FRANKSTON ISD

BENEFIT GUIDE

WWW.MYBENEFITSHUB.COM/FRANKSTONISD

PLAN YEAR: 2020-2021

HOW TO LOG IN

1 VISIT WWW.MYBENEFITSHUB.COM/FRANKSTONISD

2 CLICK **LOGIN**

3 ENTER USERNAME & PASSWORD

All login credentials have been RESET to the default described below:

Username: the first six (6) characters of your last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

Default Password: last name (excluding punctuation) followed by the last four (4) digits of your Social Security Number.

GENERAL INFORMATION

Frankston Independent School District offers a wide range of benefits to eligible employees and their family members. All new or newly eligible employees will go online to enroll in benefits . The district benefit site contains all plan summaries, rate summaries, claim forms and additional product information for employees to access online. Employees are encouraged to browse the plan information provided on the benefit site prior to enrolling. The Advanced Financial Group is the Third-Party Administrator for the district's supplemental benefits and will be assisting on site during the open enrollment period. The annual open enrollment period ends Friday August 21st. The plan options and coverage levels you select for the plan year will remain in effect from September 1, 2020 through August 31, 2021.

New or newly eligible employees will have 31 days from their hire date to complete their enrollment. Failure to enroll within 31 days could result in exclusion from benefits. Employees will be required to provide the name, date of birth and social security number for any dependents (this includes spouse).

MAKING CHANGES/SPECIAL ENROLLMENT EVENTS

After the initial open enrollment period, you can only add or change coverage during the year if you have a Qualified Family Status Change/Special Enrollment event such as: Marriage, Divorce, Birth or adoption, Death, Court Order (child(ren) coverage only), or if a spouse gains or loses employment. You must submit all the required documentation to the district administrators and make your plan changes within 31 days from the date of the event. If you do not request the appropriate changes during the applicable special enrollment period, the changes cannot be made until the next plan enrollment period or, if applicable, until another special enrollment event occurs.

ALL CURRENT BENEFIT ELECTIONS FROM 2019/20 WILL BE ROLLED FORWARD WITH THE EXCEPTION OF FSA. FLEXIBLE SPENDING ACCOUNT ANNUAL AMOUNTS MUST BE ENTERED EACH YEAR.
WE HIGHLY ENCOURAGE EMPLOYEES TO LOGIN AND REVIEW BENEFITS AND BENEFICIARIES.

2020-21 HIGHLIGHTS

CHANGES FOR THE 2020 PLAN YEAR

-Blue Cross Blue Shield of Texas will be the new plan administrator for the health insurance offering for TRS ActiveCare members. Please use the online provider search at TRS ActiveCare Blue Cross to learn more about your network options.

-The FSA maximum annual limit for 2020 will be $2750. You MUST login to elect this benefit and assign the annual contribution amount.

-2020 Dental Rates have had a small increase.

UPDATES/REMINDERS

-FISD will offer an Emergency Transport Benefit this year through MASA. This service is designed to drastically reduce if not completely cover a participants out of network costs associated with air or ground emergency ambulance transport. Please find more information on the district benefit site or in this booklet.

-FISD provides all full time employees with a $10,000 life insurance policy. Please make sure you have named/updated the beneficiary for this policy inside the benefit system.

MEDICAL INSURANCE

ABOUT THIS BENEFIT:

Medical insurance, also known as health insurance, is coverage that helps you pay the high cost of medical and hospital expenses.

Depending on the coverage you choose, this insurance will help pay toward or completely annual physicals, doctor visits, hospitalization and emergency room visits. Many times you will be offered more than one plan to choose from, so please review the summary of benefits in detail to determine which plan is right for you.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

TRS-ActiveCare: What's New and What's Changing

Effective: Sept. 1, 2020

We listened to what your district leadership had to say about providing you enhanced health plan choices. **Here are some key changes you'll see for each plan.**

		Total Premium Before Your District Contribution			
		Current 2019-20 Total Premium	New 2020-21 Total Premium	Change in Dollar Amount	Key Plan Changes
TRS-ActiveCare Primary (New!)	Employee Only		$386.00		• New plan with lowest premium and copays for doctor visits and generic drugs before you meet the deductible. • Statewide network. • Participants must select a primary care provider who will make referrals to specialists.
	Employee and Spouse		$1,089.00		
	Employee and Children		$695.00		
	Employee and Family		$1,301.00		
TRS-ActiveCare HD (formerly 1-HD)	Employee Only	$378.00	$397.00	**$19.00**	• Less than $20 increase in premiums for employee-only tier and reduced premiums for tiers with children. • New deductible cap for indiviudals on family plans means coinsurance coverage takes effect sooner. • Increase in deductible (+$50 individual/+$100 family) and maximum out-of-pocket (+$150 individual/+$300 family) to align with IRS guidelines
	Employee and Spouse	$1,066.00	$1,120.00	**$54.00**	
	Employee and Children	$722.00	$715.00	**– $7.00**	
	Employee and Family	$1,415.00	$1,338.00	**– $77.00**	
TRS-ActiveCare Primary+ (formerly Select)	Employee Only	$556.00	$514.00	**– $42.00**	• 8% reduction in premiums for all tiers. • Reduced maximum-out-of-pocket by $1,000 for individuals and $2,000 for family plans. • Statewide network. • Participants must select a primary care provider who will make referrals to specialists.
	Employee and Spouse	$1,367.00	$1,264.00	**– $103.00**	
	Employee and Children	$902.00	$834.00	**– $68.00**	
	Employee and Family	$1,718.00	$1,588.00	**– $130.00**	
TRS-ActiveCare 2 (closed to new enrollees)	Employee Only	$852.00	$937.00	**$85.00**	• TRS-ActiveCare 2 has experienced a decline in membership and a steady rise in high cost claims. To keep pace with higher health care costs, premiums for TRS-ActiveCare 2 will increase by 10%. • This plan is closed to new enrollees.
	Employee and Spouse	$2,020.00	$2,222.00	**$202.00**	
	Employee and Children	$1,267.00	$1,393.00	**$126.00**	
	Employee and Family	$2,389.00	$2,627.00	**$238.00**	

At a Glance

	Primary	HD	Primary+
Premiums	Lowest	Lower	Higher
Deductible	Mid-range	High	Low
Copays	Yes	No	Yes
Network	Statewide	Nationwide	Statewide
PCP Required?	Yes	No	Yes
HSA-eligible?	No	Yes	No

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

2020-21 TRS-ActiveCare Plan Highlights Sept. 1, 2020 – Aug. 31, 2021

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

What's New

- Primary plan with a **lower premium and copays**
- Primary+ (formerly Select) **decreased premiums** by up to 8%
- **Broader networks** of health care providers
- **Lower premiums** for families with children

Leverage Your $0 Preventive Care*

- Annual routine physicals (ages 12+)
- Annual mammogram (ages 40+)
- Annual OBGYN exam & pap smear (ages 18+)
- Annual prostate cancer screening (ages 45+)
- Well-child care (unlimited up to age 12)
- Healthy diet/obesity counseling (unlimited to age 22; ages 22+ get twenty-six visits per year)
- Smoking cessation counseling (8 visits per year)
- Breastfeeding support (six per year)
- Colonoscopy (ages 50+ once every ten years)

Available for all plans. See benefits guides for more details.

Did You Know

- Our provider search tool will be available in June.
- Choosing a PCP helps you meet your health goals faster.
- Generic medications save money! Ask your provider if your medicine has a generic.

All TRS-ActiveCare participants have **three plan options**. Each is designed with the unique needs of our members in mind.

	NEW: TRS-ActiveCare Primary	TRS-ActiveCare HD	TRS-ActiveCare Primary+
Plan summary	• Lower premium • Copays for doctor visits before you meet deductible • Statewide network • PCP referrals required to see specialists • Not compatible with health savings account (HSA) • No out-of-network coverage	• Similar to current 1-HD • Lower premium • Compatible with health savings account (HSA) • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet deductible before plan pays for non-preventive care	• Simpler version of the current Select plan • Lower deductible than HD and primary plans • Copays for many services and drugs • Higher premium • Statewide network • PCP referrals required to see specialists • Not compatible with a health savings account (HSA) • No out-of-network coverage
If you make no changes during Annual Enrollment, you'll have the following plan...	Only employees that choose this new plan during Annual Enrollment will be enrolled in it.	If you're currently in TRS-ActiveCare 1-HD and you make no change during Annual Enrollment, this will be your plan next year.	If you're currently in TRS-ActiveCare Select and you make no changes during Annual Enrollment, this will be your plan next year.

Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$386	$ 35	$397	$ 46	$514	$ 163
Employee and Spouse	$1,089	$ 738	$1,120	$ 769	$1,264	$ 913
Employee and Children	$695	$ 344	$715	$ 364	$834	$ 483
Employee and Family	$1,301	$ 950	$1,338	$ 987	$1,588	$ 1237

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network	Out-of-Network	In-Network Coverage Only
Individual/Family Deductible	$2,500/$5,000	$2,800/$5,600	$5,500/$11,000	$1,200/$3,600
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible
Individual/Family Maximum Out-of-Pocket	$8,150/$16,300	$6,900/$13,800	$20,250/$40,500	$6,900/$13,800
Network	Statewide Network	Nationwide Network		Statewide Network
Primary Care Provider (PCP) Required	Yes	No		Yes

Doctor Visits				
Primary Care	$30 copay	You pay 20% after deductible	You pay 40% after deductible	$30 copay
Specialist	$70 copay	You pay 20% after deductible	You pay 40% after deductible	$70 copay
TRS Virtual Health	$0 per consultation	$30 per consultation		$0 per consultation

Immediate Care				
Urgent Care	$50 copay	You pay 20% after deductible	You pay 40% after deductible	$50 copay
Emergency Care	You pay 30% after deductible	You pay 20% after deductible		You pay 20% after deductible
TRS Virtual Health	$0 per consultation	$30 per consultation		$0 per consultation

Prescription Drugs			
Drug Deductible	Integrated with medical	Integrated with medical	$200 brand deductible
Generics (30-Day Supply / 90-Day Supply)	$15/$45 copay	$0 for certain generic drugs	$15/$45 copay
Preferred Brand	You pay 30% after deductible	You pay 25% after deductible	You pay 25% after deductible
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible

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

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in plan • Lower deductible • Copays for many drugs and services • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals
If you're currently in TRS-ActiveCare 2, and you make no changes during Annual Enrollment, you will remain in TRS-ActiveCare 2 next year.

