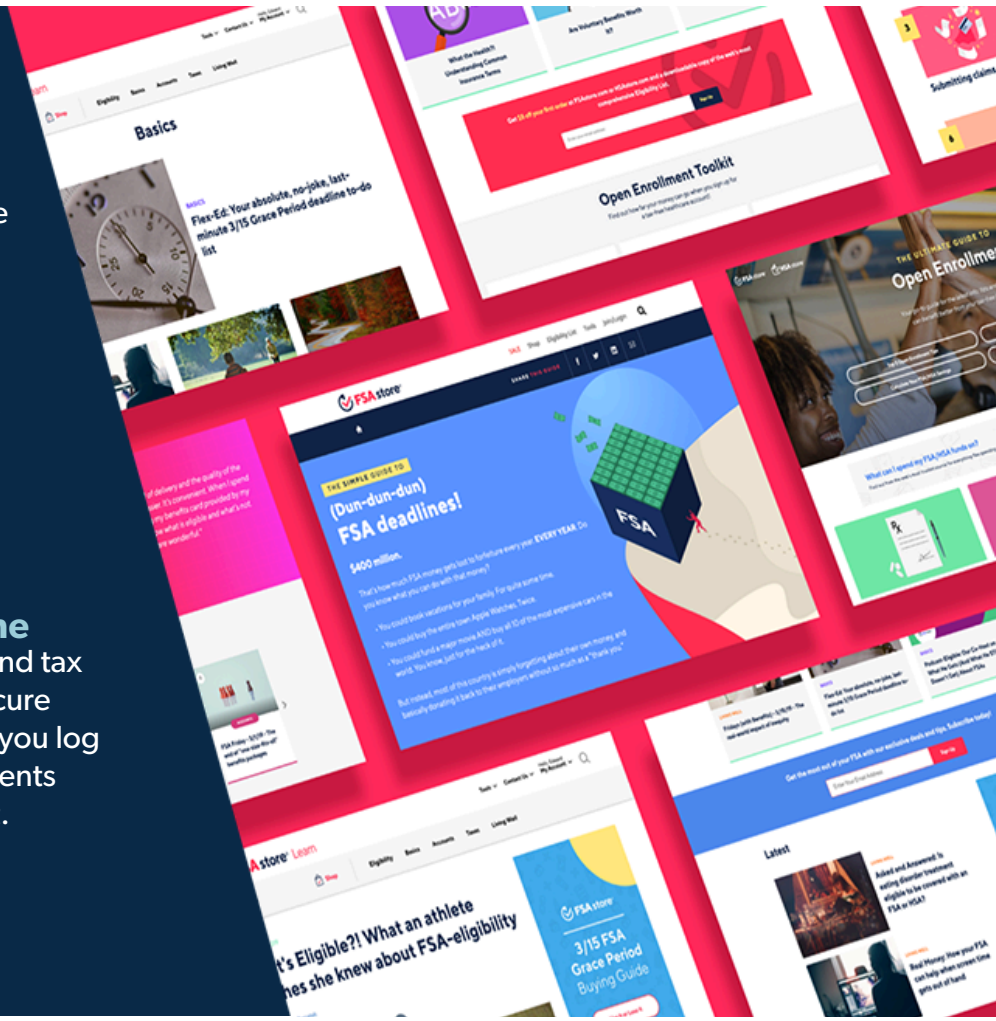
- You must be enrolled in a qualified High Deductible Health Plan (HDHP).
- You cannot be enrolled in Tricare or Medicare or covered under your spouse's traditional (non-HDHP) health care plan.
- You cannot participate in a general purpose Flexible Spending Account (FSA) or Health Reimbursement Arrangement.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

	2024	2025
HSA Contribution Limits	• Self: $4,150 • Family: $8,300	• Self Only: $4,300 • Family: $8,550
Health Insurance Deductible Limits	• Self Only: $1,600 • Family: $3,200	• Self Only: $1,650 • Family: $3,300
$1,000 catch-up contributions (age 55 or older)		

FSA & HSA Resources

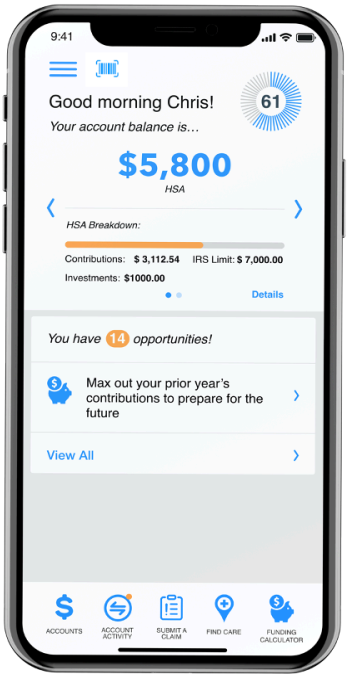
Benefits Card

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



View Your Account Details Online

Sign up to view your account balance, find tax 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/HSA Store

FFGA has partnered with the FSA Store and HSA Store to bring you easy-to-use online stores 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 stores at http://www.ffga.com/individuals/#stores for more details and special deals.

FSA store®
Everything Flex Spending.

HSA store®
Health Saving, Simplified.

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.

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) $10,000	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
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

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

Indicates Spouse Coverage Available

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

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

TEXASLIFE INSURANCE COMPANY

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) $10,000	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
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

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

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

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

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

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

CHILDREN AND GRANDCHILDREN (TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

Issue Age	Premium $25,000	Premium $50,000	Guaranteed Period
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

Disability Insurance

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 you are unable to work due to those reasons. You can choose the benefit amount, which is the amount of your income to replace, and the waiting period that you begin receiving payments.

How do you decide if you need disability insurance? Consider these questions when making your decision:

- How much employer leave do you have?
- Do you have savings?
- Do you have other income you can rely on, such as from your spouse or from child support?
- How close are you to retirement?
- Could you go on Social Security Disability or take a Disability Retirement?
- What are your other sources of income?

Standard Insurance Company
Educator Options Voluntary Long Term Disability Coverage Highlights
ESC Region 12

Voluntary Long Term Disability (LTD) Insurance

Long Term Disability insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need. Standard Insurance Company (The Standard) has developed this document to provide you with information about the optional coverage you may select through ESC Region 12.

Eligibility Requirements

Policy #762505

Employee	• A regular employee of ESC Region 12 • Actively working at least 20 hours each week • A citizen or resident of the United States or Canada • Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible
Premium	• You pay 100 percent of the premium for this coverage through easy payroll deduction

Benefit Amount

Benefit Amount	You may select a monthly benefit amount in $100 increments, based on the tables and guidelines presented in the Rates section of these Coverage Highlights. The monthly benefit amount must not exceed 66 2/3 percent of your monthly predisability earnings. The minimum monthly amount you may elect is $200.
Plan Maximum Monthly Benefit	The lesser of $8,000 or 66 2/3 percent of your predisability earnings
Plan Minimum Monthly Benefit	25 percent of your LTD benefit before reduction by deductible income

Note:

- If you do not apply for this coverage within 31 days after becoming eligible, and later decide to do so, you must wait until your employer holds an annual enrollment.

