GUARDIAN®

Group Number: 00551779

SHERMAN INDEPENDENT SCHOOL DISTRICT

ALL ELIGIBLE EMPLOYEES

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Cancer

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Group Number: 00551779

Cancer Benefit Summary

About Your Benefits:

Cancer is a terrible disease, but fortunately, more and more people are beating it through earlier diagnosis and the ever improving treatments available. However, treatment can be costly. Did you know an average out-of-pocket cost for cancer care is more than $1200 per month.[1] That's where Cancer insurance can help. It supplements your medical and disability income insurance and helps protect you and your family from the financial hardship you may face while fighting the disease. Cancer Insurance pays benefits to you based on the treatments you receive related to a covered cancer diagnosis. The benefit payment is paid in addition to your medical insurance plan. Coverage is surprisingly affordable, so enroll today and get covered!

[1]Duke University Medical Center, 2011 http://clearhealthcosts.com/tag/duke-university-medical-center/

What Your Benefits Cover:

	CANCER	
COVERAGE - DETAILS	**Option 1: Advantage Plan**	**Option 2: Premier Plan**
Your Monthly premium	$18.80	$29.87
You and Spouse	$34.28	$53.58
You and Child(ren)	$21.92	$34.75
You, Spouse and Child(ren)	$37.40	$58.46
INITIAL DIAGNOSIS BENEFIT - Benefit is paid when you are diagnosed with Internal 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	$50; $50 for Follow-Up screening	$75; $75 for Follow-Up screening
RADIATION THERAPY OR CHEMOTHERAPY		
Benefit	Schedule amounts up to a $10,000 benefit year maximum.	Schedule amounts up to a $15,000 benefit year maximum.
Conditional Issue - The "conditional" means the applicant (employee, spouse or child) can qualify for coverage if he/she responds "No" to the conditional medical question on the enrollment form.	You will be required to answer one medical question as a part of your enrollment form.	Not Applicable
Pre-Existing Conditions Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/ 6 months treatment free/ 12 months after.	3 months prior/ 6 months treatment free/ 12 months after.
Portability: Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70.	Included	Included
Child(ren) Age Limits	Children age birth to 26 years	Children age birth to 26 years
FEATURES		
Air Ambulance	$1,500/trip, limit 2 trips per hospital confinement	$2,000/trip, limit 2 trips per hospital confinement
Alternative Care	No Benefit	$50/visit up to 20 visits