Total Premium	Your Premium
$937	$ 586
$2,222	$ 1871
$1,393	$ 1042
$2,627	$ 2276

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

$30 copay / You pay 40% after deductible
$70 copay / You pay 40% after deductible
$0 per consultation

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

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
You pay 20% after deductible ($200 min/$900 max)/ No 90-Day Supply of Specialty Medications

Compare Pricing for Common Medical Services

REMEMBER: You can use the cost estimator tool on www.bcbstx.com/trsactivecare starting Sept. 1 to shop for the best prices through different providers.

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

**Pre-certification for genetic and specialty testing may apply. Contact your Personal Health Guide at 1-866-355-5999 with questions.*

ACCIDENT INSURANCE

ABOUT THIS BENEFIT:

Accidents are nearly impossible to predict, but with accident insurance they're easy to prepare for. Accident Insurance allows you to concentrate on your health instead of your finances by issuing a lump-sum benefit when you suffer a covered accident.

LEARN MORE

While prices vary, the average cost of a trip to the emergency room will run you $1,233[1]. You can use this money to help pay toward your emergency room fees, co-pays, and hospital bills.

[1]2013 National Institute of Health

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

More than 3.5 million children ages 14 and younger get hurt annually playing sports or participating in recreational activities.[1]

Advanced Financial School Block

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Accident insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		
Coverage Type		Off-job only
BENEFITS		
EMERGENCY, HOSPITAL & TREATMENT CARE		
Accident Follow-Up	Up to 3 visits per accident	$100
Acupuncture/Chiropractic Care	Up to 10 visits each per accident	$25
Physical Therapy	Up to 10 visits each per accident	$60
Ambulance – Air	Once per accident	$600
Ambulance – Ground	Once per accident	$200
Blood/Plasma/Platelets	Once per accident	$600
Child Care	Up to 30 days per accident while insured is confined	$25
Daily Hospital Confinement Daily	Up to 365 days per lifetime	$200
ICU Confinement	Up to 30 days per accident	$400
Diagnostic Exam	Once per accident	$100
Emergency Dental	Once per accident	Up to $150
Emergency Room	Once per accident	$200
Hospital Admission	Once per accident	$1,000
Initial Physician Office Visit	Once per accident	$100
Lodging	Up to 30 nights per lifetime	$200
Medical Appliance	Once per accident	$250
Rehabilitation Facility	Up to 15 days per lifetime	$200
Transportation	Up to 3 trips per accident	$400
Urgent Care	Once per accident	$100
X-ray	Once per accident	$200
SPECIFIED INJURY & SURGERY		
Abdominal/Thoracic Surgery	Once per accident	$2,000
Arthroscopic Surgery	Once per accident	$300
Burn	Once per accident	$1,000
Burn – Skin Graft	Once per accident for third degree burn(s)	50% of burn benefit
Concussion	Up to 3 per year	$300
Dislocation	Once per joint per lifetime	Up to $8,000
Eye Injury	Once per accident	Up to $200
Fracture	Once per bone per accident	Up to $8,000

Hernia Repair	Once per accident	$100
Joint Replacement	Once per accident	$1,500
Knee Cartilage	Once per accident	Up to $1,000
Laceration	Once per accident	Up to $200
Ruptured Disc	Once per accident	$1,000
Tendon/Ligament/Rotator Cuff	Up to 1 per accident	Up to $1,500
CATASTROPHIC		
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$40,000
Common Carrier Death	Within 90 days	5 times death benefit
Coma	Once per accident	$20,000
Dismemberment	Once per accident	Up to $40,000
Home Health Care	Up to 30 days per accident	$50
Paralysis	Once per accident	Up to $30,000
Prosthesis	Up to 2 per accident	Up to $2,000
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM2] – Administrative & clinical support following serious illness or injury		Included

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 15 hours per week on a regularly scheduled basis, and are less than age 80.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to “spouse” in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family’s health. All you have to do is elect the coverage to become insured.

HOW DO I PAY FOR THIS INSURANCE?

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don’t have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

The initial effective date of this coverage is September 1, 2019. Subject to any eligibility waiting period established by your employer, if you enroll for coverage prior to this date, insurance will become effective on this date. If you enroll for coverage after this date, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

CRITICAL ILLNESS

ABOUT THIS BENEFIT:

Critical illness insurance is a policy that provides a lump-sum benefit when you are diagnosed with a covered critical illness like a heart-attack, stroke, and other serious conditions – even cancer if it's included in your policy.

This money can be used for anything from minimizing out of pocket costs to other expenses like your mortgage, groceries, or what your medical plan doesn't cover.

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

65% of American cancer survivors did not have sufficient income to cover **out-of-pocket expenses** for cancer treatment and other incurred debts **related to the illness**.[1]

Advanced Financial School Block

Facing a serious illness can be devastating both emotionally and financially. Major medical insurance may pick up most of the tab, but can still leave out-of-pocket expenses that add up quickly. Critical illness insurance can provide a lump-sum benefit upon diagnosis that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

To learn more about critical illness insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

Benefit amounts for covered illnesses are based on the coverage amount in effect for you or an insured dependent at the time of diagnosis.

COVERAGE AMOUNT	
Employee Coverage Amount	$10,000 or $20,000
Spouse Coverage Amount	50% of your coverage amount
Child(ren) Coverage Amount	$5,000
COVERED ILLNESSES	**BENEFIT AMOUNTS**
VASCULAR CONDITIONS	
Heart Attack*; Heart Transplant*; Stroke*	100% of coverage amount
Aneurysm; Angioplasty/Stent; Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
Coma*; End Stage Renal Failure; Loss of Hearing; Loss of Speech; Loss of Vision; Major Organ Transplant*; Paralysis;	100% of coverage amount
Bone Marrow Transplant	25% of coverage amount
NEUROLOGICAL CONDITIONS	
Advanced Multiple Sclerosis; Advanced Parkinson's; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	100% of coverage amount
CHILD CONDITIONS	
Cerebral Palsy; Congenital Heart Disease; Cystic Fibrosis; Muscular Dystrophy; Spina Bifida;	100% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount
Transportation	$100 per trip up to 5 trips
Lodging	$100 per night up to 5 nights
Health Screening Benefit	$50 once per year per covered person
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured & Spouse	500% of coverage amount
Coverage Maximum – Child(ren)	300% of coverage amount
Ability Assist® EAP[2]– 24/7/365 access to help for financial, legal or emotional issues	
HealthChampion℠[2] – Administrative and clinical support following serious illness or injury	

PREMIUMS

See the Premium Worksheet.[3]

CANCER INSURANCE

ABOUT THIS BENEFIT:

Cancer Insurance provides financial assistance in the form of a cash benefit upon a cancer diagnosis and treatment, ensuring you can concentrate on your health instead of your finances.

LEARN MORE

Cancer is one of the most debilitating diseases to bounce back from financially. So much so, that 42% of cancer patients drain their life savings within two years of diagnosis[2]. You can use your benefit to help pay toward costly medicine, medical bills, co-pays or even travel and lodging associated with cancer treatment.

[2]The American Journal of Medicine

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GC14
Limited Benefit Group Specified Disease Cancer Indemnity Insurance
For Employees of TAFG School Cancer Business

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

Summary of Benefits **Cancer Treatment Policy Benefits**	**Plan 1** **Level 3**
Radiation Therapy, Chemotherapy, Immunotherapy - Maximum per 12-month period	$15,000
Hormone Therapy - Maximum of 12 treatments per calendar year	$50 per treatment
Experimental Treatment	paid in same manner and under the same maximums as any other benefit
Cancer Screening Rider Benefits	Level 1
Diagnostic Testing - 1 test per calendar year	$50 per test
Follow-Up Diagnostic Testing - 1 test per calendar year	$100 per test
Medical Imaging - per calendar year	$500 per test / 1 test per calendar year
Surgical Rider Benefits	Level 1
Surgical	$30 unit dollar amount Max $3,000 per operation
Anesthesia	25% of amount paid for covered surgery
Bone Marrow Transplant - Maximum per lifetime	$6,000
Stem Cell Transplant - Maximum per lifetime	$600
Prosthesis - Surgical Implantation/Non-Surgical (not Hair Piece) 1 device per site, per lifetime	$1,000/$100
Miscellaneous Care Rider Benefits	Level 1
Cancer Treatment Center Evaluation or Consultation - 1 per lifetime	Not Included
Evaluation or Consultation Travel and Lodging - 1 per lifetime	Not Included
Second / Third Surgical Opinion - per diagnosis of cancer	$300 / $300
Drugs and Medicine - Inpatient / Outpatient (maximum $150 per month)	$150 per confinement $50 per prescription
Hair Piece (Wig) - 1 per lifetime	$150
Transportation - Maximum 12 trips per calendar year for all modes of transportation combined Travel by bus, plane or train Travel by car Lodging - up to a maximum of 100 days per calendar year	 actual coach fare or $0.40 per mile $0.40 per mile $50 per day
Family Transportation - Maximum 12 trips per calendar year for all modes of transportation combined Travel by bus, plane or train Travel by car Family Lodging - up to a maximum of 100 days per calendar year	 actual coach fare or $0.40 per mile $0.40 per mile $50 per day
Blood, Plasma and Platelets	$300 per day
Ambulance - Ground/Air - Maximum of 2 trips per Hospital Confinement for all modes of transportation combined	$200 / $2,000 per trip
Inpatient Special Nursing Services - per day of Hospital Confinement	$150 per day
Outpatient Special Nursing Services - Up to same number of Hospital Confinement days	$150 per day
Medical Equipment - Maximum of 1 benefit per calendar year	Not Included
Physical, Occupational, Speech, Audio Therapy & Psychotherapy / Maximum per calendar year	$25 per visit / $1,000
Waiver of Premium	Waive Premium
Internal Cancer First Occurrence Rider Benefits	Level 2
Lump Sum Benefit - Maximum 1 per Covered Person per lifetime	$5,000
Lump Sum for Eligible Dependent Children - Maximum 1 per Covered Person per lifetime	$7,500