Disability Needs Calculator

Your family has a unique set of circumstances and financial demands. To help you figure out the amount of Disability insurance you may need if you become unable to work, The Standard has created a Disability Needs Calculator found at: http://www.standard.com/calculators/dineeds.html

Employee Coverage Effective Date

To become insured, you must satisfy the eligibility requirements listed above, serve an eligibility waiting period, receive medical underwriting approval (if applicable), and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance. If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative for more information regarding the requirements that must be satisfied for your insurance to become effective.

Understanding Your Plan Design

Benefit Waiting Period

The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. Benefits are not payable during the benefit waiting period. The benefit waiting period options associated with your plan include:

Accidental Injury	Other Disabilities
0 days	7 days
14 days	14 days
30 days	30 days
60 days	60 days
90 days	90 days
180 days	180 days

Own Occupation Definition of Disability

For the benefit waiting period and the first 24 months for which LTD benefits are paid, you are considered disabled when you are unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of your own occupation **AND** are suffering a loss of at least 20 percent of your indexed predisability earnings when working in your own occupation. You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Any Occupation Definition of Disability

After the own occupation period of disability, you will be considered disabled if you are unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any occupation.

Deductible Income

Deductible income is income you receive or are eligible to receive while LTD benefits are payable. Deductible income includes, but is not limited to:

- Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts) paid
- Benefits under any workers' compensation law or similar law
- Amounts under unemployment compensation law
- Social Security disability or retirement benefits, including benefits for your spouse and children
- Disability benefits from any other group insurance
- Disability or retirement benefits under your employer's retirement plan
- Benefits under any state disability income benefit law or similar law
- Earnings or compensation included in predisability earnings which you receive or are eligible to receive while LTD benefits are payable
- Earnings from work activity while you are disabled, plus the earnings you could receive if you worked as much as your disability allows
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

Understanding Your Plan Design

Maximum Benefit Period

The maximum period for which benefits are payable is shown in the table below:

If you become disabled before age 62, LTD benefits may continue during disability until you reach age 65. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Benefit Calculation

Example

You select the amount of your LTD benefit when you enroll for coverage in the plan. The dollar amount selected must be a multiple of $100, from a minimum of $200 to a maximum of the lesser of $8,000 or 66 2/3 percent of your predisability earnings. This amount is then reduced by deductible income you receive, or are eligible to receive, while LTD benefits are payable. As an example, if your monthly predisability earnings are $4,500, you may select any dollar amount (in $100 increments) between $200 and $2,700 (66 2/3 percent of predisability earnings). In the example below, assume you elected the maximum benefit amount of $2,700, and you now receive a monthly Social Security disability benefit of $1,200 and a monthly retirement benefit of $900. Your monthly LTD benefit would be calculated as follows:

Insured predisability earnings	$4,500
Maximum benefit percentage	X 66 2/3%
Maximum benefit amount	$3,000
Less Social Security disability benefit	-$1,200
Less retirement benefit	-$900
Amount of LTD benefit	**$900**

Additional Features

Please see your human resources representative for additional information about the features and benefits below.

Rehabilitation Plan	If you are participating in an approved Rehabilitation Plan, The Standard may include payment of some of the expenses you incur in connection with the plan including but not limited to: training and education expenses, family (child and elder) care expenses, job related expenses and job search expenses.
Reasonable Accommodation Expense Benefit	If your employer makes an approved work-site modification that enables you to return to work while disabled, The Standard will reimburse your employer up to a pre-approved amount for some or all of the cost of the modification.
Employee Assistance Program	Includes an Employee Assistance Program and WorkLife Services to offer support, guidance and resources to help you and your household members resolve personal issues.
Survivors Benefit	If you die while LTD benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, a survivors benefit equal to three time your unreduced LTD benefit may be payable (any survivors benefit payable will first be applied to any overpayment of your claim due to The Standard).
First Day Hospital Benefit	If you are hospital confined for at least 4 hours during the benefit waiting period, the following will apply; the remainder of your benefit waiting period will be waived, LTD benefits will become payable on the first day you are hospital confined, and your maximum benefit period will begin on the date your LTD benefits are payable. You are eligible for this benefit only if your elected benefit waiting period is less than 45 days.
Family Care Expense Benefit	Applies when a disabled employee has returned to work and continues to receive LTD benefits. For 12 months, a portion of expenses (up to $250 per dependent or $500 per family, per month) is deducted from the amount of your work earnings.

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- If applicable, with respect to insurance increases, you are not covered for the insurance increase if your disability is caused or contributed by a preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the specified exclusion and limitation period, and you have been actively at work for at least one full day after the end of the specified exclusion and limitation period

Preexisting Condition Provision

Preexisting Condition For the first 90 days of disability, we will pay benefits even if you have a condition subject to the preexisting condition limitation. After 90 days, we will continue benefits only for conditions for which the preexisting condition exclusion or limitation does not apply. Benefit amounts subject to the preexisting condition exclusion will be excluded from payment.

A preexisting condition is a mental or physical condition:

- For which you or a reasonably prudent person would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications
- Which, as a result of any medical examination, including routine examination, was discovered or suspected

Preexisting Condition Period The 90-day period just before your insurance becomes effective or any insurance increases become effective

Specified Exclusion and Limitation Period 12 months

Limitations

LTD benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your indexed predisability earnings, but you elect not to work during the first 24 months after the end of the benefit waiting period the responsibility to work is limited to work in your own occupation; thereafter, the responsibility to work includes work in any occupation

In addition, payment of LTD benefits is limited in duration:

- If you reside outside the United States or Canada
- If applicable, if your disability is caused or contributed by a preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the specified exclusion and limitation period, and you have been actively at work for at least one full day after the end of the specified exclusion and limitation period
- If your disability is caused or contributed to by mental disorders, substance abuse or the environment, chronic fatigue conditions, chronic pain conditions, carpal tunnel or repetitive motion syndrome or temporomandibular joint disorder or craniomandibular joint disorder

When Benefits End

LTD benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date benefits become payable under any other LTD disability insurance plan under which you become insured through employment during a period of temporary recovery
- The date you fail to provide proof of continued disability and entitlement to benefits

When Insurance Ends

Insurance ends automatically on the earliest of the following:

- The last day of the last period for which you make a premium contribution (except if premiums are waived while disabled)
- The date your employment terminates
- The date the group policy terminates
- The date you cease to meet the eligibility requirements (coverage may continue for limited periods under certain circumstances)
- If applicable, the date your employer ceases to participate under the group policy

Group Insurance Certificate

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

Rates

Employees can select a monthly LTD benefit ranging from a minimum of $200 to a maximum amount based on how much they earn. Referencing the appropriate attached charts, follow these steps to find the monthly cost for your desired level of monthly LTD benefit and benefit waiting period:

- Find the maximum LTD benefit by locating the amount of your earnings in either the annual earnings or Monthly Earnings column. The LTD benefit amount shown associated with these earnings is the maximum amount you can receive. If your earnings fall between two amounts, you must select the lower amount.
- Select the desired monthly LTD benefit between the minimum of $200 and the determined maximum amount, making sure not to exceed the maximum for your earnings.
- In the same row, select the desired benefit waiting period to see the monthly cost for that selection.

