

Provided by:



SALEM
CITY SCHOOLS

EMPLOYEE BENEFITS HANDBOOK

January 1, 2025 - December 31, 2025

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All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.



DISCLAIMER

This guide is a brief summary of benefits offered to your group and does not constitute a policy.

Your employer may amend the benefits program at any time. Your Summary Plan Description (SPD) will contain the actual detailed provisions of your benefits. The SPD will be available at mymarkiii.com.

If there are any discrepancies between the information in this guide and the SPD, the language in the SPD will always prevail.



Important Points

- ✓ Your plan year runs from January 1, 2025 to December 31, 2025. This means your benefit elections will take effect January 1, 2025 unless otherwise noted.
- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending and Dependent Care accounts each year! It will not automatically renew.
- ✓ This benefits guide is equipped with mobile-friendly barcodes commonly referred to as QR Codes. Use your smartphone to scan the QR codes to view your benefit summaries.
- ✓ All policy information can be found on your employee benefits portal at <https://mymarkiii.com/salemcityschoolsva/>.



Qualifying Life Events

Open Enrollment selections are generally locked for the plan year, but certain exceptions called Qualifying Life Events (QLEs) can grant you a special enrollment period in which to make midyear changes. You are permitted to change benefit elections if you have a “change in status” and you make an election change that is consistent with the “change in status.” Post-Tax benefits can be changed during the plan year without a QLE. Please contact your Group Contact for information on cancelling post-tax benefits.

Examples of QLEs

The following events will open a special **30-day** enrollment period from the date of the event, allowing you to make changes to your coverage. Documentation will be required.



marriage



divorce



childbirth/
adoption



death of a
family
member



loss of
parental
coverage



spouse gains
or loses
coverage

Welcome to Your Benefits!

Mark III Employee Benefits is here to help guide you through the benefits offered by your employer. This guide is simply a brief summary of benefits offered and does not constitute a policy.



Pre-Tax Benefit Information

A **“pre-tax basis”** means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or unless you have a qualifying life event (i.e. birth of a child, divorce, separation, reduction in hours, etc.). If your premiums are deducted on a pre-tax basis, any benefits received under the plan could be treated as taxable income.

- ✓ Anthem Medical
- ✓ FBA Flexible Spending Accounts
- ✓ Delta Dental
- ✓ Manhattan Life Group Cancer
- ✓ Aflac Group Accident
- ✓ Aflac Group Hospital Indemnity
- ✓ FBA Health Savings Accounts

Post-Tax Benefit Information

A **“post-tax basis”** means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. Although you do not get any savings from taxes, you have the flexibility of dropping your coverage at any time. Please contact your Group Contact for information on cancelling post-tax benefits.

- ✓ Aflac Group Critical Illness
- ✓ AUL Short-Term Disability
- ✓ AUL Long-Term Disability
- ✓ Boston Mutual Whole Life
- ✓ LegalShield/IDShield Legal and ID Protection Services

How to Enroll at Open Enrollment

Onsite Enrollment

Our trusted Mark III Benefits Counselors will be available to meet with employees onsite to explain the benefits offered and to help get you enrolled.

Self-Service Enrollment

You have the option to self-enroll in your benefits through the online enrollment platform. Visit the link below to self-enroll.

To Self-Enroll Visit: <https://mymarkiii.com/salemcityschoolsva/enrollment/>

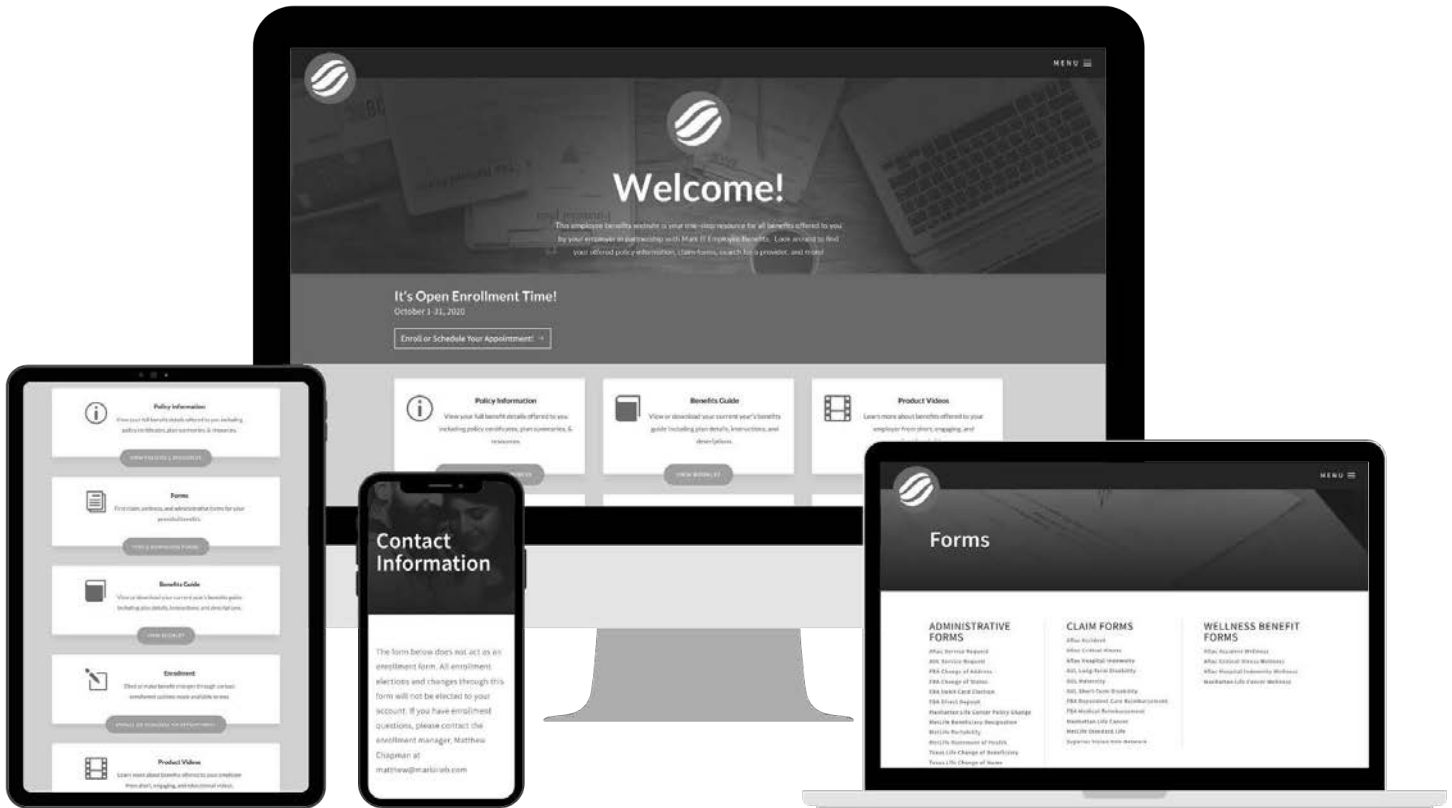
Employee Benefits Portal

Use your smartphone to scan the QR code for quick access to your employee benefits portal page. Review your benefits guide online, download claim forms, and much more!



Employee Benefits Portal

Find details about all of your benefits, download forms, submit claims, ask questions, and more at <https://mymarkiii.com/salemcityschoolsva/>.



- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

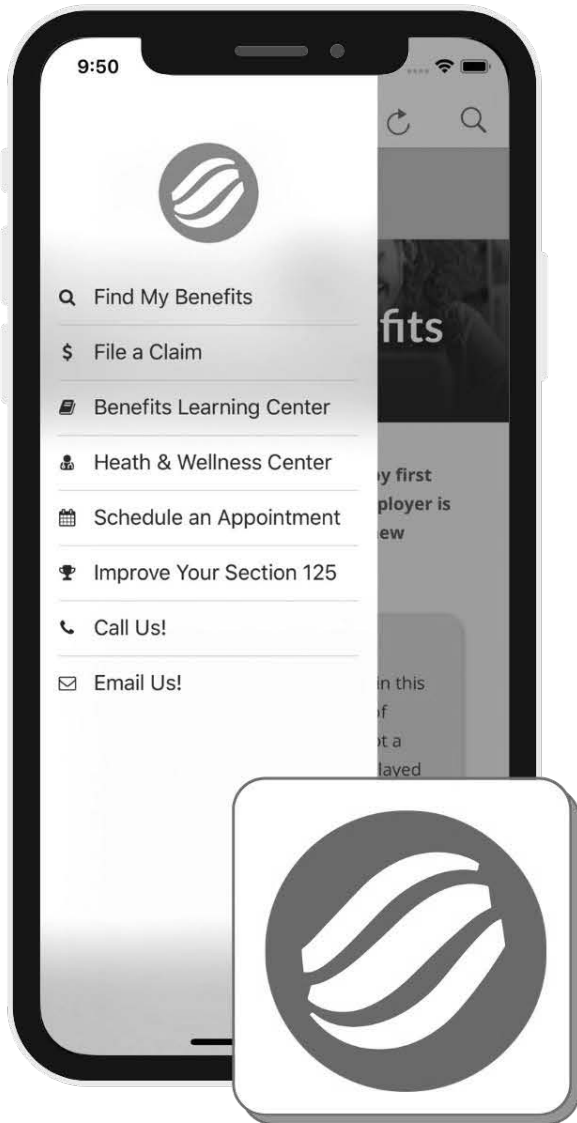


Available 24/7* from any internet enabled device for your convenience.

**As with all technology, due to technical difficulties beyond our control there may be small windows of time the benefits website is down. In the case of outage, plan information can always be requested from your HR office or Mark III Employee Benefits.*

MyMark III Mobile App

Find details about all of your benefits, download forms, submit claims, ask questions, and more on the MyMark III Mobile App!



- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

Search for “MyMark III” to access benefit information on the go!

Available on:



*Your Trusted Benefits
Partners at your fingertips!*



FOR YOUR REFERENCE

*Additional benefit information
from your employer.*



Medical Plan

Health Benefits - Anthem

Salem City Schools currently have two (2) medical insurance plans through Anthem Blue Cross Blue Shield, which include prescription and vision benefits. All plans use the same KeyCare PPO/BlueCard National PPO network of providers.

- Anthem KeyCare 30
- Anthem HDHP + HSA

Choosing and personalizing your benefits depends on your specific health care needs, doctor preferences, budget and the type of plan you prefer. Please use the comparison chart to determine which of the following plans best suits your medical needs.

Which Plan is Right For You?

The best medical plan for you depends on a number of factors:

- What are your anticipated medical expenses during the plan year? Please note that both plans accumulate on a calendar year basis – the deductible, visit limits and out-of-pocket amounts re-set every January 1.
- Do you want to participate in a Health Savings Account or a Flexible Spending Account? The IRS does not allow you or your family to have both at the same time.
- What can you afford to pay out-of-pocket (in terms of deductibles and copayments) if you or a covered dependent needs medical care?
- Do you have other medical coverage (for example, through your spouse's employer)?
- Do any of your dependents need on-going routine medical care?
- How often do you or your family members go to the doctor or fill prescriptions?
- Do you have any planned procedures or surgeries?
- Do you have a chronic condition that needs to be managed?
- How do you prefer to pay for your healthcare? Pay more up front through higher insurance premiums or pay lower premiums and pay more when you use healthcare services?

Cost of Coverage

You and Salem City Schools share the monthly cost for medical coverage. Your cost is based on:

- The plan you choose, coverage level and if you qualified under the wellness incentive program.