GC14
Limited Benefit Group Specified Disease Cancer Indemnity Insurance

Hospital Intensive Care Unit Rider Benefits	Level 1
Intensive Care Unit	$600 per day
Step Down Unit - Maximum of 45 days per Confinement for any combination of Intensive Care Unit or Step Down Unit	$300 per day

Total Monthly Premiums by Plan**

Issue Ages	Individual	Individual & Spouse	1 Parent Family	2 Parent Family
	Plan 1	Plan 1	Plan 1	Plan 1
18+	$21.78	$45.74	$27.70	$51.64

**Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice.
The premium and amount of benefits vary dependent upon the Plan selected at time of application.

Benefits are only payable following a diagnosis of cancer for a loss incurred for the treatment of cancer while covered under the policy. A charge must be incurred for benefits to be payable. When coverage terminates for loss incurred after the coverage termination date, our obligation to pay benefits also terminates for a specified disease that manifested itself while the person was covered under the policy. All benefits are subject to the benefit maximums.

Cancer Treatment Benefits

Eligibility
You and your eligible dependents are eligible to be insured under this certificate if you and your eligible dependents meet our underwriting rules and you are actively at work with the policyholder and qualify for coverage as defined in the master application.

Limitations and Exclusions
No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; or losses or medical expenses incurred prior to the covered person's effective date regardless of when specified disease was diagnosed.

Only Loss for Cancer
The policy pays only for loss resulting from definitive cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. The policy also covers other conditions or diseases directly caused by cancer or the treatment of cancer. The policy does not cover any other disease, sickness or incapacity which existed prior to the diagnosis of cancer, even though after contracting cancer it may have been complicated, aggravated or affected by cancer or the treatment of cancer.

Pre-Existing Condition Exclusion
No benefits are payable for any loss incurred during the pre-existing condition exclusion period, following the covered person's effective date as the result of a pre-existing condition. Pre-existing conditions specifically named or described as excluded in any part of the policy are never covered. If any change to coverage after the certificate effective date results in an increase or addition to coverage, the time limit on certain defenses and pre-existing condition exclusion for such increase will be based on the effective date of such increase.

Waiting Period
The policy and any attached riders contain a waiting period during which no benefits will be paid. If any covered person has a specified disease diagnosed before the end of the waiting period immediately following the covered person's effective date, coverage for that person will apply only to loss that is incurred after one year from the covered person's effective date. If any covered person is diagnosed as having a specified disease during the waiting period immediately following the covered person's effective date, you may elect to void the certificate from the beginning and receive a full refund of premium.

If the policy replaced group specified disease cancer coverage from any company that terminated within 30 days of the certificate effective date, the waiting period will be waived for those covered persons that were covered under the prior coverage. However, the pre-existing condition exclusion provision will still apply.

Termination of Certificate
Insurance coverage under the certificate and any attached riders will end on the earliest of these dates: the date the policy terminates; the end of the grace period if the premium remains unpaid; the date insurance has ceased on all persons covered under this certificate; the end of the certificate month in which the policyholder requests to terminate this coverage; the date you no longer qualify as an insured; or the date of your death.

Termination of Coverage
Insurance coverage for a covered person under the certificate and any attached riders for a covered person will end as follows: the date the policy terminates; the date the certificate terminates; the end of the grace period if the premium remains unpaid; the end of the certificate month in which the policyholder requests to terminate the coverage for an eligible dependent; the date a covered person no longer qualifies as an insured or eligible dependent; or the date of the covered person's death.

We may end the coverage of any Covered Person who submits a fraudulent claim.

Cancer Screening Benefits

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition o f e xperimental treatment; losses or medical expenses incurred prior to the covered person's effective date of this rider; or loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as a result of a pre-existing condition. For the purpose of benefits under this rider, the waiting period will begin on the covered person's effective date of this rider.

Surgical Benefits

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; losses or medical expenses incurred prior to the covered person's effective date of this rider regardless of when a specified disease was diagnosed; or loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as a result of a pre-existing condition. For the purpose of benefits under this rider, the waiting period will begin on the covered person's effective date of this rider.

Miscellaneous Benefits

Waiver of Premium

When the certificate i s i n f orce a nd y ou b ecome d isabled, w e w ill w aive a ll premiums due including premiums for any riders attached to the certificate. Disability must be due to cancer and occur while receiving treatment for such cancer.

You must remain disabled for 60 continuous days before this benefit will begin. The waiver of premium will begin on the next premium due date following the 60 consecutive days of disability. This benefit will continue for as long as you remain disabled until the earliest of either of the following: the date you are no longer disabled; the date coverage ends according to the termination provisions in the certificate; or the date coverage ends according to the termination provisions in this rider. Proof of disability must be provided for each new period of disability before a new waiver of premium benefit is payable.

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; losses or medical expenses incurred prior to the covered person's effective date of this rider regardless of when a specified disease was diagnosed; or loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as a result of a pre-existing condition. For the purpose of benefits under this rider, the waiting period will begin on the covered person's effective date of this rider.

Termination of Cancer Screening, Surgical & Miscellaneous Benefit Rider(s)

The above listed rider(s) will terminate and coverage will end for all covered persons on the earliest of: the end of the grace period if the premium for the rider remains unpaid; the date the policy or certificate to which the rider is attached terminates; the end of the certificate month in which APL receives a request from the policyholder to terminate the rider; or the date of your death. Coverage on an eligible dependent terminates under the rider when such person ceases to meet the definition of eligible dependent.

Internal Cancer First Occurrence Benefits

Pays a lump sum benefit amount when a covered person receives a first diagnosis of internal cancer and the date of diagnosis occurs after the waiting period. Only one benefit per covered person, per lifetime is payable under this benefit and the lump sum benefit amount will reduce by 50% at age 70.

Limitations and Exclusions

We will not pay benefits for a diagnosis of internal cancer received outside the territorial limits of the United States or a metastasis to a new site of any cancer diagnosed prior to the covered person's effective date, as this is not considered a first diagnosis of an internal cancer.

Pre-Existing Condition Exclusion

No benefits are payable for any loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as the result of a pre-existing condition.

Waiting Period

This rider contains a 30-day waiting period during which no benefits will be paid. If any internal cancer is diagnosed before the end of the waiting period immediately following the covered person's effective date of this rider, coverage will apply only to loss that is incurred after one year from the covered person's effective date of this rider.

Termination

This rider will terminate and coverage will end for all covered persons on the earliest of any of the following: the end of the grace period if the premium for this rider remains unpaid; the date the policy or certificate to which this rider is attached terminates; the end of the certificate month in which we receive a request from the policyholder to terminate this rider; the date of covered person's death or the date the lump sum benefit amount for internal cancer has been paid for all covered persons under this rider. Coverage on an eligible dependent terminates under this rider when such person ceases to meet the definition of eligible dependent.

Hospital Intensive Care Unit Benefits

Pays a daily benefit amount, up to the maximum number of days for any combination of confinement, for each day charges are incurred for room and board in an intensive care unit (ICU) or step-down unit due to an accident or sickness. Benefits will be paid beginning on the first day a covered person is confined in an ICU or step-down unit due to an accident or sickness that begins after the effective date of this rider. This benefit will reduce by 50% at age 70.

Limitations and Exclusions

For a newborn child born within the 10-month period following the effective date, no benefits under this rider will be provided for confinements that begin within the first 30 days following the birth of such child. No benefits under this rider will be provided during the first two years following the effective date for confinements caused by any heart condition when any heart condition was diagnosed or treated prior to the end of the 30-day period following the covered person's effective date. The heart condition causing the confinement need not be the same condition diagnosed or treated prior to the effective date.

We will not pay benefits for any loss caused by or resulting from any of the following: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; alcoholism or drug addiction; any act of war, declared or undeclared, or any act related to war, or active service in the armed forces, or military service for any country at war (if coverage is suspended for any covered person during a period of military service, we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of the policyholder's written request); participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions; participation in, or attempting to participate in, a felony, riot or insurrection (a felony is defined by the law of the jurisdiction in which the activity takes place).

Termination

This rider will terminate and coverage will end for all covered persons on the earliest of any of the following: the end of the grace period if the premium for this rider remains unpaid; the date the policy or certificate to which this rider is attached terminates; the end of the certificate month in which we receive a request from the policyholder to terminate this rider or the date of the covered person's death. Coverage on an eligible dependent terminates under this rider when such person ceases to meet the definition of eligible dependent.