If you have questions regarding how to determine your monthly LTD benefit, the benefit waiting period, or the premium payment of your desired benefit, please contact your human resources representative.

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Accident/Sickness Benefit Waiting Period Cost Per Month					
			0-7	14-14	30-30	60-60	90-90	180-180
3,600	300	200	6.44	5.46	4.55	2.80	2.07	1.35
5,400	450	300	9.66	8.19	6.83	4.20	3.11	2.02
7,200	600	400	12.88	10.92	9.10	5.60	4.15	2.69
9,000	750	500	16.11	13.65	11.38	7.01	5.19	3.37
10,800	900	600	19.33	16.38	13.65	8.41	6.22	4.04
12,600	1,050	700	22.55	19.11	15.93	9.81	7.26	4.71
14,400	1,200	800	25.77	21.84	18.20	11.21	8.30	5.38
16,200	1,350	900	28.99	24.57	20.48	12.61	9.33	6.06
18,000	1,500	1,000	32.21	27.30	22.75	14.01	10.37	6.73
19,800	1,650	1,100	35.43	30.03	25.03	15.41	11.41	7.40
21,600	1,800	1,200	38.65	32.76	27.30	16.81	12.44	8.08
23,400	1,950	1,300	41.87	35.49	29.58	18.21	13.48	8.75
25,200	2,100	1,400	45.09	38.22	31.85	19.61	14.52	9.42
27,000	2,250	1,500	48.32	40.95	34.13	21.02	15.56	10.10
28,800	2,400	1,600	51.54	43.68	36.40	22.42	16.59	10.77
30,600	2,550	1,700	54.76	46.41	38.68	23.82	17.63	11.44
32,400	2,700	1,800	57.98	49.14	40.95	25.22	18.67	12.11
34,200	2,850	1,900	61.20	51.87	43.23	26.62	19.70	12.79
36,000	3,000	2,000	64.42	54.60	45.50	28.02	20.74	13.46
37,800	3,150	2,100	67.64	57.33	47.78	29.42	21.78	14.13
39,600	3,300	2,200	70.86	60.06	50.05	30.82	22.81	14.81
41,400	3,450	2,300	74.08	62.79	52.33	32.22	23.85	15.48
43,200	3,600	2,400	77.30	65.52	54.60	33.62	24.89	16.15
45,000	3,750	2,500	80.53	68.25	56.88	35.03	25.93	16.83
46,800	3,900	2,600	83.75	70.98	59.15	36.43	26.96	17.50
48,600	4,050	2,700	86.97	73.71	61.43	37.83	28.00	18.17
50,400	4,200	2,800	90.19	76.44	63.70	39.23	29.04	18.84
52,200	4,350	2,900	93.41	79.17	65.98	40.63	30.07	19.52
54,000	4,500	3,000	96.63	81.90	68.25	42.03	31.11	20.19
55,800	4,650	3,100	99.85	84.63	70.53	43.43	32.15	20.86
57,600	4,800	3,200	103.07	87.36	72.80	44.83	33.18	21.54
59,400	4,950	3,300	106.29	90.09	75.08	46.23	34.22	22.21
61,200	5,100	3,400	109.51	92.82	77.35	47.63	35.26	22.88
63,000	5,250	3,500	112.74	95.55	79.63	49.04	36.30	23.56
64,800	5,400	3,600	115.96	98.28	81.90	50.44	37.33	24.23
66,600	5,550	3,700	119.18	101.01	84.18	51.84	38.37	24.90
68,400	5,700	3,800	122.40	103.74	86.45	53.24	39.41	25.57
70,200	5,850	3,900	125.62	106.47	88.73	54.64	40.44	26.25
72,000	6,000	4,000	128.84	109.20	91.00	56.04	41.48	26.92

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Accident/Sickness Benefit Waiting Period Cost Per Month					
			0-7	14-14	30-30	60-60	90-90	180-180
73,800	6,150	4,100	132.06	111.93	93.28	57.44	42.52	27.59
75,600	6,300	4,200	135.28	114.66	95.55	58.84	43.55	28.27
77,400	6,450	4,300	138.50	117.39	97.83	60.24	44.59	28.94
79,200	6,600	4,400	141.72	120.12	100.10	61.64	45.63	29.61
81,000	6,750	4,500	144.95	122.85	102.38	63.05	46.67	30.29
82,800	6,900	4,600	148.17	125.58	104.65	64.45	47.70	30.96
84,600	7,050	4,700	151.39	128.31	106.93	65.85	48.74	31.63
86,400	7,200	4,800	154.61	131.04	109.20	67.25	49.78	32.30
88,200	7,350	4,900	157.83	133.77	111.48	68.65	50.81	32.98
90,000	7,500	5,000	161.05	136.50	113.75	70.05	51.85	33.65
91,800	7,650	5,100	164.27	139.23	116.03	71.45	52.89	34.32
93,600	7,800	5,200	167.49	141.96	118.30	72.85	53.92	35.00
95,400	7,950	5,300	170.71	144.69	120.58	74.25	54.96	35.67
97,200	8,100	5,400	173.93	147.42	122.85	75.65	56.00	36.34
99,000	8,250	5,500	177.16	150.15	125.13	77.06	57.04	37.02
100,800	8,400	5,600	180.38	152.88	127.40	78.46	58.07	37.69
102,600	8,550	5,700	183.60	155.61	129.68	79.86	59.11	38.36
104,400	8,700	5,800	186.82	158.34	131.95	81.26	60.15	39.03
106,200	8,850	5,900	190.04	161.07	134.23	82.66	61.18	39.71
108,000	9,000	6,000	193.26	163.80	136.50	84.06	62.22	40.38
109,800	9,150	6,100	196.48	166.53	138.78	85.46	63.26	41.05
111,600	9,300	6,200	199.70	169.26	141.05	86.86	64.29	41.73
113,400	9,450	6,300	202.92	171.99	143.33	88.26	65.33	42.40
115,200	9,600	6,400	206.14	174.72	145.60	89.66	66.37	43.07
117,000	9,750	6,500	209.37	177.45	147.88	91.07	67.41	43.75
118,800	9,900	6,600	212.59	180.18	150.15	92.47	68.44	44.42
120,600	10,050	6,700	215.81	182.91	152.43	93.87	69.48	45.09
122,400	10,200	6,800	219.03	185.64	154.70	95.27	70.52	45.76
124,200	10,350	6,900	222.25	188.37	156.98	96.67	71.55	46.44
126,000	10,500	7,000	225.47	191.10	159.25	98.07	72.59	47.11
127,800	10,650	7,100	228.69	193.83	161.53	99.47	73.63	47.78
129,600	10,800	7,200	231.91	196.56	163.80	100.87	74.66	48.46
131,400	10,950	7,300	235.13	199.29	166.08	102.27	75.70	49.13
133,200	11,100	7,400	238.35	202.02	168.35	103.67	76.74	49.80
135,000	11,250	7,500	241.58	204.75	170.63	105.08	77.78	50.48
136,800	11,400	7,600	244.80	207.48	172.90	106.48	78.81	51.15
138,600	11,550	7,700	248.02	210.21	175.18	107.88	79.85	51.82
140,400	11,700	7,800	251.24	212.94	177.45	109.28	80.89	52.49
142,200	11,850	7,900	254.46	215.67	179.73	110.68	81.92	53.17
144,000	12,000	8,000	257.68	218.40	182.00	112.08	82.96	53.84