Medical Plan



Anthem KeyCare 30 & Anthem HDHP Summary

Covered Medical Benefits	KeyCare 30 Cost if you use an In-Network Provider	KeyCare 30 Cost if you use a Non-Network Provider	Anthem HDHP Cost if you use an In-Network Provider	Anthem HDHP Cost if you use a Non-Network Provider
Overall Deductible	\$2,000 person / \$4,000 family	\$3,000 person / \$6,000 family	\$3,500 person / \$7,000 family <i>In-Network and out-of-network deductibles are combined</i>	
Out-of-Pocket Limit	\$5,000 person / \$10,000 family	\$7,250 person / \$14,500 family	\$4,000 person / \$8,000 family	\$6,000 person / \$12,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.				
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met	No charge	20% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions per IRS guidelines	No charge	40% coinsurance after medical deductible is met	No charge	20% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) <i>Virtual Visits - Online visits with Doctors who also provide services in person</i>	<ul style="list-style-type: none"> \$30 copay per visit medical deductible does not apply \$30 copay per visit medical deductible does not apply \$50 copay per visit medical deductible does not apply 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com; our mobile app, website or Anthem-enabled device	<ul style="list-style-type: none"> Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care 	<ul style="list-style-type: none"> No charge medical deductible does not apply \$50 copay per visit medical deductible does not apply 	<ul style="list-style-type: none"> 0% coinsurance after deductible is met 0% coinsurance after deductible is met 	
Visits in an Office	<ul style="list-style-type: none"> Primary Care (PCP) Specialist Care 	<ul style="list-style-type: none"> \$30 copay per visit medical deductible does not apply \$50 copay per visit medical deductible does not apply 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met
Other Practitioner Visits	<ul style="list-style-type: none"> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic for care and treatment of common illnesses; usually found in major pharmacies and retail stores Manipulation Therapy Coverage is limited to 30 visits per benefit period 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met \$30 copay per visit medical deductible does not apply \$25 copay per visit medical deductible does not apply 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met
Other Services in an Office	<ul style="list-style-type: none"> Allergy Testing Chemo/Radiation Therapy Office and outpatient hospital Dialysis/Hemodialysis Office and outpatient hospital Prescription Drugs Dispensed in the office Surgery 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met \$30 copay (PCP)/ \$50 copay (Specialist) no medical deductible applies 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Diagnostic Services	<ul style="list-style-type: none"> Lab Office Preferred Reference Lab Outpatient Hospital 	<ul style="list-style-type: none"> No Charge No Charge 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
X-Ray	<ul style="list-style-type: none"> Office Outpatient Hospital 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met

Covered Medical Benefits	KeyCare 30 Cost if you use an In-Network Provider	KeyCare 30 Cost if you use a Non-Network Provider	Anthem HDHP Cost if you use an In-Network Provider	Anthem HDHP Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging for <i>example: MRI, PET and CAT scans</i> • Office • Outpatient Hospital	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Emergency and Urgent Care • Urgent Care • Emergency Room Facility Services • Emergency Room Doctor and Other Services • Ambulance	<p><i>Includes doctor services. Additional charges may apply depending on the care provided.</i></p> <ul style="list-style-type: none"> \$30 PCP/\$50 Specialist copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered at In-Network 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered at In-Network
Outpatient Mental Health and Substance Abuse Services at a Facility • Facility Fees • Doctor Services	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Outpatient Surgery <i>Facility Fees</i> • Hospital • Ambulatory Surgical Center (Anthem HDHP only) <i>Physician and Other Services (including surgeon fees)</i> • Hospital	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse) • Facility Fees • Physician and other services <i>including surgeon fees</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Recovery & Rehabilitation <i>Home Health Care</i> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Rehabilitation services <i>(including physical, occupational and speech therapies)</i> <i>Coverage for rehabilitative and habitative physical therapy and occupational therapy combined is limited to 30 visits (KeyCare 30) & 90 visits (Anthem HDHP) per benefit period. Coverage for rehabilitative and habitative speech therapy is limited to 30 visits (KeyCare 30) & 90 visits Anthem HDHP) per benefit period.</i> • Office • Outpatient Hospital	<ul style="list-style-type: none"> \$30 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met
Pulmonary rehabilitation <i>Office and Outpatient Hospital</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Cardiac rehabilitation <i>Office and Outpatient Hospital</i> <i>Coverage is unlimited</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Inpatient Hospice	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Durable Medical Equipment	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 0% coinsurance after medical deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	KeyCare 30 Cost if you use an In-Network Provider	KeyCare 30 Cost if you use a Non-Network Provider	Anthem HDHP Cost if you use an In-Network Provider	Anthem HDHP Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Combined w/ medical deductible	
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage: Base (National) Network Cost shares for drugs included on the National Direct Plus drug list appear below. Drugs not included on the list will not be covered.				

Day Supply Limits:

- **Retail Pharmacy** 30 day supply limit (cost shares noted below).
- **Retail 90 Pharmacy** 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). You may receive up to a 90 day supply of medication at any retail location at 3 times the 30 day supply cost share charged at in-network pharmacies.
- **Home Delivery Pharmacy** 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service. Home Delivery is an **optional** service on this plan.
- **Specialty Pharmacy** 30 day supply (cost shares noted below for retail and home delivery apply). Certain drugs with special handling, provider coordination or patient education may be required to be filled by a designated specialty pharmacy.

Covered Prescription Drug Benefits	KeyCare 30 Cost if you use an In-Network Provider	KeyCare 30 Cost if you use a Non-Network Provider	Anthem HDHP Cost if you use an In-Network Provider	Anthem HDHP Cost if you use a Non-Network Provider
Tier 1 - Typically Generic	Retail: \$15 copay per prescription, deductible does not apply Home Delivery: \$38 copay per prescription, deductible does not apply	Retail: \$15 copay per prescription, deductible does not apply Home Delivery: Not Covered	Retail: \$10 copay per prescription after deductible is met Home Delivery: \$25 copay per prescription after deductible is met	Retail: \$10 copay per prescription after deductible is met Home Delivery: Not Covered
Tier 2 - Typically Preferred Brand	Retail: \$40 copay per prescription, deductible does not apply Home Delivery: \$100 copay per prescription, deductible does not apply	Retail: \$40 copay per prescription, deductible does not apply Home Delivery: Not Covered	Retail: \$30 copay per prescription after deductible is met Home Delivery: \$75 copay per prescription after deductible is met	Retail: \$30 copay per prescription after deductible is met Home Delivery: Not Covered
Tier 3 - Typically Non-Preferred Brand	Retail: \$75 copay per prescription, deductible does not apply Home Delivery: \$188 copay per prescription, deductible does not apply	Retail: \$75 copay per prescription, deductible does not apply Home Delivery: Not Covered	Retail: \$50 copay per prescription after deductible is met Home Delivery: \$125 copay per prescription after deductible is met	Retail: \$50 copay per prescription after deductible is met Home Delivery: Not Covered
Tier 4 - Typically Specialty (brand and generic)	Retail: 20% coinsurance up to \$200 per prescription, deductible does not apply Home Delivery: 20% coinsurance up to \$400, deductible does not apply	Not covered	Retail & Home Delivery: 20% coinsurance for min. \$10 – max. \$200 per prescription after deductible is met	Not covered
Covered Vision Benefits	KeyCare 30 Cost if you use an In-Network Provider	KeyCare 30 Cost if you use a Non-Network Provider	Anthem HDHP Cost if you use an In-Network Provider	Anthem HDHP Cost if you use a Non-Network Provider

This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.

Children's Vision Exam (up to age 19) <i>Limited to 1 exam per benefit period</i>	No charge	Reimbursed up to \$30	No charge	Reimbursed up to \$30
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period</i>	\$15 copay	Reimbursed up to \$30	\$15 copay	Reimbursed up to \$30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational and speech therapy, if any apply to this plan, will not apply if you get care as part of the mental health and substance use disorder benefit.



This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

KeyCare 30 – Health Insurance Rates (Effective January 1 – December 31, 2025)

	Wellness Premium Paid by Employee	Non-Wellness Premium Paid by Employee
Employee Only	\$66.82	\$116.82
Employee + Child	\$241.82	\$291.82
Employee + Children	\$735.36	\$785.36
Employee + Spouse	\$668.44	\$718.44
Employee + Family	\$834.76	\$884.76
Both Working Spouse – School/City	\$133.64	\$233.64

Anthem HDHP + HSA – Health Insurance Rates (Effective January 1 – December 31, 2025)

	Wellness Premium Paid by Employee	Non-Wellness Premium Paid by Employee
Employee Only	\$21.52	\$71.52
Employee + Child	\$140.30	\$190.30
Employee + Children	\$409.60	\$459.60
Employee + Spouse	\$363.26	\$413.26
Employee + Family	\$468.54	\$518.54
Both Working Spouse – School/City	\$43.04	\$143.04

****NEW ENROLLEE OF THE Anthem HDHP+HSA PLAN:** Salem City Schools will offer a one-time deposit to the health savings account (HSA) for any new enrollees that sign up for this coverage. The deposit will be \$800 for the individual coverage and \$1,200 for all other plan choices. This will only apply to any employee that is enrolling in the Anthem HDHP plan for the first time. This deposit will be made after accounts have been established for the employee on this plan.

****CURRENT MEMBER OF THE Anthem HDHP+HSA PLAN:** Salem City Schools will provide monthly deposits into HSA accounts for employees that have the Anthem HDHP plan as of December 31, 2024. The amount will be \$101.00/month for individual coverage and \$131.00/month for all other plan choices. These deposits will total \$1,212 per year for individual coverage and \$1,572 per year for all other plan choices.



This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.



Vision Plan



Welcome to Your Blue View Vision Plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select Find a Doctor. You may also call member services for assistance at the number on the back of your ID card.

Your Blue View Vision Plan Benefits	In-Network	Out-of-Network	Frequency
Routine Eye Exam			
A comprehensive eye examination	\$15 copay	Up to \$30 allowance	Once every calendar year

Using Your Blue View Vision Plan

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

Out-of-Network

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at anthem.com, or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

To Fax: 866-293-7373 | To Email: oonclaims@eyewearspecialoffers.com
 To Mail: Blue View Vision, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Optional Savings Available From Blue View Vision In-Network Providers Only		Member Pays
Retinal Imaging	At member's option can be performed at time of eye exam	Not more than \$39
Eyeglass Frame	When purchases as part of a complete pair of eyeglasses*	35% off retail price
Eyeglass Lenses Standard plastic material	When purchased as part of a complete pair of eyeglasses*: - Single Vision - Bifocal - Trifocal	\$50 \$70 \$105
Eyeglass Lens Options and Upgrades <i>When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.</i>	When purchased as part of a complete pair of eyeglasses*: - UV Coating - Tint (Solid and Gradient) - Standard Scratch-Resistant Coating - Standard Polycarbonate - Standard Anti-Reflective Coating - Standard Progressive Lenses (add-on to Bifocal) - Other Add-Ons	\$15 \$15 \$15 \$40 \$45 \$65 20% off retail price
Conventional Contact Lenses (non-disposable type)	Discount applies to materials only	15% off retail price

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Additional Savings Available Through Anthem's Special Offers Program

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at the number on the back of your ID card. This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.



Wellness Program

Salem City Schools have incorporated a Wellness and Non-Wellness premium rate for the health insurance plan. Those choosing not to participate in the wellness program, will pay more per month for coverage. Employees can earn the discounted Wellness rate through engaging in the Wellness program outlined below.

Spouses on the City of Salem medical insurance are also a part of the wellness program with the same program requirements to complete a health risk assessment and one follow-up visit. Both the employee and covered spouse must complete the program to receive the Wellness rate.

To receive the wellness rate, all activities must be completed by October 31, 2025 and recorded by Synergy Healthcare to be eligible for the Wellness rate that will be effective January 1, 2026.

Step 1: Complete Your Health Risk Assessment

To earn your 2026 medical premium differential, your first activity is to complete your Health Risk Assessment by October 31, 2025. We encourage employees and spouses to complete the Health Risk Assessment at the annual screening event instead of at the onsite clinic. We will not be scheduling HRA's in the health clinic due to the increased number of required participants. Dates will be released in advance so you can schedule your appointment. It is important to schedule at the annual screening event in order to keep onsite clinic appointments open for follow-up visits and sick visits. You may also complete your health risk assessment at your physician's office if you would like.

To complete the Health Risk Assessment, you will need to do the following steps:

1. Complete the Know Your Number Questionnaire & Consent Form
2. Complete your Annual Health Screening Event (This includes biometrics: height, weight, waist, pulse, blood pressure; and labs: lipid panel and glucose panel). This is a fasted blood draw – please fast for 8 hours, please drink water.
3. If your HRA is done at your physician's office, please send all of the documentation in one packet to Synergy Healthcare by mail, fax, or email. Please do not send or drop-off any of this documentation at the City of Salem Onsite Clinic, or Human Resources Department.