Optionally Renewable

This policy/riders are optionally renewable. The policyholder or we have the right to terminate the policy/riders on any premium due date after the first anniversary following the policy/riders effective date. We must give at least 60 days written notice to the policyholder prior to cancellation.

Portability (Voluntary Plans Only)

When you no longer meet the definition of Insured, you will have the option to continue this coverage, including any attached riders. No Evidence of Insurability will be required. Portability must meet all of the following conditions: the certificate has been continuously in force for the last 12 months; we receive a request and payment of the first premium for the portability coverage no later than 30 days after the date you no longer qualify as an eligible insured; and the policy, under which this certificate was issued, continues to be in force on the date you cease to qualify for coverage. All future premiums due will be billed directly to you. You are responsible for payment of all premiums for the portability coverage.

The benefits, terms and condition of the portability coverage will be the same as those elected under the certificate immediately prior to the date you exercised portability. Portability coverage may include any eligible dependents who were covered under the certificate at the time you ceased to qualify as an eligible insured. No new eligible dependents may be added to the portability coverage except as provided in the New Born and Adopted Children provision. No increases in coverage will be allowed while you are exercising your rights under this rider. The premium for the portability coverage will be based on the premium tables used for such coverage at the time of the portability request.

Coverage under this rider will terminate in accordance with the provisions of the Termination of Coverage in the certificate. If the policy is no longer in force, then portability coverage is not available.

DENTAL INSURANCE

ABOUT THIS BENEFIT:

The first thing that someone notices about you is your smile. If you're not doing everything you can to protect the appearance and health of your teeth, Dental Insurance may be in your best interest.

LEARN MORE

This benefit helps cover the cost of regular checkups and teeth cleanings, basic procedures, major procedures and depending on your plan may also include a benefit for orthodontia.

Already proud of your smile? It's still recommended you go to the dentist for regular checkups no matter how perfect your teeth are. Dentists can help spot the likes of heart disease, diabetes and oral cancer before it gets too serious.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Unum Dental℠

A smile-worthy dental plan

The Advanced Financial Group School Block

Effective date: 09/01/2020
Dual Option Plan

Plan features:

- See any dentist or maximize your benefits by utilizing our national network of more than 323,000+ dental access points[1] with discounted fees for in-network services.
- Find an in-network provider at unumdentalcare.com
- Manage benefits online with AlwaysAssist.com and on-the-go with the AlwaysAssist mobile app.

AlwaysAssist.com
Online benefits management

AlwaysAssist App
Available on the App Store | GET IT ON Google play

Monthly Premium Rates*:

*Rates guaranteed for 24 months from the effective date with 50% participation and at least 5 enrolled in each plan.

HIGH OPTION		LOW OPTION	
Employee Only	$34.32	Employee Only	$23.28
Employee & Spouse	$79.38	Employee & Spouse	$53.86
Employee & Children	$78.56	Employee & Children	$48.56
Employee & Family	$119.32	Employee & Family	$75.08

Outstanding Customer Service

- Professionally-staffed customer service with extended hours from 8:00 a.m. to 8:00 p.m. Monday-Friday and Saturday 10 a.m. to 4 p.m. (ET).
- Our service statistics exceed the industry average:[2]
  - 80% calls answered within 30 seconds on average.
  - Less than 2% of our calls are abandoned.
  - We resolve 95% of issues during the first call.
- An interactive voice response system is available 24/7 for benefit and eligibility information.
- We are highly skilled in the area of "takeover" business and offer an extremely smooth business transition process.

1. Netminder data (September 2016)
2. Starmount/AlwaysCare Benefits internal data (2016).

Overview:

Outline of Benefits	High Option	Low Option
Calendar Year Maximum	$1250 for Class A, B, C.	$500 for Class A, B, C.
Deductible	$50 per calendar year. Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.	$50 per calendar year. Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.
Carryover Benefit	Included (Takeover Applies)	Included (Takeover Applies)
Coinsurance	In-Network / Non-Network Class A 100% / 100% Class B 80% / 80% Class C 50% / 50% Class D 50% / 50%	In-Network / Non-Network Class A 100% / 100% Class B 70% / 70% Class C 40% / 40%

Covered procedures and waiting periods:

Outline of Benefits	High Option	Low Option

Class A
Preventative Services
	Waiting Period: None
	• Routine exams (2 per 12 months)
	• Prophylaxis (2 per 12 months)
	  ○ (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy)
	• Bitewing x-rays (max 4 films; 1 per 12 months)
	• Full mouth x-ray (1 per 24 months)
	• Emergency pain (1 per 12 months)
	• Fluoride to age 16 (1 per 12 months)
	• Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)
	• Sealants to age 16 (permanent molars, 1 per 36 months)
	• Space maintainers to age 16 (1 per 24 months)
		Waiting Period: None
		• Routine exams (2 per 12 months)
		• Prophylaxis (2 per 12 months)
		  ○ (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy)
		• Bitewing x-rays (max 4 films; 1 per 12 months)
		• Full mouth x-ray (1 per 24 months)
		• Emergency pain (1 per 12 months)
		• Fluoride to age 16 (1 per 12 months)
		• Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)
		• Sealants to age 16 (permanent molars, 1 per 36 months)
		• Space maintainers to age 16 (1 per 24 months)

Class B Basic Services	Waiting Period: None • Fillings • Posterior composite restorations • Simple extractions • Periodontal Maintenance (2 per 12 months in addition to Prophylaxis) • Repair of Crown, denture, or bridge	Waiting Period: None • Fillings • Posterior composite restorations • Simple extractions • Periodontal Maintenance (2 per 12 months in addition to Prophylaxis) • Repair of Crown, denture, or bridge
Class C Major Services	Waiting Period: None • Inlays and Onlays • Non-surgical periodontics • Oral surgery (surgical extractions & impactions) • Endodontics (root canals) • Surgical periodontics (gum treatments) • Anesthesia (subject to review, covered with complex oral surgery) • Crowns, Bridges, Dentures and Endosteal Implants (in lieu of an approved 3-unit bridge)	Waiting Period: None • Inlays and Onlays • Non-surgical periodontics • Oral surgery (surgical extractions & impactions) • Endodontics (root canals) • Surgical periodontics (gum treatments) • Anesthesia (subject to review, covered with complex oral surgery) • Crowns, Bridges, Dentures and Endosteal Implants (in lieu of an approved 3-unit bridge)
Class D Orthodontics	Waiting Period: None • Separate Lifetime maximum: $1500 • Up to 25% of lifetime allowance may be payable on initial banding. • Dep. Children to age 19 only	Not Covered

Dental carryover benefit

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! If an Insured submits qualifying claims for covered expenses during a benefit year and, in that benefit year, receives benefits that are less than their group's threshold limit, the insured will be credited a carryover benefit. Carryover benefits will be accrued and stored in the insured's carryover account to be used in the next benefit year. If an insured reaches his or her certificate year maximum benefit, we will pay a benefit from the insured's carryover account up to the amount stored in the insured's carryover account. The accrued carryover benefits stored in the carryover account may not be greater than the carryover account limit.

The limits for this policy/certificate are:

- High Option - Carryover benefit **$300**, threshold limit **$600**, carryover account Limit **$1200**.
- Low Option - Carryover benefit **$100**, threshold limit **$200**, carryover account Limit **$500**.

Other specifications:

- An insured's carryover account will be eliminated, and the accrued carryover benefits lost, if the insured has a break in coverage of any length of time, for any reason.
- Eligibility for a carryover benefit will be established or reestablished at the time the first qualifying claim in a benefit year is received for covered expenses incurred during that benefit year.
- In order to be eligible to accumulate the carryover benefit, an insured must be enrolled in the plan at least four months prior to the start of the new policy year. Example: If the plan effective date is January 1st, the insured must be enrolled by September 1st.
- Only claims incurred on or after the start of the next policy year will count toward the threshold Limit.
- Carryover benefits will not be applied to an insured's carryover account until the policy year that starts one year from the date the rider first applies.
- If charges for Class C services are not payable for an insured due to a benefit waiting period for certain covered procedures, this rider will not apply to the insured until the end of such waiting period. And, if the waiting period ends within the three months prior to the start of this plan's next benefit year, this rider will not apply to the insured until the next benefit year.
- Carryover benefits will not be applied to an insured's carryover account until the benefit year that starts one year from the date the rider first applies.

Definitions:

- "Benefit year" means calendar year or policy year, according to the type of plan applicable under the policy/certificate to which this rider is attached.
- "Carryover account" means the amount of an insured's accrued carryover benefits.
- "Carryover account limit" means the maximum amount of cumulative Carryover benefits that an insured can store in his or her carryover account.
- "Carryover benefit" means the dollar amount, which will be added to an insured's carryover account when he or she receives benefits in a benefit year that do not exceed the threshold limit.
- Qualifying claim means a claim under procedure classes A, B, C, and class D, orthodontia and must include 1 exam & 1 cleaning.
- "Threshold limit" means the maximum amount of benefits for all procedure classes A, B, C and D that an insured can receive during a benefit year and still be entitled to receive the carryover benefit.

Dependent children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at (888) 400-9304.

Services not listed: If you expect to require a dental or vision service not included on this brochure, it may still be covered. Please contact customer service at (888) 400-9304 to confirm your exact benefits.

Alternate treatment: Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.

Exclusions/limitations:

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Other implants or implant related services are not covered.