Cancer Insurance

Guardian | www.guardiananytime.com | 800-541-7846

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	**Plan 1**	**Plan 2**
Employee	$22.51	$29.28
Employee + Spouse	$35.95	$48.66
Employee + Children	$23.97	$31.18
Employee + Family	$37.41	$50.56

Guardian®

Your cancer coverage

	CANCER	
COVERAGE - DETAILS	**Option 1**	**Option 2**
Your Monthly premium	$22.51	$29.28
You and Spouse	$35.95	$48.66
You and Child(ren)	$23.97	$31.18
You, Spouse and Child(ren)	$37.41	$50.56
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 Spouse $2,500 Child $2,500	Employee $5,000 Spouse $5,000 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	$100; $100 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 $10,000 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	$2,000/trip, limit 2 trips per hospital confinement	$2,000/trip, limit 2 trips per hospital confinement
Alternative Care	$50/visit up to 20 visits	$50/visit up to 20 visits
Ambulance	$250/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 $250 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	$200/day up to $10,000 per year	$200/day up to $10,000 per year
Bone Marrow/Stem Cell	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant. $1,500 benefit if a donor	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant. $1,500 benefit if a donor

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Guardian®

Your cancer coverage

FEATURES (Cont.)	Option 1	Option 2
Experimental Treatment	$200/day up to $2,400/month	$200/day up to $2,400/month
Extended Care Facility/Skilled Nursing care	$150/day up to 90 days per year	$150/day up to 90 days per year
Government or Charity Hospital	$400 per day in lieu of all other benefits	$400 per day in lieu of all other benefits
Home Health Care	$100/visit up to 30 visits per year	$100/visit up to 30 visits per year
Hormone Therapy	$50/treatment up to 12 treatments per year	$50/treatment up to 12 treatments per year
Hospice	$100/day up to 100 days/lifetime	$100/day up to 100 days/lifetime
Hospital Confinement	$400/day for first 30 days; $800/day for 31st day thereafter per confinement	$400/day for first 30 days; $800/day for 31st day thereafter per confinement
ICU Confinement	$600/day for first 30 days; $800/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, $2500 lifetime max	$500 per month, $2500 lifetime max
Inpatient Special Nursing	$150/day up to 30 days per year	$150/day up to 30 days per year
Medical Imaging	$200/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.	$100/day, up to 90 days per year	$100/day, up to 90 days per year
Outpatient or Ambulatory Surgical Center	$350/day, 3 days per procedure	$350/day, 3 days per procedure
Physical or Speech Therapy	$50/visit up to 4 visits per month, $1,000 lifetime max	$50/visit up to 4 visits per month, $1,000 lifetime max
Prosthetic	Surgically Implanted: $3,000/device, $6,000 lifetime max Non-Surgically: $300/device, $600 lifetime max	Surgically Implanted: $3,000/device, $6,000 lifetime max Non-Surgically: $300/device, $600 lifetime max
Reconstructive Surgery	Breast TRAM $3,000 Breast reconstruction $700 Breast Symmetry $350 Facial reconstruction $700	Breast TRAM $3,000 Breast reconstruction $700 Breast Symmetry $350 Facial reconstruction $700
Reproductive Benefit	$1,500 egg harvesting, $500 egg or sperm storage, $2,000 lifetime max	$1,500 egg harvesting, $500 egg or sperm storage, $2,000 lifetime max
Second Surgical Opinion	$300/surgery procedure	$300/surgery procedure
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600
Surgical Benefit	Schedule amount up to $5,500	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 $1,500 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

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Critical Illness Insurance

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

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.

Aetna Critical Illness Plan

Be prepared for what happens next
Critical illness insurance coverage can keep you focused on your health when it matters most. This extra coverage can help ease some financial worries during a difficult time.

What is the Critical Illness Plan?
The Aetna Critical Illness Plan pays benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more*. You can use the benefits to help pay out-of-pocket medical costs or towards 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 can come with a serious illness.

The Aetna Critical Illness 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 paying for:

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

...or for 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 diagnosis for a covered illness. And, benefits get paid directly to you by check or direct deposit.

*Refer to your plan documents to see all covered illnesses under the plan.

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

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Did you know?

More than **1 in 3** Americans have heart disease, making it the most expensive health condition in the U.S. at a combined $555 billion[1].

Having less to worry about

Dan* knows that heart disease runs in his family. And when a heart attack struck, he was thankful he had the Aetna Critical Illness plan.

He submitted his claim easily online and his benefits were deposited directly into his bank account.

He was able to use the money to help pay his out-of-pocket medical costs and other bills such as his children's daycare tuition.

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]WebMD. Top 11 Medical Expenses. November, 2021. Available at: https://www.webmd.com/healthy-aging/ss/slideshow-top-11-medical-expenses. Accessed June 3, 2022.
*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-96843, AL HCOC-VOL CI 01, AL HPOL-VOL CI 01.
Policy forms issued in Missouri include: GR-96844 01, AL HCOC-VOL CI 01, AL HPOL-VOL CI 01.

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BENEFIT SUMMARY

Education Service Center Region XII
802376
Aetna Critical Illness Basic

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 are diagnosed with a covered Critical Illness. Unless otherwise indicated, all benefits and limitations are per covered person.