Step 2: Complete One Follow-Up Visit

Complete one follow-up visit at the City of Salem Onsite Clinic or at your Primary Care Physician's Office by October 31, 2025. This visit should be related to a chronic condition, or a preventive care screening outlined below. If you visit the City of Salem Onsite Clinic, no further action is required for this step – Synergy Healthcare will receive documentation of your visit. If you visit your Primary Care Physician's Office, you will need to send documentation of your visit to Synergy Healthcare for them to give credit for this activity (documentation accepted would be a superbill, visit receipt, or Explanation of Benefits (EOB) and must include the date of your visit). Send all of the documentation to Synergy Healthcare by mail, fax, or email. Please do not send or drop-off any of this documentation at the City of Salem Onsite Clinic, or Human Resources Department.

Examples of follow-up visits that can be completed for Step 2:

Chronic Condition Visit	A visit related to a chronic health condition, such as, high cholesterol, high blood pressure, asthma, diabetes, etc. Sick visits do not qualify.	
Preventative Care Screening	Preventive Care Screening Preventive care screenings are outlined below by gender.	
	Male Physical Exam, Eye Exam, Prostate Specific Antigen Test (PSA), Colonoscopy, Osteoporosis Screen (Bone Density)	Female Physical Exam, Eye Exam, Well Woman/PAP Exam, Mammogram, Colonoscopy, Osteoporosis Screen (Bone Density)

Step 3: Submit Documentation for Step 1 and Step 2

Once Step 1 and Step 2 requirements have been met and documentation is hand, please submit

- a) Mail: P.O. Box 1069, Denver, N.C. 28037
- b) Fax: 704-966-0056
- c) Email documents or upload picture to: info@synergyhealthcare.net

Confidentiality

All programs are confidential and in compliance with the Health Insurance Portability Accountability Act (HIPAA). Any information shared with the Synergy Healthcare team will not be disclosed except in accordance with HIPAA laws. Your Protected Health Information will not be shared with your employer.

EMPLOYEE HEALTH CLINIC

For employees and their dependents that are enrolled in the school divisions' health care plan has access to the Employee Health Clinic (managed by Synergy Healthcare). Services provided are sick visits, chronic illness visits, prescriptions, labs/blood work, sports physicals, weight management, tobacco cessation, etc. The intent of the clinic is not to replace your primary care provider but rather to be an additional support and resource with no cost to the employee for visits or for services performed by clinic staff.

You can now schedule your Salem Health Clinic appointment online with the Synergy Healthcare Scheduler. Please visit www.timecenter.com/cityofsalem.

The clinic hours are as follows:

Monday - Thursday	7:00am – 5:00pm (closed noon- 1pm)
Friday	8:00am - Noon

Employee Health Clinic Phone Number: 540-378-0190

Employee Health Clinic Location: 15 East Clay Street, Salem, VA 24153

BENEFIT RESOURCE CENTER (BRC)

Occasionally, employees experience situations requiring an expert to resolve. Benefit Resource Center (BRC) provides Personal Benefit Advocates who are familiar with Salem's insurance plans, know carriers and are committed to assisting employees in resolving complex issues you may face. Benefit Resource Center (BRC) is a toll-free one-call benefits information hotline specifically designed to act as a single point of contact for all benefit and claim issues. Your Personal Benefit Advocate will be able to:

- ✓ answer benefit plan/policy questions
- ✓ assist with eligibility and claim problems with carriers
- ✓ provide claim appeals information and explain the process
- ✓ explain allowable family status election changes (adding newborns, marriage, divorce, etc.)
- ✓ provide vendor plan contact information

To speak to your Personal Benefit Advocate, please call 1-855-874-6699 or email BRCEast@usi.com





Dental Plan



Delta Dental – Salem City Schools

Annual Deductible (Applies to Basic)	\$25 per person; \$75 per family
Annual Maximum	\$1,000 per person, per calendar year
MaxOver™ Carryover	You plan allows a portion of an enrollee's annual maximum to be carried over to the next year.
Health Smile, Healthy You® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the Healthy Smile, Healthy You Program is simple. Visit DeltaDentalVA.com to print an enrollment form.

Coverage is Available for:

- Enrollee, spouse
- Dependent children to the end of the calendar year they reach age 26 (the "limiting age").

Covered Benefits

Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.

Coverage	In-Network		Out-of-Network	Benefit Waiting Period
	PPO	Premier		
Diagnostic & Preventive Services Oral exams and cleanings <ul style="list-style-type: none"> • Twice in a calendar year. Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings. Fluoride applications <ul style="list-style-type: none"> • Once in a calendar year for enrollees under the age of 19. Bitewing X-rays <ul style="list-style-type: none"> • Bitewing X-rays are limited to once in a calendar year limited to a maximum of 4 films or a set (7-8 films) of vertical bitewings. Full mouth/panelpipe X-rays <ul style="list-style-type: none"> • Once in a 3-year period. Sealants <ul style="list-style-type: none"> • One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1st and 2nd permanent molars. Space maintainers <ul style="list-style-type: none"> • Once per quadrant per arch for enrollees under the age of 14. 	100%	100%	100%	None
Basic Services Amalgam (silver) and composite (white) fillings <ul style="list-style-type: none"> • Once per surface in a 24-month period; Composite (white) fillings are limited to the upper and lower 6 front teeth. Stainless steel crowns <ul style="list-style-type: none"> • Primary (baby) teeth for enrollees under the age of 14. Simple extractions Endodontic services/root canal therapy <ul style="list-style-type: none"> • Retreatment only after 24 months from initial root canal therapy treatment. 	80%	80%	80%	80%

Coverage	In-Network		Out-of-Network	Benefit Waiting Period
	PPO	Premier		
Basic Services Periodontics services <ul style="list-style-type: none"> Once per quadrant in a 24-36 month period based on services rendered. Complex oral surgery <ul style="list-style-type: none"> Surgical extractions and other surgical procedures. Denture repair and recementation of crowns, bridges and dentures <ul style="list-style-type: none"> Once in a 12-month period after 6 months from initial placement. 	80%	80%	80%	None
Major Services Crowns <ul style="list-style-type: none"> Once per tooth in a 60-month period for enrollees age 12 & older. Prosthodontics, removable & fixed <ul style="list-style-type: none"> Once in a 60-month period for enrollees age 16 & older. Implants <ul style="list-style-type: none"> Once per site for enrollees age 16 & older. 	50%	50%	50%	None
Orthodontic Services Treatment for the proper alignment of teeth <ul style="list-style-type: none"> For subscriber & covered dependents. \$1,000 lifetime maximum 	50%	50%	50%	None

Choosing a Dentist

You may select the dentist of your choice. However, to get the full advantage of your Delta Dental coverage, you should choose a dentist who participates in the Delta Dental network(s) covered by your plan. Delta Dental PPO and Delta Dental Premier dentists have agreed to accept Delta Dental's plan allowance, plus any required coinsurance and deductible (if applicable) as payment in full. In addition, Delta Dental PPO and Delta Dental Premier dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist. Non-Participating dentists have not agreed to accept Delta Dental's plan allowance as full payment. After Delta Dental pays its portion of the bill, you are responsible for any required coinsurance and deductible (if applicable), as well as the difference between the non-participating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

Please visit DeltaDentalVA.com to find a participating dentist in your area. The following chart illustrates how choosing a network dentist helps you save on out-of-pocket costs.

	PPO Network Dentist	Premier Network Dentist	Non-Participating Dentist
Dentist's Charge for Covered Procedure	\$215.00	\$215.00	\$215.00
Delta Dental's Plan Allowance	\$126.00	\$169.00	\$113.00
Coinsurance Percentage	80%	80%	80%
Delta Dental's Payment	\$100.80	\$135.20	\$90.40
Patient Payment	\$25.20	\$33.80	\$124.60

The example shown is for illustrative purposes only. Payment structures may vary between plans.

Monthly Premiums

Subscriber Only	\$0.00
Subscriber + One Dependent	\$24.40
Family	\$59.50
Both Working Spouse – School/City	\$0.00



The preceding information is a brief description of the services covered under your plan. It is not intended for use as a summary plan description nor is it designed to serve as an Evidence of Coverage. If you have specific questions regarding benefit structure, limitations or exclusions, consult the plan document or call Delta Dental's Benefit Services Department at 800-237-6060.



Dependent Eligibility

Salem City Schools requires documentation demonstrating all insured dependents meet eligibility criteria. You have 30 calendar days from a qualifying event or if you are adding a dependent to your medical and/or dental plan during open enrollment.

<i>Dependents</i>	<i>Eligibility Definition</i>	<i>Documentation Required</i>
Spouse	A person to whom you are legally married	Photocopy of marriage certificate
Biological Child	A biological son or daughter	Photocopy of birth certificate showing employee's name
Adopted Child	An adopted son or daughter	Photocopy of the Final Adoption Decree OR Photocopy of the child's birth certificate showing the employee as the adopting parent
Stepchild of a Current Marriage	A stepson or stepdaughter	Photocopy of birth certificate showing employee's spouse name AND Photocopy of marriage certificate showing the employee and child's parent's name
Child under Legal Custody	A child for whom the employee has been granted legal custody	Photocopy of court order of custody affirming the child's placement in legal custody of the named employee
Foster Child	Certain eligible foster children	Photocopy of the certified foster care documents with the name of the child and the name of the employee
Disabled Child	A child age 26 or older who is wholly dependent on the employee for support and maintenance due to a disability that occurred prior to age 26	Photocopy of birth certificate showing employee's name AND completed Disability Certification form that has been approved by the carrier

Examples of ineligible individuals include:

- Former spouse
- Former spouse's child not biologically related to you (exceptions may apply with applicable court orders)
- Child age 26 or older unless they are disabled and dependent on you for support as defined above





Terms & Definitions

After-Tax Deduction	A deduction from an employee's pay that does not reduce the employee's taxable wages. It is taken out only after all applicable taxes and other deductions have been withheld.
Annual Deductible	The amount you pay out-of-pocket before the plan begins to pay benefits. For example, if your deductible is \$500, the plan won't pay anything until you have met your \$500 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. The deductible amount varies by plan. Deductibles are figured by calendar year: January-December.
Coinsurance	Shared cost for services between you and the company after the plan deductible is met
Copayment	A flat-dollar fee that is charged when you receive healthcare services
Deduction	An amount subtracted from an employee's gross pay to reach net pay
Dependent Care FSA	An account that allows you to set aside pre-tax dollars to pay for eligible child care expenses such as before- and after-school care and tuition, or elder care expenses such as in-home care and convalescent home expenses.
Healthcare FSA	An account that allows you to set aside pre-tax dollars to pay for out-of-pocket medical, dental, and vision expenses, including deductibles, coinsurance, and eligible services and supplies not covered by those health plans. NOTE: If you or a family member is enrolled in a high-deductible plan then you are not allowed to participate in a Healthcare FSA.
Health Savings Plan	Provides comprehensive medical coverage through Anthem and qualifies for a Health Savings Account. The plan gives you the flexibility to use pre-tax dollars to pay for your current or future eligible health expenses.
In-Network	Healthcare services from a healthcare facility, physician or professional that is contracted with Anthem. Using in-network services will typically lower your out-of-pocket costs. To find out if a healthcare provider is in-network, visit www.anthem.com .
Limited Healthcare FSA	Only participants in the Anthem HDHP plan can use this account to set aside pre-tax dollars to pay for out-of-pocket dental and vision expenses only. Medical expenses can be paid for on a tax-free basis using the Health Savings Account.
Out-of-Network	Healthcare services from a healthcare facility, physician or professional that is not contracted with Anthem. If you receive services out-of-network, you will typically have higher out-of-pocket costs.
Out-of-Pocket Maximum	The maximum amount that you could spend on covered health expenses each calendar year. In-network medical and prescription deductibles, copays and coinsurance apply toward the out-of-pocket maximum. NOTE: The following do not count toward the out-of-pocket maximum: routine vision care, costs above any benefit limits and non-covered services or supplies, or amounts health care providers not in the Anthem network may bill above the allowance.
Premium or Payroll	The amount you pay each pay period to have coverage through Salem City Contribution: Schools health and/or dental care plans. This amount is automatically deducted pre-taxed.
Pre-Taxed Premiums	Insurance premiums are automatically deducted before taxes are calculated. This reduces your taxable income. If you DO NOT want your premiums pre-taxed, you must submit a pre-tax waiver form. Please contact the Benefits Office for this form.
Preventative Care	Services such as annual physical exams, routine health screenings such as mammograms, prostate exams and colonoscopies, well-child care and routine and adult immunizations are covered at 100%. NOTE: Once you've been diagnosed with a condition or disease such as asthma, diabetes or hypertension, visits to your doctor to control or maintain those conditions are not considered preventative care.