The following dental services are not covered:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- the correction of congenital malformations;
- the replacement of lost, discarded, or stolen appliances;
- replacement of bridges, dentures, crowns, inlays, onlays or dentures unless more than [5] years old and cannot be made serviceable;
- appliances, services or procedures relating to: (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition, abrasion, erosion or a fraction; (v) bite registration; or (vi) bite analysis;
- services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments, and related procedures;
- dentures for teeth missing prior to effective date of coverage; some exceptions apply and are detailed in the Certificate of Coverage;
- multiple x-rays done on same date of service will be combined to a full-mouth x-ray;
- cosmetic restorations on posterior permanent teeth and all primary teeth will be given alternate benefit;
- Anesthesia is covered with complex oral surgery only. Charges are subject to review. Pre-treatment estimate is recommended.

Takeover benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to us.

Application of takeover benefits is subject to Underwriting review and approval.

New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, certificate of creditable coverage, etc.).

Late entrants: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with Unum will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.

The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series DN2002, DN2007, and DN2015 or contact your Unum Dental representative.

Starmount Life Insurance Company
8485 Goodwood Boulevard • Baton Rouge, LA 70806
PH: (888) 400-9304
Policy Forms: Dental – DN2002, DN2007, and DN2015

(06-18)

Dental plans are marketed by Unum, administered and underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

EDUCATOR DISABILITY

ABOUT THIS BENEFIT:

Could you imagine going months without a source of income? If you're like 69% of Americans who don't have as much as $1,000 set aside in their savings account, you could run out of funds quickly[3]. Enrolling in Educator LTD helps you protect your paycheck if you were to suffer an injury or illness that left you unable to work.

LEARN MORE

Designed with school employees like you in mind, Educator LTD ensures you get the coverage you need when it matters most. These plans can let you choose the amount of money you'll receive every month, when your benefits begin and how long you'll receive the cash benefit.

Whether you're the primary source of income for your household or your income is supplemental, Educator LTD can help protect your paycheck.

[3]GoBanking

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

unum
Better benefits at work.

Why buy Long Term Disability Insurance?

If you can't work due to an injury or illness, long term disability insurance can replace part of your paycheck for several months or years. The benefits are paid directly to you. Use the payments to pay bills, buy groceries — or however you need.

Leading causes of Unum long term disability claims[1]

- Cancer
- Back disorders (excluding injuries)
- Injuries
- Cardiovascular
- Joint disorders

More than **50%** of U.S. consumers worry they would not be able to support themselves if they became disabled and couldn't work.[2]

The risk of becoming disabled may be greater than you think

1 in 4 of today's 20-year-olds will become disabled before reaching age 67.[3]

48% of current retirees say they retired earlier than they planned, mainly because of health problems or disabilities.[4]

Workers' compensation or Social Security disability may not help

From 2006 to 2015, only **34%** of Social Security Disability Insurance claimants had their applications approved.[5]

Most disabilities are not work-related and therefore are not covered by workers' compensation.[6]

Long Term Disability Insurance can help when you need it most.

Having Unum disability coverage in place can make all the difference when you're unable earn your income.

Unum is the smart solution

We've been the leading provider of group disability benefits in the U.S. for

years.[7]

94% **of long term disability claimants are satisfied** with the overall quality of interaction with their Unum contact.[8]

Unum paid $5.8 billion in benefits in 2016.[9]

We serve 53% of Fortune 100 companies or their subsidiaries and affiliates.[10]

7 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976–1990" (1977–1991); Gen Re, "U.S. Group Disability Market Surveys 1991–2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014–2016 Annual Sales and In Force" (2015–2017)

8 Market Decisions, "2016 Unum STD, FMLA and LTD Claimant Satisfaction Research" (2017)

9 Unum internal claims data (2016)

10 Fortune, "Fortune 500 2016" (2016); Unum customer database (2016)

To learn more about disability insurance, contact your Unum representative.

FOR BROKERS, EMPLOYERS AND EMPLOYEES

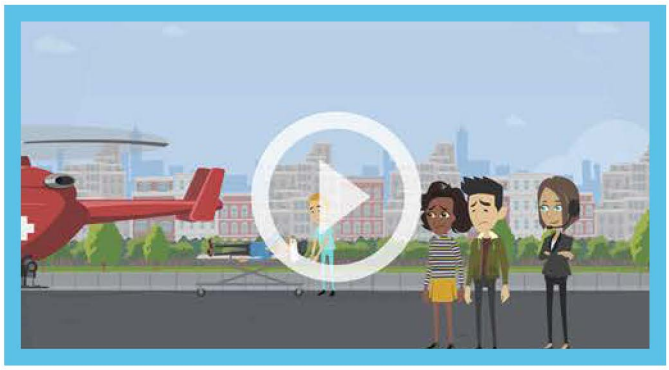
MK-3703 (5-18)

1 Unum internal data, 2017.
2 LIMRA, "2017 Insurance Barometer Study" (2017).
3 Social Security Administration, "Fact Sheet Social Security" (accessed July 5, 2017)
4 EBRI, "The 2017 Retirement Confidence Survey" (2017).
5 Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program" Chart 11 (2016)
6 National Safety Council, "Injury Facts" (2017).

EMERGENCY TRANSPORTATION

ABOUT THIS BENEFIT:

With costs of ground and air emergency transport getting more costly each year, there's a benefit out there that can drastically reduce, if not completely cover, your transport fees! It's called Emergency Transport Service!



LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away from home.

Many American employers and employees believe that their health insurance policies cover most, if not all ambulance expenses. The truth is, they DO NOT!

Even after insurance payments for emergency transportation, you could receive a bill up to $5,000 for ground ambulance and as high as $70,000 for air ambulance. The financial burdens for medical transportation costs are very real.

HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit	Emergent Plus $14/Month
Emergent Ground Transportation	U.S./Canada
Emergent Air Transportation	U.S./Canada
Non-Emergent Air Transportation	U.S./Canada
Repatriation	U.S./Canada

A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

EVERY FAMILY DESERVES A MASA MEMBERSHIP

The Ultimate Peace of Mind for Employees and Their Families

The Harrison's Story

- Jim and his family were at a local festival when his daughter, Sara, suddenly began experiencing horrible abdominal and back pain, after a fall from earlier in the day.
- His wife, Heather, called 911 and Sara was transported to a local hospital, when it was decided that she needed to be flown to another hospital.
- Upon arrival, Sara underwent multiple procedures and her condition was stabilized.
- After further testing, it was discovered that Sara needed additional specialized treatment at another hospital requiring transport on a non-emergent basis.

Based on a true story. Names were changed to protect identities in compliance with HIPAA.

MASA Medical™ Transport Solutions

And then, the Bills came!

	As a MASA Member	If a Non-MASA Member	
	Sara would pay*	If In-Network**	If Out-of-Network**
911 Ground Ambulance Cost: $1,800	$0	$300	$1,600
Emergent Air Ambulance Cost: $45,000	$0	$4,000	$30,000
Non-Emergent Air Transport† Cost: $20,000	$0	$20,000	$20,000
Total Out-of-Pocket Cost	$0	$24,300	$51,600

*Benefit is dependent on Membership Enrolled.
**Out-of-pocket dollars vary dependent on provider, distance, health plan design, current status of deductible and out-of pocket max. These figures are an example of the costs one may incur.
†More and more health plans are not covering interfacility transports on a non-emergent basis.

Any Ground. Any Air. Anywhere.™

No matter how comprehensive your local in-network coverage may be, you still have significant exposure to out-of-network emergency transportation. Moreover, when you and your family travel outside your area, there is an 80% chance of being picked up by an out-of-network provider.

A MASA Membership prepares you for the unexpected. ONLY MASA MTS provides you with:

- **Coverage ANYWHERE** in all 50 states and Canada whether at home or away
- Coverage for BOTH emergent ground ambulance and air ambulance transport **REGARDLESS of the provider**
- **Non-emergent transport services**, which are frequently covered inadequately by your insurance, if at all

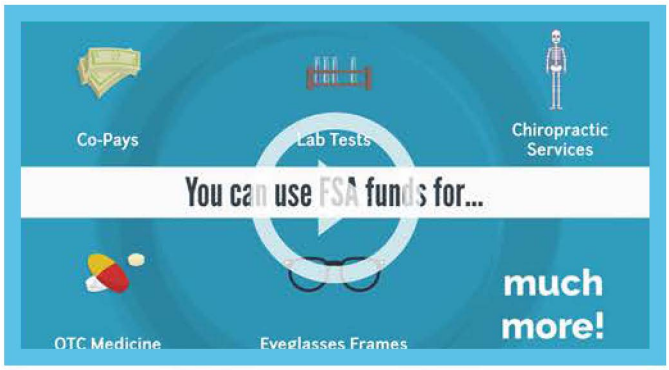
For more information, please contact your local MASA MTS representative or visit www.masamts.com

FLYER_COMP_B2B

FLEXIBLE SPENDING ACCOUNT

ABOUT THIS BENEFIT:

A flexible spending account (FSA) is one of several tax-advantaged financial accounts that can be set up through a cafeteria plan adopted by your employer.



LEARN MORE

A medical FSA is the most common type of flexible spending account allows you to set aside a portion of your earnings to pay for qualified expenses, most commonly for medical costs, such as doctors, dentists, and optometrist copays.

You CANNOT use FSA funds for expenses incurred outside the plan year!

Employees can "carryover" no more than $550 of unused funds to the 2021-22 plan-year.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Flexible Spending Account (FSA)

Two types of FSAs

For a health FSA, start by choosing an annual election amount. This amount will be available on day one of your plan year for eligible medical expenses.

Then, payroll deductions will be made throughout the plan year to fund your account.

A dependent care FSA works differently than a health FSA. Money is only available as it is contributed and can only be used for dependent care expenses.

Both are pre-tax benefits your employer offers through a cafeteria plan. Choose one or both —whichever is right for you.

What's a cafeteria plan?