Face Amounts

Covered Benefit	Amount
Employee face amount	$10,000 $20,000 $30,000 $40,000 $50,000
Spouse face amount	50% of EE face amount
Spouse benefit amount	50% of EE benefit amount
Child(ren) face amount	50% of EE face amount
Child(ren) benefit amount	50% of EE benefit amount

Critical Illness Benefits – Autoimmune

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%
Multiple sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	25%

Critical Illness Benefits – Childhood Condition

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Cerebral palsy Pays a benefit when you are diagnosed with Cerebral palsy by a physician. Diagnosis must be made before the insured child reaches the age of 5. Other similar conditions that can be outgrown, are not included in this definition.	100%
Cleft lip or cleft palate Pays a benefit when you are diagnosed with a Cleft Lip or Cleft Palate after live birth by a physician.	100%
Congenital heart defect Pays a benefit when you are diagnosed with Congenital heart defect by a physician.	100%
Cystic fibrosis Pays a benefit when you are diagnosed with Cystic fibrosis by a physician. The diagnosis must be confirmed with sweat chloride concentrations greater than 60 mmol/L.	100%
Down syndrome Pays a benefit when you are diagnosed with Down Syndrome, the first date after live birth and based on the physician's study of the 21st chromosome revealing trisomy 21, translocation, or mosaicism.	100%
Sickle cell anemia Pays a benefit when you are diagnosed with Sickle cell anemia by a physician.	100%
Spina bifida Pays a benefit when you are diagnosed with Spina bifida by a specialist physician and must be associated with neurologic symptoms including motor impairment. Spina bifida does not include spina bifida occulta.	100%

Critical Illness Benefits - Chronic Condition

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Primary sclerosing cholangitis (PSC) Pays a benefit when you are diagnosed with Primary sclerosing cholangitis (PSC), also known as "Walter Payton's disease" by a physician.	25%

Critical Illness Benefits - Infectious Disease

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Cholera Pays a benefit when you are diagnosed with Cholera by a physician.	25%
Coronavirus "Pays a benefit when you are diagnosed with Coronavirus. Coronaviruses (CoV) are a large family of viruses that cause illness in people such as: • CoV or SARS-CoV-1 is the coronavirus that causes severe acute respiratory syndrome (SARS). • SARS-CoV-2 is the coronavirus that causes COVID-19. • MERS-CoV is the coronavirus that causes Middle East Respiratory Syndrome (MERS). MIS-C and MIS-A are associated with the COVID-19 coronavirus strain. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days."	100%
Creutzfeldt-Jakob disease Pays a benefit when you are diagnosed with Creutzfeldt-Jakob disease (CJD). You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.	25%
Diphtheria Pays a benefit when you are diagnosed with Diphtheria by a physician.	25%
Ebola Pays a benefit when you are diagnosed with Ebola. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.	25%
Encephalitis Pays a benefit when you are diagnosed with Encephalitis by a physician. Encephalitis does not include encephalitis resulting from any human immuno-deficiency virus (HIV) infection or other ancillary infections resulting from the HIV infection.	25%
Hepatitis - occupational Pays a benefit when you are diagnosed with Occupational hepatitis B, C, or D resulting from accidental exposure by contaminated body fluids.	25%
Human immunodeficiency virus (HIV) Pays a benefit when you are diagnosed with Human immunodeficiency virus (HIV). HIV means the presence of HIV or antibodies to the HIV virus which is caused by an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid.	25%
Legionnaire's disease Pays a benefit when you are diagnosed with Legionnaire's disease by a physician.	25%
Lyme disease Pays a benefit when you are diagnosed with Lyme Disease by a physician.	25%
Malaria Pays a benefit when you are diagnosed with Malaria by a physician.	25%
Meningitis - Bacterial , Viral , Fungal , Parasitic , Amebic Pays a benefit when you are diagnosed with Bacterial meningitis by a physician.	25%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Methicillin-resistant staphylococcus aureus (MRSA) Pays a benefit when you are diagnosed with Methicillin-resistant staphylococcus aureus (MRSA) by a physician.	25%
Necrotizing fasciitis Pays a benefit when you are diagnosed with Necrotizing fasciitis, commonly known as flesh-eating disease or flesh-eating bacteria syndrome, and requiring a surgical procedure to be performed by a physician.	25%
Osteomyelitis Pays a benefit when you are diagnosed with Osteomyelitis by a physician.	25%
Pneumonia - Bacterial, Viral Pays a benefit if you are diagnosed with bacterial or viral pneumonia. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.	25%
Poliomyelitis Pays a benefit when you are diagnosed with Poliomyelitis resulting from poliovirus type 1, 2, or 3 that is characterized by fever, paralysis and atrophy of skeletal muscles by a physician.	25%
Rabies Pays a benefit when you are diagnosed with Rabies by a physician.	25%
Rocky mountain spotted fever (RMSF) Pays a benefit when you are diagnosed with Rocky mountain spotted fever (RMSF) by a physician.	25%
Septic shock including severe sepsis Pays a benefit if you are diagnosed with septic shock and sepsis. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days	25%
Tetanus Pays a benefit when you are diagnosed with Tetanus by a physician.	25%
Tuberculosis (TB) Pays a benefit when you are diagnosed with Tuberculosis (TB) by a physician.	25%
Tularemia Pays a benefit when diagnosed with Tularemia (sometimes called rabbit fever) by a physician.	25%
Typhoid Fever Pays a benefit when you are diagnosed with Typhoid fever by a physician.	25%
Variant influenza virus (swine flu in humans) Pays a benefit when you are diagnosed with Varient influenza virus by a physician.	25%
Maximum infectious disease diagnosis per plan year	*1*

Note: the following infectious disease benefits require a hospital stay of at least five days: Coronavirus, Creutzfeldt-Jakob disease, Ebola, Septic shock and severe sepsis, Tularemia, Variant influenza virus (swine flu in humans).

Critical Illness Benefits – Neurological (Brain)

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Amyotrophic lateral sclerosis (ALS) Pays a benefit when you are diagnosed with Advanced amyotrophic lateral sclerosis (ALS), also known as "Lou Gehrig's disease" by a physician. ALS does not include other motor neuron diseases. This disease is characterized by the progressive degeneration of motor neurons, shown by permanent neurological defect with persisting clinical signs and symptoms such as the inability to perform 3 or more activities of daily living, and or the need for either a feeding tube or non-invasive ventilation.	25%
Alzheimer's disease Pays a benefit when you are diagnosed with Alzheimer's disease, diagnosis of the disease by a psychiatrist or neurologist. You must have the inability to independently perform 3 or more of the activities of daily living.	25%
Benign brain tumor including spinal cord tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%
Coma (non-induced) Pays a benefit when you are diagnosed with Coma, characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance (a medically induced coma is not covered). The Coma must last for a period of 14 or more consecutive days.	100%
Parkinson's disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.	25%
Persistent vegetative state (PVS) Pays a benefit when diagnosed with Persistent vegetative state (PVS) by a physician.	100%
Stroke Pays a benefit when you are diagnosed with a Stroke resulting in paralysis or other measurable objective neurological defect persisting for more than 24 hours.	100%
Transient ischemic attack (TIA) Pays a benefit when you are diagnosed with Transient ischemic attack (TIA) by a physician. TIA does not include a stroke.	25%
Maximum per lifetime	*1*