Continuation Coverage Rights under COBRA

General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Salem Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Salem Schools Payroll/Benefits Office or the Human Resources Office. Official documentation will be required for this qualifying event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to: City of Salem Schools Payroll/Benefits Office or the Human Resources Office. Official documentation of disability will need to be provided within 30 days.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

City of Salem Schools
Payroll/Benefits or Human Resources Offices
510 S. College Avenue
Salem, VA 24153
Phone: (540) 389-0130



HEALTHY LIVING

*Core Benefit options to keep
you and your family healthy.*



Flexible Spending Account



Get reimbursed for out-of-pocket healthcare & child/aged adult day care expenses with tax free dollars!!

Maximize Your Income

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars!) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save approximately \$27.65 to \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Eligibility

Participation in the plan begins on January 1, 2025 and ends on December 31, 2025. You will be eligible to join the Plan if you are a full-time employee working at least 25 hours or more per week on the first of the month following your date of hire. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your Plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

The Health Care Account is a Pre-Funded Account

This means that you can submit a claim for medical expenses on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions which are taken from your paycheck on a pre-tax basis.

Contribution Limits: The maximum you may place in this account for the Plan Year is \$3,300.00.

Election Changes

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers



Reimbursement Schedule

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

Online Access

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at <https://fba.wealthcareportal.com/> to view the following features:

- FSA Login – view balances, check status and view claims history, download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

Health Care Reimbursement

With this account, you can pay for your out-of-pocket health care expenses for yourself, your spouse and all of your tax dependents for healthcare services that are incurred during your plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." This is a broad definition that lends itself to creativity.

Examples of Eligible Health Care Expenses

Fees/Co-Pays/Deductibles for:

- Acupuncture | Prescription eyeglasses/reading glasses/contact lens and supplies | Eye Exams/Laser Eye Surgery | Physician | Ambulance | Psychiatrist | Psychologist | Anesthetist | Hospital | Chiropractor | Laboratory/Diagnostic | Fertility Treatments | Surgery | Dental/Orthodontic Fees | Obstetrician | X-Rays | Eye Exams | Prescription Drugs | Artificial limbs & teeth | Orthopedic shoes/inserts | Therapeutic care for drug & alcohol addiction | Vaccinations & Immunizations | Mileage | Take-home screening kits

Diabetic supplies | Routine Physicals | Oxygen | Physical Therapy | Hearing aids & batteries | Medical equipment | Antacids | Pain relievers | Allergy & Sinus Medication

Over-the-Counter Expense (Examples of medication and drugs that may be purchased in reasonable quantities with a prescription):

- Acne Treatment | Humidifiers | Multivitamins | Herbal Supplements | Baby Formula | Fiber Supplements

Day Care/Aged Adult Care Reimbursement

The Day Care/Aged Adult Care FSA allows you to pay for daycare expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
 - Disabled spouse
 - Children who became disabled prior to age 19.
 - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- **\$5,000 (\$2,500 if married filing separately)**
- Your wages for the year or your spouse's if less than above
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

How to Receive Reimbursement

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you in your Employee Guide or on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

Eligible Day Care/Aged Adult Expenses

- Au Pair | Nannies | Before & After Care | Day Camps | Babysitters | Daycare for an Elderly Dependent | Daycare for a Disabled Dependent | Nursery School | Private Pre Schools | Sick Child Center | Licensed Day Care Centers

Ineligible Expenses:

- Overnight Camps | Babysitting for Social Events | Tuition Expenses including Kindergarten | Food Expenses (if separate from dependent care expenses) | Care provided by children under 19 (or by anyone you claim as a dependent) | Days your spouse doesn't work (though you may still have to pay the provider) | Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary | Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill | Expenses incurred while on Leave of Absence or Vacation

Forfeiting Funds

Plan carefully! Unused funds will be forfeited back to your employer as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to adopt the IRS offered 2 month 15-day grace period. Please see the Employee Guide for more information.

How to Enroll in our FSA Plan

Step 1

Carefully estimate your eligible Health Care and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at <https://fba.wealthcareportal.com/> to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	\$2,500.00	\$2,500.00
Eligible Pre-Tax employer medical insurance	\$0.00	\$200.00
Eligible Pre-Tax medical expenses	\$0.00	\$60.00
Eligible Pre-Tax dependent child care expenses	\$0.00	\$300.00
Taxable Income	\$2,500.00	\$1,940.00
Federal Tax (15%)	\$375.00	\$291.00
State Tax (5.75%)	\$125.00	\$97.00
FICA Tax (7.65%)	\$191.25	\$148.41
After-Tax employer medical insurance	\$200.00	\$0.00
After-Tax medical expenses	\$60.00	\$0.00
After-Tax dependent child care expenses	\$300.00	\$0.00
Monthly Spendable Income	\$1,248.75	\$1,403.59

By taking advantage of the Flexible Benefit Plan, this employee was able to increase his/her spendable income by \$154.84 every month! This means an annual tax savings of \$1,858.08. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

Online Wealthcare Portal

View your account status, submit claims and report your benefits card lost/stolen right from your computer. Once your account is established, you can use the same user name and password to access your account via our Mobile App!

Follow the simple steps below to establish your secure user account.

- ✓ Get started by visiting <https://fba.wealthcareportal.com/> and click the register button in the top-right corner of the homepage.
- ✓ You will be directed to the registration page.
- ✓ Follow the prompts to create your account.
 - User Name
 - Password
 - Name
 - Email Address
 - Employee ID (Your SSN, no spaces/dashes)
 - Registration ID
 - Employer ID (FBASCSC)
 - Your Benefits Card Number
- ✓ Once completed, please proceed to your account.



Benefits Card

The Benefits Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.

FBA Participant Portal, Mobile App, Benefits Card & Claim Submission

Scan the QR code with your smartphone to view the FBA Participant Portal, FBA Mobile App, FBA Benefits Card, and Claim submission information. The Participant Portal provides powerful self-service account access, plus education and decision-support tools that help put you in the driver's seat when it comes to your healthcare finances. The Mobile App offers a personalized, real-time and self-guided experience that allows you to easily manage your Benefit Account and delivers tools to help save you money. The benefits debit card eliminates the hassles of claim submission and waiting for a reimbursement check.



For more information, please call 800-437-3539
 P.O. Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com



Flexible Spending Account (Limited)



With the Limited Purpose FSA, get reimbursed for out-of-pocket dental & vision care expenses with tax free dollars!

Maximize Your Income

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars!) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save approximately \$27.65 to \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Eligibility

Participation in the Plan begins on January 1, 2025 and ends on December 31, 2025. You will be eligible to join the Plan if you are a full-time employee working at least 25 hours or more per week on the first of the month following your date of hire. You must also be enrolled in a High-Deductible Health Plan (HDHP). Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your Plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

The Limited FSA Accounts is a Prefunded Account

This means that you can submit a claim for qualified expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions are deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Plan Year is \$3,300.00.

Election Changes

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers



Reimbursement Schedule

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

Online Access

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at <https://fba.wealthcareportal.com/> to view the following features:

- FSA Login – view balances, check status and view claims history, download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

Benefits of Using Limited FSA with an HSA

With this account, you can pay for your out of pocket dental, vision, and preventative care expenses for yourself, your spouse and all of your dependents for services that are incurred during your plan year and while an active participant. Funds contributed to your Health Savings Account (HSA) can also cover these expenses, so why would someone choose to make a second contribution to a Limited FSA along with an HSA. Below are a few key reasons to contribute to both in order to get the most out of your HSA.

You will likely have Dental or Vision expenses early in the plan year.

A Limited FSA is prefunded at the beginning of the plan year while HSA funds are only available as they are deposited into your account. For this reason, if you are planning on incurring dental or vision expenses early in the plan year, a Limited FSA is a great way to pay for those expenses. With the Limited FSA, you can use your full election as soon as you need it in order to pay for expenses, since it acts like a tax-free, interest free loan. This is particularly useful for those who have just opened their HSA or those who haven't been able to build up a balance in their HSA account.

You want to use your HSA contributions primarily for medical expenses.

Since you are covered by a High-Deductible Health Plan, you know you may be required to pay higher amounts for medical expenses you incur. If you know you'll use most of your HSA contributions to pay for these medical expenses, it makes sense to set aside separate contributions to cover any vision or dental expenses.

You wish to use your HSA as a retirement or investment account.

HSAs offer a triple-tax advantage, meaning you get a tax advantage towards to your contributions, distributions (if used for eligible expenses), and any interest you earn from your HSA. Medicare expenses for those 65 years and older can easily add up to \$200,000 for a couple over the course of 20 years. This does not include dental, vision, hearing aids, and out-of-pocket drugs. By using funds from a Limited FSA, you can allow more money to remain in your HSA to gain interest while still getting the same tax advantage on your vision and dental expenses.

Eligible Vision & Dental Expenses

The Limited FSA allows you to pay for dental and vision expenses for you and your eligible dependents with pre-tax dollars. Eligible dental expenses include dental procedures that are not for cosmetic purposes and not covered by your insurance such as those listed below. Examples of Eligible Dental Expenses:

- Orthodontia (Braces)
- Fillings
- Crowns
- Checkups

For orthodontia expenses, you can use funds in your Limited FSA to either be reimbursed for a payment made in full on the first orthodontic visit (up to your annual election). If you pay for your orthodontia treatments over the span of multiple plan years, you can pay the monthly payment directly to your orthodontist, then send a claim form in each month to be reimbursed or you can pay your monthly payments with your Benefits Card and send FBA a copy of your orthodontic contract to keep on file so that we can setup a recurring expense on your account. Examples of Eligible Vision Expenses:

- Eyeglasses
- Routine Eye Exam
- Contact Lenses
- Prescription Sunglasses
- Lasik Eye Surgery
- Diagnostic Services

How to Receive Reimbursement

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you in your Employee Guide or on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

Eligible Preventative Care Expenses

In order for an expense to be considered "preventative care" you will need to acquire a prescription or letter of medical necessity from your medical provider that specifically states that the treatment is for the prevention of the onset of an illness. Once you are officially diagnosed with a condition, any expenses used towards treating the condition would not be eligible. Below are two examples of preventative care to prevent the onset of illnesses.

Diabetes

Your doctor may write you a letter of medical necessity stating that they recommend you get a gym membership and exercise in order to prevent the onset of Type II Diabetes.

High Blood Pressure

If you have a family history of high blood pressure, your doctor may write you a prescription for blood pressure medication preventing high blood pressure.

Other eligible "preventative care" expenses include tobacco cessation programs, cancer screening, heart and vascular care screenings, substance abuse screenings, routine prenatal care, and child and adult immunizations.

Forfeiting Funds

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to adopt the IRS offered 2 month 15-day grace period. Please see the Employee Guide for more info.

How to Enroll in our FSA Plan

Step 1

Carefully estimate your eligible dental, vision and/or preventative care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at <https://fba.wealthcareportal.com/> to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	\$2,500.00	\$2,500.00
Eligible Pre-Tax employer medical insurance	\$0.00	\$200.00
Eligible Pre-Tax medical expenses	\$0.00	\$60.00
Eligible Pre-Tax dependent child care expenses	\$0.00	\$150.00
Taxable Income	\$2,500.00	\$2,090.00
Federal Tax (15%)	\$375.00	\$315.50
State Tax (5.75%)	\$143.75	\$120.18
FICA Tax (7.65%)	\$191.25	\$159.89
After-Tax employer medical insurance	\$200.00	\$0.00
After-Tax medical expenses	\$60.00	\$0.00
After-Tax dependent child care expenses	\$150.00	\$0.00
Monthly Spendable Income	\$1,380.00	\$1,496.43

By taking advantage of the Limited FSA to cover dental and vision expenses and the HSA to cover their Medical expenses, this employee was able to increase his/her spendable income by \$116.43 every month! This means an annual tax savings of \$1,397.16. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

Online Wealthcare Portal

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- ✓ Get started by visiting <https://fba.wealthcareportal.com/> and click the register button in the top-right corner of the homepage.
- ✓ You will be directed to the registration page.
- ✓ Follow the prompts to create your account.
 - User Name
 - Password
 - Name
 - Email Address
 - Employee ID (Your SSN, no spaces/dashes)
 - Registration ID
 - Employer ID (FBASCSC)
 - Your Benefits Card Number
- ✓ Once completed, please proceed to your account.