A cafeteria plan enables you to save money on group insurance, healthcare expenses, and dependent care expenses. Your contributions are deducted from your paycheck by your employer before taxes are with withheld. These deductions lower your taxable income which can save you up to 35% on income taxes!

Partial List of Eligible Expenses:

- Medical/Dental/Vision Copays and deductibles
- Prescription Drugs
- Physical Therapy
- Chiropractor
- First-Aid Supplies
- Lab Fees
- Psychiatrist/Psychologist
- Vaccinations
- Dental Work/Orthodontia
- Eye Exams
- Laser Eye Surgery
- Eyeglasses, Contact Lenses, Lens Solution
- Prescribed OTC Medications

Enrollment Considerations

After the enrollment period ends, you may increase, decrease, or stop your contribution only when you experience a qualifying "change of status" (e.g. marriage, divorce, employment change, dependent change).

Be conservative in the total amount you elect to avoid forfeiting money at the end of the plan year.

How to Spend

Spending is easy

Our convenient NBS Benefits Card allows you to avoid out-of-pocket expenses, cumbersome claim forms and reimbursement delays. Or you may also utilize the "pay a provider" option on our web portal.

Account access is easy

Get account information from our easy-to-use online portal and mobile app. See your account balance, contributions and account history in real time.

What if I don't use it all?

Because an FSA is a planning tool with great tax benefits, you must use the account balance in its entirety before the end of the plan year or it will be forfeited. This is known as the "use-it-or-lose-it" rule.

Your employer may offer a grace period or a $550 rollover to help if you miss the mark a little bit. *Just make sure to plan carefully when you enroll.*

Healthcare Expense Account

Sample Expenses

Medical Expenses

- Acupuncture
- Addiction programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Brest pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (i.e. bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (i.e. Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Monitoring device (blood pressure, cholesterol)
- Physical exams
- Pregnancy tests
- Prescription drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician
- Wheelchair

Dental Expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crown, etc.

Vision Expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eye glasses
- Laser surgery
- Office fees
- Guide dog and upkeep/other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (deodorant, soap, body powder, sanitary products
- Addiction products
- Allergy relief (oral meds, nasal spray)
- Antacids and heart burn relief
- Anti-itch and hydrocortisone creams
- Athlete's foot treatment
- Arthritis pain relieving creams
- Cold medicines (i.e. syrups, drops, tablets)
- Cosmetic surgery
- Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil
- Counseling (i.e. marriage/family
- Dental care - routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/bleaching)
- Exercise equipment
- Fever & pain reducers (i.e. Aspirin, Tylenol)
- Haircare (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees
- Homeopathic supplement or herbs
- Household or domestic help
- Laser hair removal
- Laxatives
- Massage therapy
- Motion sickness medication
- Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
- Skin care (i.e. sun block, moisturizing lotion, lip balm)
- Sleep aids (i.e. oral meds, snoring strips)
- Smoking cessation relief (i.e. patches, gum)
- Stomach & digestive relief (i.e. Pepto-Bismol, Imodium)
- Tooth and mouth pain relief (Orajel, Anbesol)
- Vitamins
- Wart removal medicine
- Weight reduction aids (i.e. Slimfast, appetite suppressant)

nbs national benefit services

These expenses may be eligible if they are prescribed by a physician (if medically necessary for a specific condition).

Best Practices

Using your NBS Benefits Card

The NBS Benefits Card makes using your FSA easy by allowing you to pay your provider directly with funds from your FSA eliminating cashflow hardships. But even these transactions require substantation. Follow these tips to save time and simplify your experience.

Understanding Claim Substantiation

The rules that govern Flexible Spending Accounts require that all claims be reviewed and adjudicated to ensure they are being used for eligible medical expenses under section 125 of the Internal Revenue Code. NBS uses Merchant Category Codes (MCCs), Inventory Information Approval Systems, and sophisticated matching systems to auto-substantiate 80% of all debit card transactions.

For transactions that cannot be auto-substantiated, you will be asked to submit documentation to support your expense. Documentation may include an itemized receipt and/or a doctor's note of medical necessity. Use the NBS mobile app to take a picture of your receipt and upload it to the portal where it will be reviewed and eligible expenses will be approved. You will be notified if the expense requires any further documentation or if the expense is ineligible. In the case of ineligible expenses, you will be asked to refund your account or offset the expense with other eligible expenses.

1. Use your debit card at your provider.
2. Save your receipt.
3. Upload the receipt to NBS using the NBS Mobile App or my.nbsbenefits.com.
4. NBS will take care of the rest!

Before you leave, ask for a detailed receipt.

Receipt must include:

- The service or product
- The date of the service (Billing/ Statement Date insufficient)
- The amount of the charge

Over-the-counter medications will require a doctor's note of medical necessity.

HOSPITAL INDEMNITY

ABOUT THIS BENEFIT:

Hospital Indemnity insurance provides a cash benefit for every day, week or month you are hospitalized. Most policies have additional features that help with out of pocket costs related to medical care.

Benefits are paid to you directly and it works in addition to your health insurance coverage.

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

GROUP VOLUNTARY HOSPITAL INDEMNITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

A 4-day stay in the hospital could cost around $10,000.[1]

Advanced Financial School Block

Hospital Indemnity (HI) insurance pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. Even with the best primary health insurance plan, out-of-pocket costs from a hospital stay can add up.

The benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or co-pays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.).

To learn more about Hospital Indemnity insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

Benefit amounts are based on the plan in effect for you or an insured dependent at the time the covered event occurs. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		PLAN 2
Coverage Type		On and off-job (24 hour)
Covered Events		Illness and injury
HSA Compatible?		Yes
BENEFITS		
HOSPITAL CARE[2]		**PLAN 2**
First Day Hospital Confinement	Up to 1 day per year	$1,500
Daily Hospital Confinement (Day 2+)	Up to 30 days per year	$100
Daily ICU Confinement (Day 1+)	Up to 30 days per year	$200
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM2] – Administrative & clinical support following serious illness or injury		Included

ASKED & ANSWERED

IS THIS COVERAGE HSA COMPATIBLE?

If you (or any dependent(s)) currently participate in a Health Saving Account (HSA) or if you plan to do so in the future, you should be aware that the IRS limits the types of supplemental insurance you may have in addition to a HSA, while still maintaining the tax-exempt status of the HSA.

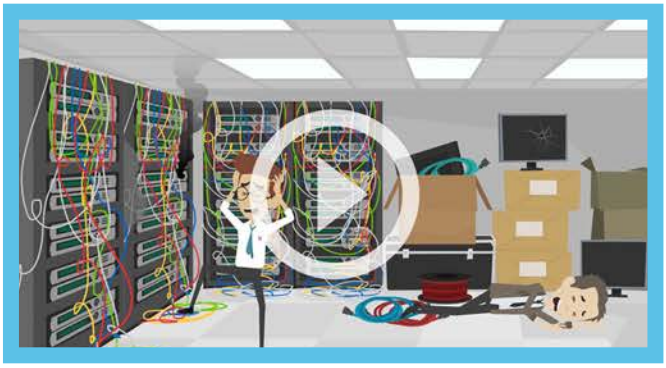
This plan design was designed to be compatible with Health Savings Accounts (HSAs). However, if you have or plan to open an HSA, please consult your tax and legal advisors to determine which supplemental benefits may be purchased by employees with an HSA.

IDENTITY THEFT PROTECTION

ABOUT THIS BENEFIT:

Identity theft claims millions of victims each year and is the fastest growing crime in the United States. Identity Theft Protection is an affordable service that can protect everything from your social security number to your social media profiles.

It actively monitors and flags any suspicious activity via identity and credit monitoring. If fraud does occur, experts will help you recover your identity and restore your credit.



LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

LifeLock
BUSINESS SOLUTIONS

The growing need for proactive protection

Every two seconds, someone is a victim of identity theft.[1]

In fact, identity theft was the number one consumer reported crime to the Federal Trade Commission in 2012 – there were over 16.6 million victims, a number expected to increase significantly.[2]

And identity theft is more than just your credit history – the average number of records compromised by data breaches from 2008-2012 was 146 million, and as a result breach victims are four times more likely to have their identities stolen.[3]

And did you know that children are at greater risk? According to a recent news article, police agencies are saying children are now the fastest growing segment of identity theft victims.[4]

Add it all up, and the costs are staggering – in 2012 alone, identity theft cost nearly $24.7 billion.[5]

Enroll in Proactive Identity Theft Protection

You have a home security system that alerts you if someone tries to rob your house. To be protected, you need an alarm system for your identity. When LifeLock detects suspicious activity within their network†, they notify members before the damage is done. LifeLock detection is different than traditional credit monitoring and offers a comprehensive set of features to protect against identity theft. Legal and remediation services only help after identity theft has occurred. As the industry leader, LifeLock provides proactive protection.

When a threat is detected, LifeLock notifies members by phone, text or email.

Worrying about your credit isn't enough

Many people believe their credit card company protects them. You can't take their word for it because a credit card company protects itself, but not other accounts. If a fraudster opens up a new Visa or MasterCard account, gets a payday loan, or starts a new wireless account in your name, one credit card company alone can't help.

Some consumers believe they can take a DIY approach to monitor credit on their own. However, you can sometimes do three things on your own:

1. Get one free credit report a year, but what do you do the rest of the year?
2. Set up fraud alerts that last 90 days and then you have to reset it.
3. Put a credit freeze on after you've been victimized.

All three of these can be inconvenient, and of limited value.