Critical Illness Benefits – Other

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
End-stage renal or kidney failure Pays a benefit when you are diagnosed with End stage renal or kidney failure, and the insured person has to undergo regular hemodialysis or peritoneal dialysis at least weekly or your physician determines that complete replacement of the entire organ is necessary, and you are placed on a national transplant list, such as UNOS (United Network for Organ Sharing).	100%
Loss of hearing Pays a benefit when you are diagnosed with Loss of hearing in both ears that cannot be corrected to any functional degree by any procedure, aid or device. Loss of hearing has to continue for a period of 90 consecutive days.	100%
Loss of sight (blindness) Pays a benefit when you are diagnosed with Loss of sight (blindness) that is total and irrecoverable loss of sight in both eyes. Loss of sight (blindness), has to continue for a period of 90 consecutive days.	100%
Loss of speech Pays a benefit when you are diagnosed with Loss of speech that cannot be corrected to any functional degree by any procedure, aid or device. Loss of speech has to continue for a period of 90 consecutive days.	100%
Major organ failure Pays a benefit when you are diagnosed with a Major organ failure of the heart, liver, lung(s), or pancreas resulting in the insured person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.	100%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	25%
Paralysis Pays a benefit when you are diagnosed with any of the types of paralysis below, and your physician confirms the paralysis continued for a period of 60 consecutive days.	
Quadriplegia	100%
Triplegia	100%
Paraplegia	100%
Hemiplegia	100%
Diplegia	100%
Monoplegia	25%
Third-degree burns Pays a benefit when you are diagnosed with a Third degree burn that covers more than 10% of total body surface (also called full-thickness burn).	100%

Critical Illness Benefits – Vascular (Heart)

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Coronary artery condition requiring bypass surgery Pays a benefit when you are diagnosed with a Coronary artery condition in which the patient is placed on a cardiac pulmonary bypass machine and a bypass graft is performed.	25%
Heart attack (myocardial infarction) Pays a benefit when you are diagnosed with a Heart attack (Myocardial Infarction) resulting from a blockage of one or more coronary arteries.	100%
Sudden cardiac arrest Pays a benefit when you are diagnosed with Sudden cardiac arrest by a physician. Sudden cardiac arrest does not include heart attack. The sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by, or contributed to by, a heart attack.	25%
Maximum per lifetime	*1*

Critical Illness Benefit Features

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Subsequent critical illness diagnosis Subsequent diagnosis of a different covered Critical Illness is payable at the original amount if it occurs after the previous date of diagnosis for which a benefit was paid.	100%
Recurrence critical illness diagnosis If an insured person has been initially diagnosed with and received a benefit under this plan for a critical illness and then is diagnosed with the same critical illness again at the number of days specified in the minimum below or later, we will pay the stated percentage of the benefit as shown in the Schedule of Benefits for the recurring critical illness diagnosed.	100%
Minimum days between diagnosis of same condition; *No benefit payable if the recurrence occurs within a timeframe that is less than the number of days specified*	*90 days*

Cancer Benefits

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Cancer (invasive) Pays a benefit when you are diagnosed with Cancer (invasive) that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.	100%
Carcinoma in situ (non-invasive) Pays a benefit when you are diagnosed with Carcinoma in situ that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this Certificate.	25%
Skin cancer Pays a benefit when you are diagnosed with Skin Cancer (melanoma of Clark's Level I or II Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin. Skin cancer benefit provides coverage for invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.	$1,000
Maximum per lifetime	*1*
Recurrence cancer (invasive) diagnosis If an insured person has been initially diagnosed with and received a benefit for cancer (invasive) under this plan and is then diagnosed with any kind of cancer (invasive) again at the number of days specified in the minimum below or later, we will pay the stated percentage of the Cancer Benefit for Cancer (invasive) as shown on the Schedule of Benefits for the cancer (invasive) diagnosed.	100%
*Minimum days between diagnosis of cancer (invasive);*** *No benefit payable if the recurrence occurs within a time frame less than the number of days specified*	*90 days*
Recurrence carcinoma in situ diagnosis If an insured person has been initially diagnosed with and received a benefit for carcinoma in situ (non-invasive) under this plan and is then diagnosed with any kind of carcinoma in situ (non-invasive) again at the number of days specified in the minimum below or later, we will pay the stated percentage of the carcinoma in situ (non-invasive) as shown on the Schedule of Benefits for the carcinoma in situ (non-invasive) diagnosed.	100%
*Minimum days between diagnosis of carcinoma in situ; *** *No benefit payable if the recurrence occurs within a time frame less than the number of days specified*	*90 days*

* For those members who were diagnosed with cancer prior to their effective date of coverage under the Aetna plan and then receive another cancer diagnosis (the first time) while covered under the Aetna plan, we will treat their diagnosis as an 'initial' diagnosis under the Aetna plan.

** In addition to the separation period, the insured person must be treatment free during the separation period. Treatment does not include maintenance drug therapy or routine follow-up visits to a physician to confirm the initial cancer or carcinoma in situ has not returned.

Health Screening Rider

Covered Benefit	Benefit Amount
Health screening*	$100
Maximum per plan year	*1*

*Covered Health Screenings

- Bone marrow screening
- Bone mass density measurement (DEXA, DXA)
- Biopsies for cancer
- Blood chemistry panel
- Breast sonogram
- Breast MRI
- Breast ultrasound
- Cancer antigen 125 blood test for ovarian cancer (CA 125)
- Carotid doppler ultrasound
- Chest x-ray (CXR)
- Cytologic screening
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- Carcinoembryonic antigen blood test for colon cancer (CEA)
- Clinical testicular exam
- Colonoscopy
- Complete blood count (CBC)
- Dental exam
- Digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)
- Electroencephalogram (EEG)
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Endoscopy
- Eye exam
- Fasting blood glucose test
- Fasting plasma glucose test
- Flexible sigmoidoscopy
- Hearing test
- Hemoccult stool analysis
- Hemoglobin A1C
- Human papillomavirus vaccination (HPV)
- Infectious disease testing
- Immunizations
- Lipoprotein profile (serum plus HDL, LDL, total cholesterol, and triglycerides)
- Mammography
- Oral cancer screening
- Pap smear
- Prostate specific antigen (PSA) test
- Routine health check-up exam
- Skin cancer biopsy
- Skin cancer screening
- Skin exam
- Serum protein electrophoresis (blood test for myeloma)
- Successful completion of smoking cessation program
- Stress test on bicycle or treadmill
- Test for sexually transmitted infections (STIs)
- Thermography
- ThinPrep pap test
- Two-hour post-load plasma glucose test
- Ultrasound for cancer detection
- Ultrasound screening for abdominal aortic aneurysms
- Virtual colonoscopy

Note: COVID-19 testing is covered as an eligible health screening benefit

Accident Insurance

Aetna | www.myaetnasupplemental.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
- Lacerations
- Broken teeth
- Emergency room visits
- Ambulance, ground or air
- Intensive care unit

Accident Insurance		
Monthly Premium	**Plan 1**	**Plan 2**
Employee	$6.92	$9.25
Employee + Spouse	$13.85	$18.50
Employee + Children	$14.54	$19.43
Employee + Family	$21.47	$28.68

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 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 paying for:

- 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).