FEATURES (Cont.)	Option 1: Advantage Plan	Option 2: Premier Plan
Ambulance	$200/trip, limit 2 trips per hospital confinement	$250/trip, limit 2 trips per hospital confinement
Anesthesia	25% of surgery benefit	25% of surgery benefit
Anti-Nausea	$50/day up to $150 per month	$50/day up to $250 per month
Attending Physician	$25/day while hospital confined. Limit 75 visits.	$25/day while hospital confined. Limit 75 visits.
Blood/Plasma/Platelets	$100/day up to $5,000 per year	$200/day up to $10,000 per year
Bone Marrow/Stem Cell	Bone Marrow: $7,500 Stem Cell: $1,500 50% benefit for 2nd transplant. $1,000 benefit if a donor	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant. $1,500 benefit if a donor
Experimental Treatment	$100/day up to $1,000/month	$200/day up to $2,400/month
Extended Care Facility/Skilled Nursing care	$100/day up to 90 days per year	$150/day up to 90 days per year
Government or Charity Hospital	$300 per day in lieu of all other benefits	$400 per day in lieu of all other benefits
Home Health Care	$50/visit up to 30 visits per year	$100/visit up to 30 visits per year
Hormone Therapy	$25/treatment up to 12 treatments per year	$50/treatment up to 12 treatments per year
Hospice	$50/day up to 100 days/lifetime	$100/day up to 100 days/lifetime
Hospital Confinement	$300/day for first 30 days; $600/day for 31st day thereafter per confinement	$400/day for first 30 days; $800/day for 31st day thereafter per confinement
ICU Confinement	$400/day for first 30 days; $600/day for 31st day thereafter per confinement	$600/day for first 30 days; $800/day for 31st day thereafter per confinement
Immunotherapy	$500 per month, $2,500 lifetime max	$500 per month, $2500 lifetime max
Inpatient Special Nursing	$100/day up to 30 days per year	$150/day up to 30 days per year
Medical Imaging	$100/image up to 2 per year	$200/image up to 2 per year
Outpatient and family member lodging - Lodging must be more than 50 miles from your home.	$75/day, up to 90 days per year	$100/day, up to 90 days per year
Outpatient or Ambulatory Surgical Center	$250/day, 3 days per procedure	$350/day, 3 days per procedure
Physical or Speech Therapy	$25/visit up to 4 visits per month, $400 lifetime max	$50/visit up to 4 visits per month, $1,000 lifetime max
Prosthetic	Surgically Implanted: $2,000/device, $4,000 lifetime max Non-Surgically: $200/device, $400 lifetime max	Surgically Implanted: $3,000/device, $6,000 lifetime max Non-Surgically: $300/device, $600 lifetime max
Reconstructive Surgery	Breast TRAM Flap $2,000 Breast reconstruction $500 Breast Symmetry $250 Facial reconstruction $500	Breast TRAM $3,000 Breast reconstruction $700 Breast Symmetry $350 Facial reconstruction $700
Reproductive Benefit	No Benefit	$1,500 egg harvesting, $500 egg or sperm storage, $2,000 lifetime max
Second Surgical Opinion	$200/surgery procedure	$300/surgery procedure
Skin Cancer	Biopsy Only: $100 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 $4,125	Schedule amount up to $5,500
Transportation/Companion Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive treatment for internal cancer.	$0.50/mile up to $1,000 per round trip/equal benefit for companion	$0.50/mile up to $1,500 per round trip/equal benefit for companion

FEATURES (Cont.)	Option 1: Advantage Plan	Option 2: Premier Plan
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

UNDERSTANDING YOUR BENEFITS :

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

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF CANCER LIMITATIONS AND EXCLUSIONS:

Conditional Issue is one medical question as a part of the enrollment form.

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

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

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

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

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GUARDIAN®

Guardian Life, P.O. Box 981585,
El Paso, TX 79998-1585

Please print clearly and mark carefully.

Employer Name: **SHERMAN INDEPENDENT SCHOOL DISTRICT**	Group Plan Number: **00551779**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

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

About You:

First, MI, Last Name:		Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Address	City	State	Zip

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

Email Address: Are you married or do you have a spouse? ❑ Yes ❑ No Date of marriage/union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job: Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jun 21, 2018

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Cancer ❑ Employee ❑ Spouse ❑ Child(ren)

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

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Cancer Coverage

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

Your Monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Advantage Plan	❑ $18.80	❑ $34.28	❑ $21.92	❑ $37.40
Option 2: Premier Plan	❑ $29.87	❑ $53.58	❑ $34.75	❑ $58.46

❑ I do not want this coverage.

Complete the following question if you are enrolling for Cancer coverage. NOTE: Additional information may be required.

Has anyone to be covered been treated for or diagnosed as having Cancer in any form, Acquired Immune Deficiency Syndrome (AIDS) or (AIDS) Related Complex (ARC) within the last 5 years?

❑ Yes, I have ❑ No, I haven't ❑ Yes, my spouse has ❑ No, my spouse hasn't ❑ Yes, my dependent child(ren) have ❑ No, my dependent child(ren) haven't

Signature

- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

Guardian Group Plan Number: **00551779** Please print employee name:

- **I attest that the information provided above is true and correct to the best of my knowledge.**

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

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

The laws of New York require the following statement appear: If you are not a resident of New York this statement does not apply to you: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Enrollment Kit 00551779, 0001, EN

Fraud Warning Statements

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

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

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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

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

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

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

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

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

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

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

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

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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