†Network does not cover all transactions.
* "2013 Employee Benefits Study", LifeLock, February 2013. Excludes those who already have identity theft protection through their employer
[1,5] CNN Money, "Identity fraud hits new victim every two seconds," Ellis, Blake, 2014
[2] "Victims of Identity Theft", U.S. Department of Justice, 2013
[3] "Use of Stolen Business EINs for Tax Fraud", BusinessIDTheft.org, 2014
[4] Source: http://www.businessweek.com/ap/financialnews/D9LNB7701.htm

The necessary, voluntary benefit

Choose the LifeLock service that's right for you

LifeLock Standard™ identity theft protection uses innovative monitoring technology and alert tools to help proactively safeguard your credit and finances.†

LifeLock Ultimate® service provides peace of mind knowing you have the most comprehensive identity theft protection available. Enhanced services include bank account application and takeover alerts, online credit reports and credit scores.†

LifeLock Junior™ is a proactive defense system rolled into family plans that helps keep your child's information safe. A child's clean and unmonitored credit file is a gold mine for identity thieves, with critical misuse and damage potentially going completely undetected for years.††

How to enroll:

1. Enroll through your employer.
2. Provide the name, Social Security number, date of birth, address , email and phone number for you and each dependent you wish to enroll.††
3. Select your level of coverage.*
4. Your LifeLock coverage will begin upon successful completion of your enrollment.
5. You will receive a welcome email from LifeLock with instructions on how to take full advantage of your LifeLock membership.

Special employee benefit rate starting as low as

$8.50 per month***

LifeLock service payroll deduction pricing – Monthly

Plan Options		LifeLock Standard	LifeLock Ultimate
	Employee Only [18 and over]	$8.50	$21.25
	Employee + Spouse	$17.00	$42.50
	Employee + Children**	$14.88	$30.81
	Employee + Family**	$23.38	$52.06

**As LifeLock Identity Theft Protection and LifeLock Ultimate service are available for adults 18 years of age and older, children under the age of 18 will receive a product designed specifically for minors. Enrollment in LifeLock service is limited to employees and their eligible dependents.

Service Features	LifeLock Standard	LifeLock Ultimate
LifeLock Identity Alert® System†	✓	✓
Lost Wallet Protection	✓	✓
Address Change Verification	✓	✓
Black Market Website Surveillance	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Live Member Support 24/7/365	✓	✓
Certified Resolution Support	✓	✓
$1 Million Total Service Guarantee‡	✓	✓
Fictitious Identity Monitoring		✓
Court Records Scanning		✓
Data Breach Notification		✓
Credit Card, Checking & Savings Account Activity Alerts†		✓
Online Annual Credit Report		✓
Online Annual Credit Score		✓
Checking & Savings Account Application Alerts†		✓
Bank Account Takeover Alerts†		✓
Investment Account Activity Alerts†		✓
Credit Inquiry Alerts		✓
Online Annual Credit Reports		✓
Online Annual Credit Scores		✓
Monthly Credit Score Tracking		✓
File-Sharing Network Searches		✓
Sex Offender Registry Reports		✓
Priority Live Member Support 24/7/365		✓

†Network does not cover all transactions.
††Must be enrolled with an adult member.
†††This information is required to receive LifeLock alerts.
* Must agree to the terms and conditions available at LifeLock.com/terms.
***Based on 26 bi-weekly deductions for standard LifeLock service, employee only.
‡The benefits under the Service Guarantee are provided under a Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com.

INDIVIDUAL LIFE

ABOUT THIS BENEFIT:

Life insurance becomes necessary the moment someone else depends on you. It can be your spouse, children, or even your parents. If your death would affect the lifestyle of someone you love, it's time to enroll.

Individual life provides a specified lump-sum benefit to your beneficiary at the time of your death. These policies do not expire, and the price of your premiums typically won't change from the date you enroll. And, even if you leave your employer the policy stays with you.

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

WOW!

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

- You own it
- You can take it with you when you change jobs or retire
- You pay for it through convenient payroll deductions: no checks to write or links to click
- You can cover your spouse, children and grandchildren, too[1]
- You can get a living benefit if you become terminally ill[2]
- It's Affordable
- You can qualify by answering just 3 questions - no exam or needles

1. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
2. Conditions apply.

Flexible Premium Adjustable Life Insurance to age 121. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18. Some limitations apply. See the PureLife-plus brochure for details. Texas Life is licensed to do business in the District of Columbia and every state but New York.

19M004-C 1003 (exp0321)

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

Life insurance can be an ideal way to provide money for your family when they need it most. PURELIFE-PLUS offers permanent insurance with a high death benefit and long guarantees[1] that can provide financial peace of mind for you and your loved ones. PURELIFE-PLUS is an ideal complement to any group term and optional term life insurance your employer might provide and has the following features:

- YOU OWN IT
- YOU CAN TAKE IT WITH YOU WHEN YOU CHANGE JOBS OR RETIRE
- YOU PAY FOR IT THROUGH CONVENIENT PAYROLL DEDUCTIONS
- YOU CAN COVER YOUR SPOUSE, CHILDREN AND GRANDCHILDREN, TOO[2]
- YOU CAN GET A LIVING BENEFIT IF YOU BECOME TERMINALLY ILL[3]
- IT'S AFFORDABLE

3 QUICK QUESTIONS

You can qualify by answering just 3 questions – no exams or needles.

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

1. Been actively at work on a full time basis, performing usual duties?
2. Been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days?
3. Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation, dialysis treatment, or treatment for alcohol or drug abuse?

1. After the guarantee period, premiums may go down, stay the same or go up.
2. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
3. Conditions apply.

Flexible Premium Adjustable Life Insurance to age 121. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18. Some limitations apply. See the PureLife-plus brochure for details. Texas Life is licensed to do business in the District of Columbia and every state but New York.

19M016-C 1092 (exp0321)

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

TELEHEALTH

ABOUT THIS BENEFIT:

With telehealth, you can get the treatment you need for minor sicknesses without having to visit your doctor's office.

By enrolling in this benefit, you'll gain access to medical consultations through phone call, email, and video chat. Telehealth will typically have you talking to a doctor within 30 minutes of setting up the appointment.

You'll speak to a doctor who can diagnose your minor aches and illnesses, and they can even prescribe medication for the likes of the common cold, flu, pink eye, and many other medical conditions.

LEARN MORE

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1.800MD is a fast, convenient alternative to waiting days for an appointment or spending hours sitting in the doctor's office, urgent care or ER. Whether it is 2 a.m. from your toddler's room or 7 p.m. from your business trip destination, our telehealth solutions save you time and money while providing peace of mind.

Quality Care When You Need It Most

Looking for care that fits your schedule? 1.800MD offers reliable, quality health care at your fingertips with a remarkable reputation.

WHY CHOOSE 1.800MD?

SAVES MONEY

Visits to the emergency room or urgent care are costly prices to pay when many visits can be handled by calling 1.800MD. As a low-cost alternative 1.800MD physicians treat many common conditions via phone or video consultations, reducing unnecessary doctor's visits and saving you money.

CONVENIENCE AND QUALITY CARE

With more than a decade of experience, 1.800MD provides individuals, families, employers and groups with best of class medical care 24/7/365. Available any time day or night, our board certified physicians are equipped to diagnose, recommend treatment and prescribe medications while in the comfort of your home, office or business trip destination.

SUPPORT

Independently owned, 1.800MD focuses on customer satisfaction. Our member service representatives are available any time to assist you or answer any questions you may have.

CUTTING EDGE TECHNOLOGY

1.800MD's website and mobile app are extensions of our customer service commitment. They provide consumers with access to fast, convenient access to health care. Individual secure member portals contain information and tools to help make informed health care decisions.

SAVE MONEY AND TIME!

HOW DOES IT WORK?

Call 1.800.530.8666 or visit www.1800MD.com to secure convenient care anywhere.