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BENEFIT SUMMARY

Education Service Center Region XII
802376
Aetna Off 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 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.	$300	$300
Air ambulance 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.	$1,500	$1,500
Maximum trips per accident, air and ground combined	*1*	*1*
Initial Treatment		
Emergency room/Hospital 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.	$250	$300

Covered Benefit	Low	High
Physician's office/Urgent care facility 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.	$250	$300
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 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.	$50	$75
Medical imaging 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.	$150	$200

Follow-up Care

Covered Benefit	Low	High
Accident follow-up		
Emergency room/Hospital	$100	$125
Pays a benefit if an insured person receives follow-up treatment in emergency room or hospital for an accidental injury within one year of the accident.		
Physician's office/Urgent care facility	$100	$125
Pays a benefit if an insured person receives follow-up treatment in a physician's office or urgent care center 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	*3*	*4*
Maximum visits per plan year, combined for all places of service	*9*	*12*
Appliances		
Major: Back brace, body jacket, knee scooter, wheelchair, motorized scooter or wheelchair	$300	$300
Minor: Brace, cane, crutches, walker, walking boot, other medical devices to aid in your physical movement	$150	$150
Chiropractic treatment and alternative therapy	$35	$35
Maximum visits per accident	*10*	*10*
Maximum visits per plan year	*30*	*30*
Pain management (epidural anesthesia)	$150	$150
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	$1,500	$1,500
Multiple limbs	$3,000	$3,000
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	$35	$35
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	$250	$300
Pays a benefit if an insured person has a stay in a hospital due to an accidental injury.		
ICU daily	$500	$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	$500	$600
Maximum days per accident (combined for all stays due to the same accident)	*365*	*365*
Rehabilitation unit stay – daily	$300	$350
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	$400	$500
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	$200	$300
Surgery (without repair)		
Arthroscopic or exploratory	$150	$300
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	$250	$300
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	$1,000
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	$250	$300
Outpatient	$250	$300
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	$450	$500
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

Dislocations - Closed Reduction

Pays a benefit if an insured person sustains a dislocation as the result of an accidental injury.
A physician must diagnose the dislocation within 90 days after the accidental injury and correct it by ***closed reduction (non-surgical repair).***

Open reduction

Pays a benefit if an insured person sustains a dislocation as the result of an accidental injury.
A physician must diagnose the dislocation within 90 days after the accidental injury and correct it by open reduction *(surgical repair).*

Covered Benefit	Low	High
Dislocations – Closed Reduction*		
Hip	$4,000	$6,000
Knee	$1,500	$3,000
Ankle – bone or bones of the foot (other than toes)	$750	$1,500
Collarbone (sternoclavicular)	$750	$1,200
Lower jaw	$750	$1,200
Shoulder (glenohumeral)	$750	$1,200
Elbow	$750	$1,200
Wrist	$750	$1,200
Bone or bones of the hand (other than fingers)	$750	$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	$5,500	$8,250
Skull (except bones of the face or nose), non-depressed	$5,500	$8,250
Hip, thigh (femur)	$1,725	$3,450
Vertebrae, body of (excluding vertebral processes)	$1,725	$2,250
Pelvis (inc. ilium, ischium, pubis, acetabulum except coccyx)	$1,725	$2,250
Leg (tibia and/or fibula malleolus)	$1,725	$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	$50,000	$100,000
Covered dependent spouse	$25,000	$50,000
Covered dependent children	$25,000	$50,000
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	$100,000	$200,000
Covered dependent spouse	$50,000	$100,000
Covered dependent children	$50,000	$100,000
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	$12,500	$20,000
Loss of hand	$12,500	$20,000
Loss of leg	$12,500	$20,000
Loss of foot	$12,500	$20,000
Loss of sight	$12,500	$20,000
Loss of ability to speak	$25,000	$30,000
Loss of hearing	$12,500	$20,000
Maximum dismemberments per accident (non-finger, toe)	*2*	*2*
Loss of finger	$3,250	$5,000
Loss of toe	$3,250	$5,000
Maximum dismemberments per accident (finger, toe)	*4*	*4*
Home and vehicle alteration	$2,500	$2,500
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	$25,000	$40,000
Triplegia	$15,000	$25,000
Paraplegia	$12,500	$20,000
Hemiplegia	$12,500	$20,000
Diplegia	$12,500	$20,000
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	$150	$200
Moderate/Severe traumatic brain injury	$450	$600
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	$2,000	$2,000
Third degree burn, less than 5% of total body surface	$2,000	$2,500
Third degree burn, 5-10% of total body surface	$6,000	$9,000
Third degree burn, greater than 10% of total body surface	$18,000	$27,000
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)	$10,000	$20,000
PVS	$10,000	$20,000
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	$75	$100
Crown	$225	$300
Gunshot wound	$1,500	$2,000
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	$25	$25
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*

Waiver of Premium

Covered Benefit	Benefit Amount
If, as a result of an accidental injury you miss 30 continuous days of work we will waive the premium beginning on the first premium due date that occurs after the 30th day of your absence, through the next 6 months of coverage. During such absence, you must remain employed with the policyholder. The premium waiver does not apply to your covered dependents.	Included

Organized Sports Rider

Covered Benefit	Benefit Amount
If while you are playing as a registered member of an organized sporting activity, you sustain an accidental injury, benefits payable under the certificate will be increased by the percentage shown, except for the excluded benefits below:	25%

Excluded benefits for Organized Sports Rider

- Accidental death
- Accidental death common carrier
- Animal bite
- Burn
- Burn skin graft
- Gunshot wound
- Service Dog

Health Screening Rider

Covered Benefit	Benefit Amount
Health screening* *Maximum 1 test per plan year*	$50

***Covered Health Screenings**

- Bone marrow screening
- Bone mass density measurement (DEXA, DXA)
- Biopsies for cancer
- Blood chemistry panel
- Breast sonogram
- Cancer antigen 125 blood test for ovarian cancer (CA 125)
- Carotid doppler ultrasound
- Chest x-ray (CXR)
- Cytologic screening
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- Carcinoembryonic antigen blood test for colon cancer (CEA)
- Clinical testicular exam
- Colonoscopy
- Complete blood count (CBC)
- Dental exam
- Digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)
- Electroencephalogram (EEG)
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Endoscopy
- Eye exam
- Fasting blood glucose test
- Fasting plasma glucose test
- Flexible sigmoidoscopy
- Hearing test
- Hemoccult stool analysis
- Hemoglobin A1C
- Human papillomavirus vaccination (HPV)
- Immunizations
- Lipoprotein profile (serum plus HDL, LDL, total cholesterol, and triglycerides)
- Mammography
- Oral cancer screening
- Pap smear
- Prostate specific antigen (PSA) test
- Routine health check-up exam
- Skin cancer biopsy
- Skin cancer screening
- Skin exam
- Serum protein electrophoresis (blood test for myeloma)
- Successful completion of smoking cessation program
- Stress test on bicycle or treadmill
- Test for sexually transmitted infections (STIs)
- Thermography
- ThinPrep pap test
- Two-hour post-load plasma glucose test
- Ultrasound for cancer detection
- Ultrasound screening for abdominal aortic aneurysms
- Virtual colonoscopy

Note: COVID-19 testing is covered as an eligible health screening benefit

Hospital Indemnity Insurance

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

Hospital stays are costly. If you or a family member find yourself in the hospital due to a sudden accident or illness, you may struggle financially, even if you have a good medical plan. With a hospital indemnity plan, you can rest assured those extra expenses won't be a financial burden.