FBA Participant Portal, Mobile App, Benefits Card & Claim Submission

Scan the QR code with your smartphone to view the FBA Participant Portal, FBA Mobile App, FBA Benefits Card, and Claim submission information. The Participant Portal provides powerful self-service account access, plus education and decision-support tools that help put you in the driver's seat when it comes to your healthcare finances. The Mobile App offers a personalized, real-time and self-guided experience that allows you to easily manage your Benefit Account and delivers tools to help save you money. The benefits debit card eliminates the hassles of claim submission and waiting for a reimbursement check.



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Health Savings Account (FAQ)



What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

Funds contributed to an HSA are triple-tax-advantaged.

1. Money goes in tax-free. Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited into your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.
2. Money comes out tax-free. Eligible healthcare purchases can be made tax-free when you use your HSA. Purchases can be made directly from your HSA account, either by using your benefits debit card, ACH, online bill-pay, or check, you can pay out-of-pocket and then reimburse yourself from your HSA.
3. Earn interest, tax-free. The interest on HSA funds grows on a tax-free basis. And, unlike most savings accounts, interest earned on an HSA is not considered taxable income when the funds are used for eligible medical expenses.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, vision, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

Am I eligible to participate?

In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.

What is a high-deductible health plan?

A HDHP is a health insurance plan with deductible amounts that are greater than \$1,650 for individual or \$3,300 for family coverage and have an out-of-pocket maximum that does not exceed \$8,300 for individual or \$16,600 for family coverage for 2025.

How do I contribute money to my HSA?

Payroll deduction is most likely offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

Can I change my contributions to my HSA during the year?

Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed \$4,300 for singles or \$8,550 for families in 2025. Individuals aged 55 and over may make an additional \$1,000 catch-up contributions.

Do I have to spend all my contributions by the end of the plan year?

No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-deferred.

What happens if my employment is terminated?

HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.

How do I access the funds in my HSA?

Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your HSA.

Can I withdraw the money for non-healthcare purchases?

Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll pay a 20% excise tax. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.

Can I roll over or transfer funds from my HSA or Medical Savings Account (or Archer MSA) into an HSA?

Yes. Pre-existing HSA funds or MSA monies may be rolled into an HSA and will continue their tax-free status.

Can I control how the funds are invested?

Yes. Once your HSA cash account balance reaches the minimum amount required by the custodian, you can transfer funds to an HSA investment account. You can choose from a selection of mutual funds and setup and allocation model for future transfers like you would for a 401k plan.

Can I transfer funds between the cash and investment accounts?

Yes. You can transfer money between your HSA cash and HSA investment account at any time.





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*Voluntary Benefit options
that enhance you and your
family's well being.*



Cancer Plan



ManhattanLife™



BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Plan Features

- ✓ Donor Benefits
- ✓ Wellness Benefits
- ✓ Many Benefits have No Lifetime Maximum
- ✓ Covers certain Lodging & Transportation
- ✓ Portable (take it with you)
- ✓ In & Out of hospital benefits
- ✓ Pays regardless of other coverage

Benefit	Benefit Option
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, Hemocult stool specimen, or prostate screen. No Lifetime Maximum	\$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to \$300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	1. \$0 2. \$2,500 3. \$0 4. \$5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or .50¢ per mile if a personal vehicle is used
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to \$75 per day for lodging .50¢ per mile if a personal vehicle is used
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to \$3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to \$50 per day for lodging and meals expense for donor to remain near Hospital.	a. \$200 b. Actual billed charges for round trip coach fare; or personal automobile expense of .50¢ per mile c. Actual billed charges up to \$50 per day
Bone Marrow and Stem Cell Transplant. We will pay Incurred Expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of \$15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	Up to 25% of surgical benefit paid. \$100 max per covered person for skin cancer
Ambulatory Surgical Center. We will pay the actual billed charges at an Ambulatory Surgical Center. No Lifetime Maximum	\$250 per day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to \$25 per day, \$600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to \$250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	1 & 2: Incurred Expenses up to \$2,500 per month 3 & 4: Incurred Expenses up to \$5,000 per month

<i>Benefit</i>	<i>Benefit Option</i>
Miscellaneous Diagnostic Charges. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime max of \$10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to \$4,000 per month
Colony Stimulating Factors. We will pay incurred expenses for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Incurred Expenses up to \$500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to \$200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to \$35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to \$100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if a Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non- Local Transportation Benefits of the policy.	Actual billed charges limited to a lifetime max up to \$750 for evaluation. Actual billed charges limited to a lifetime max up to \$350 for transportation & lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to \$1,500 lifetime max per amputation
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	Up to \$35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	\$300 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	Up to \$50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	Up to \$100 per day
New or Experimental Treatment. We will pay the actual billed charges by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to \$7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	Up to \$50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	\$200 per day
Hairpiece. We will pay the actual billed charges per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual billed charges up to a lifetime max of \$150
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to \$1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	\$100 per day

Other Specified Diseases Covered:

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

Payment of Benefits

Benefits are payable for a Covered Person's Positive Diagnosis, subject to the Pre-Existing Condition Limitation, unless coverage replaces a prior plan of similar coverage that was in force when the Policy was issued.

Pre-Existing Condition Limitation

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

Pre-Existing Condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions & Other Limitations

The policy pays benefits only for diagnoses resulting from Cancer of Specified Diseases, as defined in the Policy. It does not cover:

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by: Specified Disease or Specified Disease Treatment; or Cancer or Cancer treatment, or unless otherwise defined in the Policy;
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary; or
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Termination of Coverage

A Covered Person's insurance under the Policy will automatically terminate on the earliest of the following dates:

1. the date that the Policy terminates.
2. the date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the date the Policy is amended to terminate the eligibility of the Employee class.
4. any premium due date, if premium remains unpaid by the end of the grace period.
5. the premium due date coinciding with or next following the date the Covered Person ceases to be a member of an eligible class.
6. the date the Policyholder no longer meets participation requirements.

Portability

On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates. The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

- a) the Named Insured; or
- b) any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
- c) any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
- d) a newborn child (as described in the Eligibility Section).

Child (Children) means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

In consideration of additional premium, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits

Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit

You may choose the benefit of \$325 (Option 2) or \$625 (Option 4) per day. It is reduced by one-half at age 75.

Double Benefits

We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the named insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU

We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU, if you are admitted on an emergency basis, and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit

We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step Down Unit.

Exceptions and Other Limitations

Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable: if you go into an ICU before the Certificate Effective Date; if you go into an ICU for intentionally self-inflicted injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law in the jurisdiction where the accident or cause of loss occurred.

Group Cancer Rate Quote

Monthly Rates				
Coverage Tier	Option 1	Option 2	Option 3	Option 4
Employee	\$17.65	\$23.38	\$19.63	\$30.89
Employee + Spouse	\$35.57	\$47.60	\$39.44	\$62.87
Employee + Child(ren)	\$25.19	\$33.20	\$27.64	\$43.36
Family	\$43.10	\$57.43	\$47.45	\$75.34

Variable Benefit Elections				
Benefit	Option 1	Option 2	Option 3	Option 4
Hospital Confinement	\$100	\$100	\$100	\$100
Surgical	\$3,000	\$3,000	\$3,000	\$3,000
Radiation/ Chemotherapy	\$2,500 per month	\$2,500 per month	\$5,000 per month	\$5,000 per month
First Diagnosis	\$0	\$2,500	\$0	\$5,000
Colony Stimulating Factors	\$500 per month	\$500 per month	\$500 per month	\$500 per month
Wellness	\$100	\$100	\$100	\$100
Intensive Care Rider	\$0	\$325	\$0	\$625



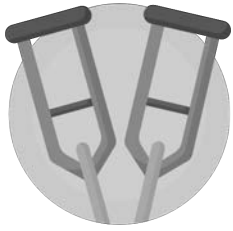
ManhattanLife™



BAY BRIDGE
ADMINISTRATORS

"Your solutions begin
at the Bridge"®

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company. This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected. Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact: Bay Bridge Administrators P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519



Group Accident Plan



Plan Features

- Benefits are payable regardless of any other insurance programs.
- Coverage is guaranteed-issue, provided the applicant is eligible for coverage.
- The plan features benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits are available for spouse and/or dependent children.
- There's no limit on the number of claims an insured can file.
- Premiums are paid by convenient payroll deduction.
- Immediate effective date – Coverage will be effective the date the employee signs the application.
- 24-Hour Coverage.

Eligibility (Issue Ages)

- Employee at least age 18
- Spouse at least age 18
- Children under age 26

The employee may purchase Accident Plus coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

Coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Accident Benefits – High Option

	Complete Fractures		Closed Reduction Benefits	
		Employee		Spouse/Child(ren)
Hip/Thigh		\$4,500		\$4,000
Vertebrae		\$4,050		\$3,600
Pelvis		\$3,600		\$3,200
Skull (depressed)		\$3,375		\$3,000
Leg		\$2,700		\$2,400
Forearm/Hand/Wrist		\$2,250		\$2,000
Foot/Ankle/Knee Cap		\$2,250		\$2,000
Shoulder Blade/Collar Bone		\$1,800		\$1,600
Lower Jaw (mandible)		\$1,800		\$1,600
Skull (simple)		\$1,575		\$1,400
Upper Arm/Upper Jaw		\$1,575		\$1,400
Facial Bones (except teeth)		\$1,350		\$1,200
Vertebral Processes		\$900		\$800
Coccyx/Rib/Finger/Toe		\$360		\$320

If the fracture requires open reduction, we will pay 150% of the amount shown. A **fracture** is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown. **Multiple fractures** refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture. However, we will pay no more than 150% of the benefit amount for the fractured bone which has the highest dollar amount. **Chip fracture** refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown for the affected bone. The maximum amount payable for the Fracture Benefit per covered accident is 150% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations

	Employee Closed Reduction	Spouse/Child(ren) Closed Reduction
Hip	\$4,000	\$3,000
Knee (not kneecap)	\$2,600	\$1,950
Shoulder	\$2,000	\$1,500
Foot/Ankle	\$1,600	\$1,200
Hand	\$1,400	\$1,050
Lower Jaw	\$1,200	\$900
Wrist	\$1,000	\$750
Elbow	\$800	\$600
Finger/Toe	\$320	\$240

If the dislocation requires open reduction, we will pay 150% of the amount shown. **Dislocation** refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan. **Multiple dislocations** refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 150% of the benefit amount for the dislocated joint that has the higher dollar amount. **Partial dislocation** is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint. The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount. If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis

Quadriplegia	\$10,000
Paraplegia	\$5,000

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident:

- The insured is injured,
- The injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations

Up to 2" long	\$50
2"-6" long	\$200
More than 6" long	\$400
Lacerations not requiring stitches	\$25

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration. If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery

Eye Injuries (treatment & surgery within 90 days)	\$250
Removal of foreign body from eye (requiring no surgery)	\$50
Tendons/Ligaments* (treatment within 60 days, surgical repair within 90 days)	
• Single	\$400
• Multiple	\$600
If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	
Ruptured Disc (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	\$100
• Injury occurs after first certificate year	\$400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	\$100
• Injury occurs after first certificate year	\$400

Burns (treatment within 14 days, first degree burns not covered)

Second Degree	
• Less than 10% of body surface covered	\$100
• At least 10%, but not more than 25% of body surface covered	\$200
• At least 25%, but not more than 35% of body surface covered	\$500
• More than 35% of body surface covered	\$1,000
Third Degree	
• Less than 10% of body surface covered	\$1,000
• At least 10%, but not more than 25% of body surface covered	\$5,000
• At least 25%, but not more than 35% of body surface covered	\$10,000
• More than 35% of body surface covered	\$20,000
Concussion (A concussion or Mild Traumatic Brain Injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: Concussion and MTBI are used interchangeably. The concussion must be diagnosed by a doctor.)	\$200
Coma (state of profound unconsciousness lasting 30 days or more)	\$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	\$1,000
Exploratory Surgery (without repair. i.e. arthroscopy)	\$250
Emergency Dental Work (injury to sound, natural teeth)	
• Repaired with crown	\$150
• Resulting in extractions	\$50

Medical Fees (for each accident)

Employee or Spouse	\$125
Child(ren)	\$75

We will pay the amount shown for X-rays or doctor services. For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident. We will pay the Medical Fees Benefit:

- For treatment received due to injuries from a covered accident **and**
- For each covered accident up to one year after the accident date.