Unlike medical plans, there are no deductibles to meet with a hospital indemnity plan. As soon as you incur a qualified event, you can file a claim and start receiving benefits.

The plan pays a lump sum benefit in a previously specified amount. The money can be used for medical costs, insurance deductibles, groceries, transportation, childcare – the choice is up to you!

Hospital Indemnity Insurance		
Monthly Premium	**Low Plan**	**High Plan**
Employee	$20.77	$35.57
Employee + Spouse	$44.24	$74.30
Employee + Children	$32.62	$55.73
Employee + Family	$52.62	$89.39

Less stress

Aetna Hospital Indemnity Plan

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

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

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

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

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

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

...or for 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 stay in a hospital. And, benefits get paid directly to you by check or direct deposit.

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

aetna®

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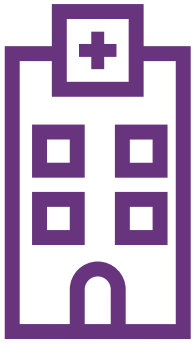
Because it happens

$1.24 trillion was spent on hospital services in 2020. **60%-65%** of all bankruptcies are related to medical expenses[1].



Ready...or not

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

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

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

A Simplified Claims Experience™

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

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

[1]Debt.org. Hospital and Surgery Costs. October 2021. Available at: https://www.debt.org/medical/hospital-surgery-costs/. Accessed June 3, 2022.
*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.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. 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 Missouri and Oklahoma include: GR-96172 01, AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.

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BENEFIT SUMMARY

Education Service Center Region XII
802376

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:

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

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

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

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

Inpatient Stays

Covered Benefit	Low	High
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. *Maximum 1 stay per plan year*	$1,000	$2,000
Hospital stay - Daily Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital. *Maximum 60 days per plan year*	$150	$200
Hospital stay - (ICU) Daily Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital. *Maximum 60 days per plan year*	$300	$400
Newborn routine care Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.	$100	$200
Observation unit Provides a lump sum benefit for the initial day of your stay in an observation unit as the result of an illness or accidental injury. *Maximum 1 day per plan year*	$100	$200
Substance abuse stay - Daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. *Maximum 60 days per plan year*	$100	$150
Mental disorder stay - Daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. *Maximum 60 days per plan year*	$100	$150
Rehabilitation unit stay - Daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. *Maximum 60 days per plan year*	$50	$75

Important Note:
All daily inpatient stay benefits begin on day two and count toward the plan year maximum.

Waiver of premium

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

Portability

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

Exclusions and Limitations

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

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

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

Questions and Answers

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

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

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

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

What is considered a hospital stay?

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

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

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

How do I file a claim?

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

What should I do in case of an emergency?

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

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

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

Important information about your benefits

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

Complaints and appeals

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

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

We protect your privacy

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

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

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

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

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

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

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

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

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

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

Financial Sanctions Exclusions Clause

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

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

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

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

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.

Ilock360 Insurance		
Monthly Premium	**Plus**	**Premium**
Employee	$8.00	$15.00
Employee + Spouse	$15.00	$22.00
Employee + Children	$13.00	$20.00
Employee + Family	$20.00	$27.00

Legal Plan

ARAG Legal | www.ARAGLegal.com | 800-247-4184

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.

Legal Plan Insurance	
Family Coverage	**Monthly Premiums**
Ultimate Advisor	$18.25
Ultimate Advisor Plus	$21.00

Medical Transport

MASA | www.masamts.com | 800-643-9023

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

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

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

Medical Transport	
Family Coverage	**Monthly Premiums**
Emergent	$9.00
Emergent Plus	$14.00
Platinum	$39.00

TeleHealth

Recuro | www.wrecurohealth.com | 855-673-2876

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

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

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

TeleHealth	
Family Coverage	**Monthly Premiums**
Emergent	$9.00
Emergent Plus	$14.00
Platinum	$39.00

COBRA

First Financial Administrators, Inc. | www.ffga.com | 800-523-8422, option 4

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

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.

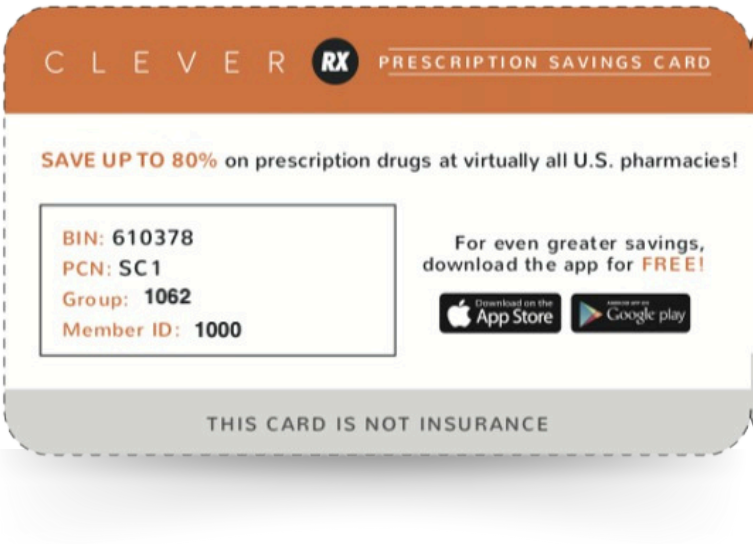
First Financial Administrators, Inc. provides COBRA administration services for the following plan
Dental, Vision, and FSA

Clever RX

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!

Contact Information

Rapoport Academy
1020 Elm Ave Waco, TX 78947
254-754-8000
www.rapoportacademy

Devin Taylor, Sr. Account Manager
281-582-6676 | devin.taylor@ffga.com
Sherry Skidmore, Account Rep.
512-461-6794 | sherry.skidmore@ffga.com

Product	Carrier	Website	Phone
Medical	TRS	www.trs.com	555-555-5555
Dental	Cigna	www.cigna.com	800-244-6224
Vision	Superior Vision	www.superiorvision.com	800-507-3800
FSA & Dependent Care	FFGA	www.ffga.com	866-853-3539
HSA	FFGA	www.ffga.com	866-853-3539
Permanent Life	Texas Life	www.texaslife.com	800-283-9233
Cancer	Guardian	www.guardiananytime.com	800-541-7846
Critical Illness	Aetna	www.myaetnasupplemental.cor	800-872-3862
Accident	Aetna	www.myaetnasupplemental.cor	800-872-3862
Hospital Indemnity Plan	Aetna	www.myaetnasupplemental.cor	800-872-3862
Identity Theft	iLock360	www.iLock360.com	855-287-8888
Legal	ARAG Legal	www.ARAGLegal.com	800-247-4184
Medical Transport	MASA	www.masamts.com	800-643-9023
Telehealth	Recuro	www.recurehealth.com	855-673-2876
COBRA	FFGA	www.ffga.com	866-853-3539
Prescription Discount	CLever RX	www.partner.cleverrx.com/ffga	800-873-1195