Emergency Room Treatment

Employee or Spouse	\$125
Child(ren)	\$75

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room **and**
- Receives initial treatment within 14 days after the covered accident.

This benefit is payable only once per 24-hour period and only once per covered accident.

We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit

Employee or Spouse	\$75
Child(ren)	\$45

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, **and**
- Is held in a hospital for observation for at least 24 hours, **and**
- Receives initial treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-Up Treatment	\$25
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We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 14 days of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy	\$25
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We will pay the amount shown for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 14 days of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-up Treatment benefit is paid.

Air Ambulance	\$500
Ambulance	\$100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

<i>Transportation (within 90 days)</i>	
Train or Plane	\$300
Bus	\$150

If hospital treatment or diagnostic study is recommended by your physician and is not available in the insured's city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood/Plasma	\$100
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If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	\$500
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If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids—including false teeth—are not covered.

Appliance	\$100
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We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

Family Lodging Benefit (per night)	\$100
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If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness	\$60
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This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams
- Blood screenings
- Eye examinations
- Immunizations
- Flexible sigmoidoscopies
- Ultrasounds
- Mammograms
- Pap smears
- PSA tests

Hospital Admission	\$1,000
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We will pay the amount shown, when because of a covered accident, the insured:

- Is injured,
- Requires hospital confinement, **and**
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day)	\$200
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We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day)	\$400
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We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same injury is 30 days. This benefit is payable in addition to the Hospital Confinement Benefit.

Accidental Death & Dismemberment (within 90 days)

	Employee	Spouse	Children
Accidental Death	\$50,000	\$10,000	\$5,000
Accidental Common Carrier Death	\$100,000	\$50,000	\$15,000
Single Dismemberment	\$12,500	\$5,000	\$2,500
Double Dismemberment	\$25,000	\$10,000	\$5,000
Loss of One or More Fingers or Toes	\$1,250	\$500	\$250
Partial Amputation of Finger(s) of Toe(s) (including at least one joint)	\$100	\$100	\$100

Dismemberment means:

- Loss of a hand – The hand is cut off at or above the wrist joint; **or**
- Loss of a foot – The foot is cut off at or above the ankle; **or**
- Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**
- Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**
- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Limitations & Exclusions

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- **War** – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Sports** – participating in any organized sport—professional or semiprofessional.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Aflac Group Accident Monthly Rates

24 Hour Plan	Accident Rates
Employee	\$16.20
Employee & Spouse	\$23.16
Employee & Dependent Children	\$30.90
Family	\$37.86

Wellness Benefit included in rates.



Policy form number CAI7800VA.



Group Hospital Indemnity Plan (Non-HSA)



Plan Description

The Aflac Group Hospital Indemnity plan provides cash benefits *directly to you* (unless otherwise assigned) that help pay for some of the costs—medical and nonmedical—associated with a covered hospital stay due to a sickness or accidental injury.

Plan Features

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- Premiums paid through convenient payroll deduction
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

Additional Rider Available

- Waiver of Premium

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-Issue

Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first and second anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

Late Enrollee Eligibility

For late enrollees who are not eligible for guaranteed-issue: All applicants are required to answer underwriting questions.

Individual Eligibility

Issue Ages:

- Employee: 18+
- Spouse or Domestic Partner: 18+
- Children: Under age 26

Spouse or Domestic Partner Coverage Available

To apply for spouse or domestic partner coverage, *you must also apply* and be issued coverage. *Spouse/Domestic Partner-only coverage is not available.*

Dependent Children Coverage Available

Dependent children under the age of 26 can be covered. To apply for dependent child coverage, *you must also apply* and be issued coverage. If you do not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, you must apply for coverage for the child and pay any required premium. *Children-only coverage is not available.*

Successor Insured Benefit

If spouse or domestic partner coverage is in force at the time of the primary insured's death, the surviving spouse or domestic partner may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.

Continuity of Coverage

Coverage may be continued with certain stipulations. See certificate for complete details.

Group Hospital Indemnity Benefits | Hospitalization Benefits – Base Plan

Benefits	Low	High
<p>Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured</p> <p>We will pay the amount shown when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).</p>	\$500	\$1,500
<p>Hospital Confinement (per day) – maximum of 180 days per confinement for each covered sickness or accident for each insured</p> <p>We will pay this benefit in the amount shown for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, the insured must be confined to a hospital within six months of the date of the covered accident. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</p>	\$100	\$150

*Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement only.

Health Screening Benefit – Once Per Calendar Year For Each Insured

Benefit	Benefit Amount
Health Screening Benefit	\$50 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Treatment Benefits

Benefit	Low	High
<p>Major Diagnostic Exams – once per covered sickness or accident per calendar year</p> <p>We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams:</p> <ul style="list-style-type: none"> • Computerized Tomography (CT/CAT scan) • Magnetic Resonance Imaging (MRI) • Electroencephalography (EEG) 	\$125	\$250

Surgical Benefits

Benefit	Low	High
<p>Surgical Benefit (per procedure)</p> <p>If an insured has surgery performed by a physician due to an injury or because of a covered sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a hospital (on an inpatient or outpatient basis), in an ambulatory surgical center, or in a physician's office. If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations (the operation that is nearest in severity and complexity). If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit—the largest—will be provided.</p>	Up to \$750	Up to \$1,500

Surgical Benefits Continued

Benefit	Low	High
<p>Anesthesia Benefits</p> <p>When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.</p>	Up to \$187.50	Up to \$375

Waiver of Premium Rider

If the employee becomes totally disabled due to a covered sickness or accidental injury, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Limitations & Exclusions (applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity.
- **Custodial Care** – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- **Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.**
- **Services performed by a Family Member.**
- **Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.**
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services or Treatment.**
- **Cosmetic Surgery**, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

Aflac Group Hospital Indemnity Monthly Rates

Covered	Low Option	High Option
Employee	\$20.96	\$42.32
Employee + Spouse	\$41.92	\$84.96
Employee + Child(ren)	\$30.96	\$61.76
Family	\$51.92	\$104.40





Group Hospital Indemnity Plan (HSA)



Plan Description

The Aflac Group Hospital Indemnity plan provides cash benefits **directly to you** (unless otherwise assigned) that help pay for some of the costs—medical and nonmedical—associated with a covered hospital stay due to a sickness or accidental injury.

Plan Features

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- Premiums paid through convenient payroll deduction
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

Additional Rider Available

- Waiver of Premium

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-Issue. Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first and second anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

Late Enrollee Eligibility. For late enrollees who are not eligible for guaranteed-issue: All applicants are required to answer underwriting questions.

Individual Eligibility

Issue Ages:

- Employee: 18+
- Spouse or Domestic Partner: 18+
- Children: Under age 26

Spouse or Domestic Partner Coverage Available

To apply for spouse or domestic partner coverage, **you must also apply** and be issued coverage. **Spouse/Domestic Partner-only coverage is not available.**

Dependent Children Coverage Available

Dependent children under the age of 26 can be covered. To apply for dependent child coverage, **you must also apply** and be issued coverage. If you do not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, you must apply for coverage for the child and pay any required premium. **Children-only coverage is not available.**

Successor Insured Benefit

If spouse or domestic partner coverage is in force at the time of the primary insured's death, the surviving spouse or domestic partner may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.

Portability

Coverage may be continued with certain stipulations. See certificate for complete details.

Waiver of Premium Rider

If the employee becomes totally disabled due to a covered sickness or accidental injury, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Health Screening Benefit – Once Per Calendar Year For Each Insured

Health Screening Benefit - \$50 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Group Hospital Indemnity Benefits | Hospitalization Benefits – Base Plan

Benefits	High
<p>Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured We will pay the amount shown when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).</p>	\$1,500
<p>Hospital Confinement (per day) – maximum of 180 days per confinement for each covered sickness or accident for each insured We will pay this benefit in the amount shown for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, the insured must be confined to a hospital within six months of the date of the covered accident. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</p>	\$150

*Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement only.

Limitations & Exclusions (applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity.
- **Custodial Care** – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- **Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.**
- **Services performed by a Family Member.**
- **Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.**
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services or Treatment.**
- **Cosmetic Surgery**, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

Aflac Group Hospital Indemnity Monthly Rates

Covered	High Option
Employee	\$25.70
Employee + Spouse	\$51.50
Employee + Child(ren)	\$40.36
Family	\$66.16





Group Critical Illness Plan

without Cancer



Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to \$50,000 for employees and up to \$30,000 for spouses
- Dependent children are covered at 50% of the primary insured's amount at no additional charge
- There are no pre-existing condition limitations
- The plan doesn't have a waiting period for benefits
- Benefits do not reduce as insureds get older
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Guaranteed-Issue coverage is available (which means you may qualify for coverage without having to answer health questions).

Underwriting Guidelines – Guaranteed- Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available: Up to **\$30,000** for employees and up to **\$15,000** for spouses with no participation requirement.

For employee amounts over **\$30,000** and spouse amounts over **\$15,000**:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **30 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of \$5,000. To apply for spouse coverage, **the employee must also apply**.

If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and be limited to face amounts between \$5,000 and \$30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. **Children-only coverage is not available.**

Waiver of Premium

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Heart Attack	100%
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Transient Ischemic Attack (TIA)	\$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Additional Diagnosis. Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence. Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	\$100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children.

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1 - Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%*
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2 - Invasive Procedures and Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

Limitations & Exclusions *(Applies to all riders unless otherwise noted)*

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts.
 - Insurrection or riot.
 - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
 - Abuse of legally-obtained prescription medication.
 - Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

All limitations and exclusions that apply to the critical illness plan also apply to all riders, if applicable, unless amended by the riders.

Aflac Group Critical Illness w/out Cancer – Monthly Rates

NON-TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$4.24	\$5.41	\$6.59	\$7.77	\$8.94	\$10.12	\$11.30	\$12.47	\$13.65	\$14.83
30-39	\$4.88	\$6.71	\$8.53	\$10.36	\$12.18	\$14.01	\$15.83	\$17.66	\$19.48	\$21.31
40-49	\$7.25	\$11.45	\$15.64	\$19.84	\$24.03	\$28.22	\$32.42	\$36.61	\$40.80	\$45.00
50-59	\$9.95	\$16.84	\$23.72	\$30.61	\$37.50	\$44.39	\$51.28	\$58.16	\$65.05	\$71.94
60+	\$14.33	\$25.60	\$36.87	\$48.14	\$59.41	\$70.68	\$81.95	\$93.22	\$104.49	\$115.76

NON-TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$4.24	\$5.41	\$6.59	\$7.77	\$8.94	\$10.12
30-39	\$4.88	\$6.71	\$8.53	\$10.36	\$12.18	\$14.01
40-49	\$7.25	\$11.45	\$15.64	\$19.84	\$24.03	\$28.22
50-59	\$9.95	\$16.84	\$23.72	\$30.61	\$37.50	\$44.39
60+	\$14.33	\$25.60	\$36.87	\$48.14	\$59.41	\$70.68

TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$5.28	\$7.50	\$9.72	\$11.95	\$14.17	\$16.39	\$18.61	\$20.83	\$23.05	\$25.27
30-39	\$7.38	\$11.70	\$16.02	\$20.34	\$24.66	\$28.99	\$33.31	\$37.63	\$41.95	\$46.27
40-49	\$12.19	\$21.32	\$30.45	\$39.58	\$48.71	\$57.84	\$66.97	\$76.10	\$85.23	\$94.36
50-59	\$17.40	\$31.73	\$46.07	\$60.40	\$74.74	\$89.07	\$103.41	\$117.74	\$132.08	\$146.41
60+	\$27.40	\$51.73	\$76.07	\$100.41	\$124.74	\$149.08	\$173.42	\$197.75	\$222.09	\$246.42

TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$5.28	\$7.50	\$9.72	\$11.95	\$14.17	\$16.39
30-39	\$7.38	\$11.70	\$16.02	\$20.34	\$24.66	\$28.99
40-49	\$12.19	\$21.32	\$30.45	\$39.58	\$48.71	\$57.84
50-59	\$17.40	\$31.73	\$46.07	\$60.40	\$74.74	\$89.07
60+	\$27.40	\$51.73	\$76.07	\$100.41	\$124.74	\$149.08





Group Critical Illness Plan with Cancer



Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to \$50,000 for employees and up to \$30,000 for spouses
- Dependent children are covered at 50% of the primary insured's amount at no additional charge
- There are no pre-existing condition limitations
- The plan doesn't have a waiting period for benefits
- Benefits do not reduce as insureds get older
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Guaranteed-Issue coverage is available (which means you may qualify for coverage without having to answer health questions).

Underwriting Guidelines – Guaranteed- Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available: Up to **\$30,000** for employees and up to **\$15,000** for spouses with no participation requirement.

For employee amounts over **\$30,000** and spouse amounts over **\$15,000**:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **30 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of \$5,000. To apply for spouse coverage, **the employee must also apply**.

If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and be limited to face amounts between \$5,000 and \$30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. **Children-only coverage is not available.**

Waiver of Premium

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis+

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Cancer (Internal or Invasive) ++	100%
Heart Attack	100%
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer ++	25%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Skin Cancer ++	\$250 (once per calendar year/insured)
Transient Ischemic Attack (TIA)	\$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

++For employees who have chosen the without cancer plan option, these cancer benefits do not apply.

Additional Diagnosis +

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence +

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

+ If the claim is for a cancer diagnosis, the insured must be treatment-free from cancer for at least 12 months and must be in complete remission before the date of a subsequent cancer diagnosis.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	\$100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children.

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1 - Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%*
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2 - Invasive Procedures and Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

Limitations & Exclusions *(Applies to all riders unless otherwise noted)*

Cancer Diagnosis Limitation

Benefits are payable for Cancer and/or Non-Invasive Cancer as long as the Insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts.
 - Insurrection or riot.
 - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
 - Abuse of legally-obtained prescription medication.
 - Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

All limitations and exclusions that apply to the critical illness plan also apply to all riders, if applicable, unless amended by the riders.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions. If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Aflac Group Insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company, Columbia, South Carolina.

EXP (10/23)

Aflac Group Critical Illness w/ Cancer – Monthly Rates

NON-TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$5.75	\$8.42	\$11.09	\$13.77	\$16.44	\$19.11	\$21.78	\$24.45	\$27.12	\$29.79
30-39	\$7.24	\$11.40	\$15.56	\$19.72	\$23.88	\$28.04	\$32.20	\$36.37	\$40.53	\$44.69
40-49	\$11.90	\$20.72	\$29.54	\$38.36	\$47.18	\$56.00	\$64.82	\$73.64	\$82.46	\$91.28
50-59	\$19.30	\$35.52	\$51.74	\$67.95	\$84.17	\$100.39	\$116.61	\$132.83	\$149.05	\$165.26
60+	\$32.99	\$62.90	\$92.81	\$122.72	\$152.63	\$182.54	\$212.45	\$242.36	\$272.27	\$302.18

NON-TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$5.75	\$8.42	\$11.09	\$13.77	\$16.44	\$19.11
30-39	\$7.24	\$11.40	\$15.56	\$19.72	\$23.88	\$28.04
40-49	\$11.90	\$20.72	\$29.54	\$38.36	\$47.18	\$56.00
50-59	\$19.30	\$35.52	\$51.74	\$67.95	\$84.17	\$100.39
60+	\$32.99	\$62.90	\$92.81	\$122.72	\$152.63	\$182.54

TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$7.01	\$10.94	\$14.87	\$18.80	\$22.73	\$26.66	\$30.59	\$34.52	\$38.44	\$42.37
30-39	\$10.11	\$17.13	\$24.16	\$31.18	\$38.21	\$45.23	\$52.26	\$59.28	\$66.31	\$73.33
40-49	\$18.07	\$33.06	\$48.04	\$63.03	\$78.02	\$93.01	\$108.00	\$122.99	\$137.97	\$152.96
50-59	\$31.01	\$58.94	\$86.86	\$114.79	\$142.72	\$170.65	\$198.57	\$226.50	\$254.43	\$282.36
60+	\$54.24	\$105.41	\$156.57	\$207.74	\$258.90	\$310.06	\$361.23	\$412.39	\$463.55	\$514.72

TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$7.01	\$10.94	\$14.87	\$18.80	\$22.73	\$26.66
30-39	\$10.11	\$17.13	\$24.16	\$31.18	\$38.21	\$45.23
40-49	\$18.07	\$33.06	\$48.04	\$63.03	\$78.02	\$93.01
50-59	\$31.01	\$58.94	\$86.86	\$114.79	\$142.72	\$170.65
60+	\$54.24	\$105.41	\$156.57	\$207.74	\$258.90	\$310.06





Short-Term Disability Plan



Class Description

All Eligible Employees working a minimum of 25 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

Disability

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit

You can choose a benefit in \$100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$3,000. The minimum monthly benefit is \$500.

Elimination Period

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Benefit Duration

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks.

Basis of Coverage

24 Hour Coverage, on or off the job.

Maternity Coverage

Maternity claims are standardly paid at 6 weeks for normal delivery and 8 weeks for c-section, minus the elimination period. If there are any complications with supporting medical documentation, benefits could be extended after review from the claims analyst. Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date.

Recurrent Disability

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318. The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment

Employees who did not elect coverage during their initial enrollment period are eligible to sign up for \$500 to \$1,000 monthly benefit without medical questions. Employees may increase their coverage up to \$500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in \$100 increments.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group, the group policy will prevail.

AUL Short-Term Disability Monthly Rates

Benefit Duration
13 weeks

Monthly Benefit	Monthly Premium
\$500	\$10.36
\$600	\$12.43
\$700	\$14.50
\$800	\$16.57
\$900	\$18.64
\$1,000	\$20.71
\$1,100	\$22.78
\$1,200	\$24.85
\$1,300	\$26.92
\$1,400	\$28.99
\$1,500	\$31.07
\$1,600	\$33.14
\$1,700	\$35.21
\$1,800	\$37.28
\$1,900	\$39.35
\$2,000	\$41.42
\$2,100	\$43.49
\$2,200	\$45.56
\$2,300	\$47.63
\$2,400	\$49.70
\$2,500	\$51.78
\$2,600	\$53.85
\$2,700	\$55.92
\$2,800	\$57.99
\$2,900	\$60.06
\$3,000	\$62.13



Customer Service: 800-553-5318 | Disability Claims: 855-517-6365 | Fax: 844-287-9499

Disability Claims Email: Disability.Claims@oneamerica.com | www.employeebenefits.aul.com

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group, the group policy will prevail.



Long-Term Disability Plan



LTD Class Description

All Full-Time Eligible Employees working a minimum of 25 hours per week, electing to participate in the Voluntary Long-Term Disability.

LTD Monthly Benefit

You can choose to **insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$2,000 in \$500 increments. The minimum benefit is \$500.**

LTD Elimination Period

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

LTD Benefit Duration

This is the period of time that benefits will be payable for long-term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

Age When Total Disability Begins	Maximum Period Benefits are Payable
Prior to Age 61	5 Years
61	Lesser of SSFRA or 5 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and Over	12 Months

LTD Total Disability Definition

An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefits have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

Special Conditions

Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

Mental & Nervous / Drug & Alcohol

Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

Other Income Offsets

AUL will reduce your LTD disability benefit with other disability income benefits that you might be receiving from AUL or external sources such as Social Security or other disability or income benefits you may receive, or be eligible to receive.

Waiver of Premium

AUL will waive the premium payments for your coverage while you are disabled and will continue to be waived during the elimination period and the benefit eligibility period.

Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Continuity of Coverage will apply if the employee was insured under the employers' prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

The Portability Privilege is not available to any Person that retires (when the person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 or \$1000 monthly benefit without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

Exclusions and Limitations

This plan will not cover any disability resulting from certain events or conditions such as but not limited to war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. Additional exclusions and limitations may apply.

AUL Long-Term Disability Monthly Rates

Monthly Benefit Amount	Age 0 - 29	Age 30 - 39	Age 40 - 49	Age 50 - 59	Age 60 +
\$500	\$1.95	\$3.25	\$4.25	\$11.45	\$17.15
\$1,000	\$3.90	\$6.50	\$8.50	\$22.90	\$34.30
\$1,500	\$5.85	\$9.75	\$12.75	\$34.35	\$51.45
\$2,000	\$7.80	\$13.00	\$17.00	\$45.80	\$68.60



AMERICAN UNITED LIFE
INSURANCE COMPANY®
a ONEAMERICA® company

This information is provided as a Benefit Outline. It is not part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverages under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.



Whole Life Plan

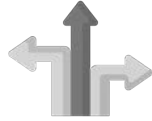


Whole Life Insurance

Employers want to provide employees with a benefits package that fits their ever-changing needs. With its guaranteed premiums, benefits, and values, as well as the option to insure your entire family, Boston Mutual's whole life insurance can help complete your benefit package. Life changes...so it may be time to review how much coverage you have and consider what your family might need if something should happen. Whether you're just starting out at your first job, or nearing retirement, whole life insurance should be an integral part of your financial plan. Just like Boston Mutual has always been there for our policyholders, whole life coverage will always be there to provide you and your family protection and security for the future.



Affordable



Flexible



Worldwide Coverage



Portable

Benefits

- ✓ Available for you, your spouse, children, and grandchildren.
- ✓ Guaranteed coverage with no medical questions, up to certain amounts.
- ✓ You select the amount of insurance you need and how much you can afford.
- ✓ Payroll deduction makes payment easy.
- ✓ Your payment amount will stay the same, even if you change employment or retire.
- ✓ Builds cash value.
- ✓ Annual statements provide current policy value information.
- ✓ Paid up options, based on accrued cash values.

Boston Mutual offers a Guarantee Issue amount for you, your Spouse, Children, and Grandchildren when you enroll. This is an amount of coverage that is issued without any medical underwriting questions.

- **EMPLOYEE Guaranteed Issue - \$100,000**
- **SPOUSE Guaranteed Issue - \$25,000**
- **CHILD & GRANDCHILD Guaranteed Issue - \$25,000**

Guaranteed Issue is offered at every annual enrollment to eligible employees, spouses, children, and grandchildren.

Guarantees

- ✓ **Premium** – As long as you continuously pay your premiums, the cost of your life insurance policy can never go up.
- ✓ **Cash Value** – The cash value illustrated at the time of purchase is guaranteed as long as your coverage stays in force*.
- ✓ **Interest Rate** – This policy provides a 3% guaranteed credited interest rate on accruing cash values.
- ✓ **Portability** – Even if your employer changes, you can arrange to pay us directly and keep your coverage.
- ✓ **Coverage Issued** – Employees and their spouses who are actively at work for a minimum of 20 hours per week can purchase this insurance up to certain limits, despite past or present health problems.
- ✓ **Additional Purchase** – If you buy a minimum amount of coverage, you guarantee yourself the right to purchase any remaining portion of the guaranteed issue limit at future approved enrollments (subject to product and payroll deduction availability).

Our Whole Life workplace insurance is an endowment at age 95 policy, which means the face value would be paid to the insured, if living, at age 95.

** The actual cash value may be decreased by loans or withdrawals.*

Additional Features (That may be available to you)

- ✓ **Accidental Death Benefit** – doubles or triples the amount paid in the event of accidental death. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage (up to \$100,000).
- ✓ **Children's Insurance Benefit** – covers all eligible natural children, stepchildren, or legally adopted children from age 15 days through age 25.
- ✓ **Payor Waiver of Premium** – pays premiums on the employee, spouse, or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60.

Not all riders will be available for purchase as they are options made available to you by your employer in their benefits offering. Riders are not approved in all states. For specific information – speak to your Boston Mutual representative.

Boston Mutual Whole Life Sample Defined Benefit Premium Rates & Values

The following are illustrations of applicable coverage and cash value accumulation at various ages and contribution levels for the whole life insurance coverage.

Non Tobacco	Issue Age*	Monthly Premium*	Guaranteed Cash Value at \$5,000	Guaranteed Cash Value at \$10,000	Guaranteed Cash Value at \$30,000	Guaranteed Cash Value at 65	Guaranteed Paid Up at 65
\$25,000	25	\$20.65	\$286	\$1,127	\$3,203	\$9,790	\$20,398
	35	\$30.18	\$518	\$1,713	\$4,766	\$8,751	\$18,232
	45	\$46.95	\$922	\$2,725	\$7,112	\$7,112	\$14,817
	55	\$77.05	\$1,525	\$4,229	\$10,426	\$4,229	\$8,811
\$50,000	25	\$38.99	\$572	\$2,255	\$6,405	\$19,580	\$40,796
	35	\$58.04	\$1,036	\$3,426	\$9,532	\$17,501	\$36,464
	45	\$91.59	\$1,844	\$5,450	\$14,223	\$14,223	\$29,634
	55	\$151.79	\$3,069	\$8,458	\$20,852	\$8,458	\$17,623
\$75,000	25	\$57.32	\$857	\$3,382	\$9,608	\$29,370	\$61,193
	35	\$85.91	\$1,553	\$5,138	\$14,297	\$26,252	\$54,695
	45	\$136.22	\$2,765	\$8,174	\$21,335	\$21,335	\$44,451
	55	\$226.53	\$4,742	\$12,698	\$31,277	\$12,698	\$26,456
\$100,000	25	\$75.66	\$1,143	\$4,509	\$12,810	\$39,160	\$81,591
	35	\$113.77	\$2,071	\$6,851	\$19,063	\$35,002	\$72,927
	45	\$180.86	\$3,687	\$10,899	\$28,446	\$28,446	\$59,268
	55	\$301.27	\$6,415	\$17,131	\$41,703	\$17,131	\$35,693
Tobacco	Issue Age*	Monthly Premium*	Guaranteed Cash Value at \$5,000	Guaranteed Cash Value at \$10,000	Guaranteed Cash Value at \$30,000	Guaranteed Cash Value at 65	Guaranteed Paid Up at 65
\$25,000	25	\$27.75	\$459	\$1,566	\$4,250	\$11,712	\$20,715
	35	\$43.25	\$783	\$2,337	\$6,102	\$10,488	\$18,549
	45	\$71.47	\$1,237	\$3,499	\$8,488	\$8,488	\$15,013
	55	\$115.82	\$1,864	\$4,944	\$10,976	\$4,944	\$8,744
\$50,000	25	\$53.18	\$918	\$3,132	\$8,500	\$23,424	\$41,430
	35	\$84.18	\$1,566	\$4,675	\$12,205	\$20,975	\$37,098
	45	\$140.63	\$2,475	\$6,998	\$16,977	\$16,977	\$30,026
	55	\$229.32	\$3,728	\$9,888	\$21,952	\$9,888	\$17,489
\$75,000	25	\$78.62	\$1,376	\$4,697	\$12,749	\$35,136	\$62,144
	35	\$125.11	\$2,348	\$7,012	\$18,307	\$31,463	\$55,647
	45	\$209.78	\$3,712	\$10,497	\$25,465	\$25,465	\$45,039
	55	\$342.82	\$5,592	\$14,832	\$32,927	\$14,832	\$26,233
\$100,000	25	\$104.05	\$1,835	\$6,263	\$16,999	\$46,848	\$82,859
	35	\$166.04	\$3,131	\$9,349	\$24,409	\$41,950	\$74,196
	45	\$278.94	\$4,949	\$13,996	\$33,953	\$33,953	\$60,052
	55	\$456.33	\$7,456	\$19,776	\$43,903	\$19,776	\$34,977

* Premiums shown include Payor Waiver of Premium. Payor Waiver of Premium pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.



120 Royall Street, Canton, MA 02021 | 800.669.2668 | www.bostonmutual.com

Policies underwritten by Boston Mutual Life Insurance Company. This information is not intended to be a complete description of the insurance coverage available. For complete details of coverage and availability, please refer to the policy form or contact your Boston Mutual representative.



Identity Theft & Legal Protection



Have You Ever?

- ✓ Needed your Will prepared or updated
- ✓ Signed a contract
- ✓ Received a moving traffic violation
- ✓ Worried about being a victim of Identity theft
- ✓ Been concerned about your child's identity
- ✓ Had social media accounts? (Facebook, Instagram, Twitter, LinkedIn, YouTube)

The LegalShield Membership Includes:

- ✓ Dedicated Law Firm
- ✓ Legal Advice/Consultation on unlimited personal issues
- ✓ Letters/Calls made on your behalf
- ✓ Contracts/Documents Reviewed up to 15 pages
- ✓ Residential Loan Document Assistance
- ✓ Lawyers prepare your Will/Living Will/Health Care
- ✓ Power of Attorney
- ✓ Speeding Ticket Assistance (available 15 days after enrollment)
- ✓ IRS Audit Assistance
- ✓ Trial Defense (if named defendant/respondent in a covered civil action suit)
- ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- ✓ 25% Preferred Member Discount (bankruptcy, criminal charges, DUI, personal injury, etc.)
- ✓ 24/7 Emergency Access for covered situations

The IDShield Membership Includes:

- ✓ Credit Monitoring Continuous credit monitoring through TransUnion
- ✓ Online Privacy Management IDShield provides consultation and guidance on ways participants can protect their privacy and personally identifiable information across the internet and on their smart devices.
- ✓ NEW! Reputation Management & Score Scans social media accounts for existing content that could be damaging to participants online reputation. Ranks your online reputation risk by giving you a score based off the content found on your social media accounts.
- ✓ Financial Account Monitoring Accounts monitored include checking, savings, employer 401k accounts, loans and more.
- ✓ \$1 Million Protection Policy Coverage for lost wages, legal defense fees, stolen funds and more.
- ✓ Unlimited Service Guarantee Ensures that we won't give up until your identity is restored!
- ✓ Identity Restoration Performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- ✓ 24/7 Emergency Access In the event of an identity theft emergency

LegalShield | IDShield Rates

Payment Frequency	Individual	Family
LegalShield	\$21.95	\$21.95
IDShield	\$12.95	\$22.95
Combined	\$34.90	\$41.90

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children.

IDShield family coverage includes, the member, member's spouse and up to 8 minor children under the age of 18. Dependents age 18-26 receive consultation and restoration only.

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.



Filing a Claim

Manhattan Life Group Cancer

Visit <https://mymarkiii.com/salemcityschoolsva/forms/> to download your claim form. You may also utilize the online claims portal simply login here https://portal.bbadmin.com/users/sign_in and submit claims in minutes.

- Please have the following information available: Claimant Name, Date of Service, Name of Service/Screening, Provider Name, and Phone Number.
- Manhattan Life Wellness Benefits can also be called into a Bay Bridge claim's examiner at (800) 845-7519.

Group Aflac

Visit <https://mymarkiii.com/salemcityschoolsva/forms/> to download your claim form or to file online visit <https://www.aflacgroupinsurance.com> and click on **Customer Service** and then **File a Claim**. Choose your claim form and follow the instructions. Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information.

AUL Disability

Visit <https://mymarkiii.com/salemcityschoolsva/forms/> to download your claim form. Complete the form and send the form and supporting documentation by email, fax, or mail. If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

Employee Benefits Portal

Use your smartphone to scan the QR code or visit the link for quick access to your employee benefits portal page. Review your benefits guide online, download claim forms, and much more!

Visit: <https://mymarkiii.com/salemcityschoolsva/>.





Wellness Benefits

What is a Wellness Benefit?

Certain plans have a wellness feature built into your benefit options. This benefit gives **money back to you** for having a qualified screening test and then filing a claim for the screening test performed.

Qualified Screening Test*

- ✓ Hemoccult stool analysis
- ✓ Breast ultrasound
- ✓ Mammography
- ✓ CA 125 (blood test for ovarian cancer)
- ✓ CA 15-3 (blood test for breast cancer)
- ✓ CEA (blood test for colon cancer)
- ✓ Colonoscopy
- ✓ Pap smears
- ✓ Blood Screenings
- ✓ PSA (blood test for prostate cancer)
- ✓ Stress test (bicycle or treadmill)
- ✓ Electrocardiogram (EKG)
- ✓ Coronavirus Testing



****The list of screening tests above is for illustrative purposes. Please see your plan provisions and limitations for a full list of qualified screening test.***

Get Paid by Staying Proactive!

- ✓ Manhattan Life Group Cancer Wellness Benefit Amount - **\$100**
- ✓ Aflac Group Accident Wellness Amount - **\$60**
- ✓ Aflac Group Hospital Indemnity Wellness Amount - **\$50**
- ✓ Aflac Group Critical Illness Wellness Amount - **\$100** (Employee/Spouse Only)

Download Your Wellness Claim(s)

Visit your employee benefits portal to download your wellness benefit claim form(s).

Employee Benefits Portal: <https://mymarkiii.com/salemcityschoolsva/>





Continuation of Benefits

If You Leave Employment

Aflac Group Plan(s)

If you are no longer employed and would like to keep your current Aflac Group plan(s) in place, you may be able to port your plans. Please visit <http://www.aflacgroupinsurance.com/>, under Customer Service > Service Requests > Continuation of Coverage. Follow the steps to port your Aflac Group plans. For more information, contact **Aflac at 1-800-433-3036**.

AUL Short & Long-Term Disability

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to port your coverage by calling **AUL at 1-800-553-5318**.

Boston Mutual Whole Life

You may continue your Whole Life policy by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. You will have 30 days from the date of your termination to contact the carrier to continue coverage. For more information, contact **Boston Mutual at 1-800-669-2668**.

FBA Flexible Spending Account

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call **FBA at 1-800-437-3539**.

Manhattan Life Group Cancer

You may continue your Manhattan Life Group Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information, contact **Bay Bridge Administrators (TPA) at 1-800-845-7519**.

VRS/Securian Financial Term Life

If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage, if elected during the limited enrolment period. Premiums may be higher than those paid by active employees. For more information, contact **VRS/Securian Financial at 1-800-441-2258**.

Contact Information

Aflac

Customer Service: 1-800-433-3036
www.aflacgroupinsurance.com

American United Life (AUL)

Claims Toll-Free Number: 1-855-517-6365
Customer Service: 1-800-553-5318
www.oneamerica.com

Boston Mutual Life Insurance Company

120 Royall Street, Canton, MA 02021
Phone: 1-800-669-2668
www.bostonmutual.com

Flexible Benefit Administrators

Phone: 1-800-437-FLEX (1-800-437-3539)
Fax: (757) 431-1155
FlexDivision@flex-admin.com
<https://fba.wealthcareportal.com/>

LegalShield

Phone: 1-800-654-7757
www.legalshield.com/

IDShield

Phone: 1-888-494-8519
www.idshield.com/

Manhattan Life

Bay Bridge Administrators, Inc.
Phone: 1-800-845-7519 | Fax: 512-275-9350
<http://www.baybridgeadministrators.com/>
Submit claims to claims@bbadmin.com

Group Health & Dental Insurance & Health Savings Account

Anthem Blue Cross Blue Shield

Phone: 1-833-592-9956 (Member Services)
24/7 Nurse Line: 1-800-337-4770
Website: www.anthem.com
Telehealth: www.livehealthonline.com

Delta Dental

Phone: 800-237-6060 (Benefit Services)
Website: www.deltadentalva.com



Contact Information

Deferred Compensation Plan Section 457 Plan

MissionSquare Retirement

Trey Sizemore, Account Representative

Website: www.missionsq.org or www.msqplanservices.org/myplan/301761

Email: tsizemore@missionsq.org

Phone: 1-202-759-7157

Tax-Deferred Annuities Section 403(b) Plan

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Phone: 1-540-588-0109

MetLife of Connecticut – Harrisonburg Office

Gregory Raines or Christy Dowdy, Account Representatives

Commonwealth Group

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Phone: 305-992-5207

Virginia Retirement Specialists

Amanda Donnelly, Account Representative

Email: apalmer@gwnsecurities.com

Phone: 1-540-731-9302





View additional benefits information
or download forms at: mymarkiii.com

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