1. ACTIVATE ACCOUNT

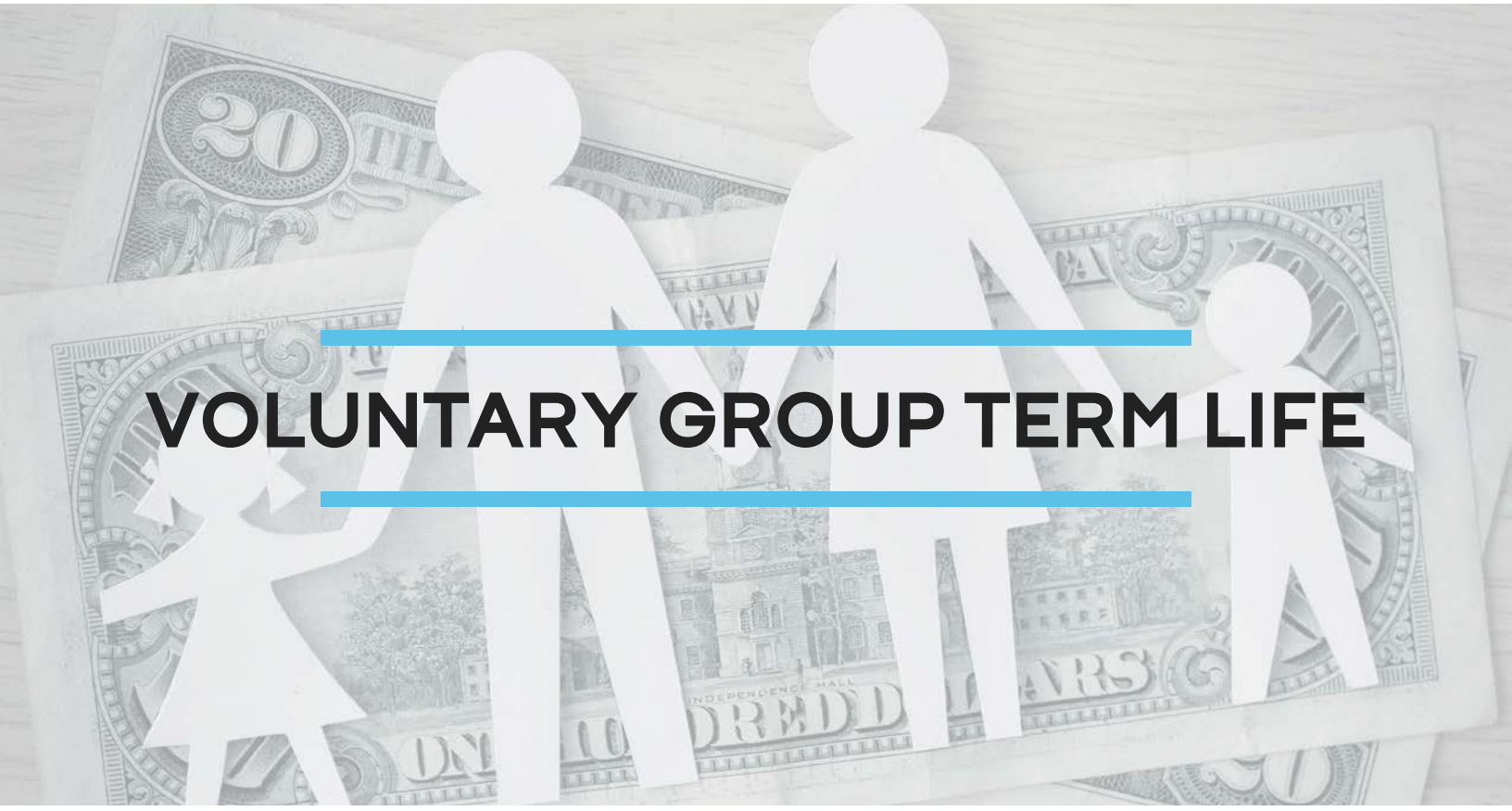
Activate your account online at **www.1800md.com** or by calling **1.800.530.8666**. Once activated, you will need to setup your member profile and complete your electronic health record.

2. REQUEST A CONSULT

Login to your account online or call member services at **1.800.530.8666** to request a consult anytime 24/7.

3. RECEIVE CARE

Receive diagnosis and treatment, giving you quality care and peace of mind wherever you are.

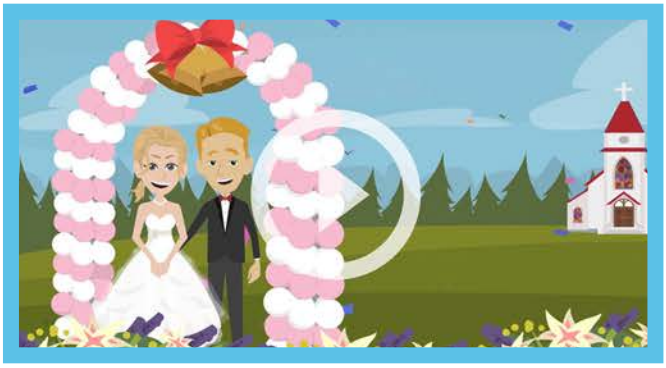


VOLUNTARY GROUP TERM LIFE

ABOUT THIS BENEFIT:

Basic life insurance provided by your employer is a good employee benefit, but the amount of coverage may not cover your obligations if you were to suddenly pass away.

Voluntary Group Term Life insurance policy issues a cash benefit to your designated beneficiary in the event of your passing. This money can be used toward anything from final costs to paying off any remaining debts; like your mortgage, car loans, or student loans.



LEARN MORE

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The Advanced Financial Group School Block Voluntary Life and AD&D Insurance Plan Highlights

Who is eligible for this coverage?	All actively employed employees working at least 15 hours each week for your employer in the U.S. and their eligible spouses and children to age 26.
What are the coverage amounts?	Employee: up to 5 times salary in increments of $10,000; not to exceed $500,000. Spouse: up to 100% of employee amount in increments of $5,000; not to exceed $500,000. Child: up to 100% of employee coverage amount in increments of $5,000; not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $5,000.
What are the AD&D coverage amounts?	Employee: up to 5 times salary in increments of $10,000; not to exceed $500,000. Spouse: up to 100% of employee amount in increments of $5,000; not to exceed $500,000. Child: up to 100% of employee coverage amount in increments of $5,000; not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $5,000. Note: You may purchase AD&D coverage for yourself regardless of whether you purchase term life coverage. In order to purchase life and AD&D coverage for your dependents, you must buy coverage for yourself.
Can I be denied coverage?	**Current employees:** If you and your eligible dependents are enrolled in the plan and wish to increase your life insurance coverage, you may apply on or before the enrollment deadline for any amount of additional coverage up to $250,000 for yourself and any amount of additional coverage up to $50,000 for your spouse. Any life insurance coverage over the guaranteed amount(s) will be subject to answers to health questions. If you and your eligible dependents are not currently enrolled in the plan, you may apply for coverage on or before the enrollment deadline and will be required to answer health questions for any amount of coverage. **New employees:** To apply for coverage, complete your enrollment within 31 days of your eligibility period. If you apply for coverage after 31 days, or if you choose coverage over the amount you are guaranteed, you will need to complete a medical questionnaire which you can get from your plan administrator. You may also be required to take certain medical tests at Unum's expense.
How do I apply?	Please see your plan administrator.
When is coverage effective?	Please see your plan administrator for your effective date. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. For your dependent spouse and children, insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Totally disabled means that as a result of an injury, sickness, or disorder, your dependent spouse and children: are confined in a hospital or similar institution; or are confined at

	home under the care of a physician for a sickness or injury. Exception: Infants are insured from live birth.
Is the coverage portable (can I keep it if I leave my employer)?	If you retire, reduce your hours or leave your employer, you can continue coverage for yourself your spouse and your dependent children at the group rate. Portability is not available for people who have a medical condition that could shorten their life expectancy — but they may be able to convert their term life policy to an individual life insurance policy.
Are there any life insurance exclusions or limitations?	Life insurance benefits will not be paid for deaths caused by suicide within the first 24 months after the date your coverage becomes effective. If you increase or add coverage, these enhancements will not be paid for deaths caused by suicide within the first 24 months after you make these changes.
Will my premiums be waived if I'm disabled?	If you become disabled (as defined by your plan) and are no longer able to work, your life premium payments will be waived until your disability period ends.
What does my AD&D insurance pay for?	The full benefit amount is paid for loss of: • life; • both hands or both feet or sight of both eyes; • one hand and one foot; • one hand or one foot and the sight of one eye; • speech and hearing. Other losses may be covered as well. Please contact your plan administrator.
Are there any AD&D exclusions or limitations?	Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from: • disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM); • suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane; • war, declared or undeclared, or any act of war; • active participation in a riot; • committing or attempting to commit a crime under state or federal law; • the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol; • intoxication – "being intoxicated" means you or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.
When does my coverage end?	You and your dependents' coverage under the Summary of Benefits ends on the earliest of: • the date the policy or plan is cancelled; • the date you no longer are in an eligible group; • the date your eligible group is no longer covered; • the last day of the period for which you made any required contributions; • the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage.

	In addition, coverage for any one dependent will end on the earliest of: • the date your coverage under a plan ends; • the date your dependent ceases to be an eligible dependent; • for a spouse, the date of a divorce or annulment; • for dependent coverage, the date of your death. Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Underwritten by Unum Life Insurance Company of America, Portland, Maine

EN-1773 (8-17) FOR EMPLOYEES

UNUM CORPORATION LIFESTYLE LIFE/AD&D RATES
The Advanced Financial Group School Block

Monthly Payroll Deduction

EMPLOYEE*

Life/AD&D

Age Band	$10,000	$20,000	$30,000	$40,000	$50,000	$70,000	$100,000	$130,000	$150,000
0-24	$0.80	$1.60	$2.40	$3.20	$4.00	$5.60	$8.00	$10.40	$12.00
25-29	$0.80	$1.60	$2.40	$3.20	$4.00	$5.60	$8.00	$10.40	$12.00
30-34	$0.90	$1.80	$2.70	$3.60	$4.50	$6.30	$9.00	$11.70	$13.50
35-39	$1.00	$2.00	$3.00	$4.00	$5.00	$7.00	$10.00	$13.00	$15.00
40-44	$1.50	$3.00	$4.50	$6.00	$7.50	$10.50	$15.00	$19.50	$22.50
45-49	$2.00	$4.00	$6.00	$8.00	$10.00	$14.00	$20.00	$26.00	$30.00
50-54	$3.30	$6.60	$9.90	$13.20	$16.50	$23.10	$33.00	$42.90	$49.50
55-59	$5.40	$10.80	$16.20	$21.60	$27.00	$37.80	$54.00	$70.20	$81.00
60-64	$8.20	$16.40	$24.60	$32.80	$41.00	$57.40	$82.00	$106.60	$123.00
65-69	$13.60	$27.20	$40.80	$54.40	$68.00	$95.20	$136.00	$176.80	$204.00
70-74	$21.49	$42.98	$64.47	$85.96	$107.45	$150.43	$214.90	$279.37	$322.35
75+	$21.49	$42.98	$64.47	$85.96	$107.45	$150.43	$214.90	$279.37	$322.35

$250,000 IS THE MAXIMUM THAT MAY BE ISSUED WITHOUT ANSWERING HEALTH QUESTIONS

SPOUSE**

Life/AD&D

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$50,000	$55,000	$60,000
0-24	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$4.00	$4.40	$4.80
25-29	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$4.00	$4.40	$4.80
30-34	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$4.50	$4.95	$5.40
35-39	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$5.00	$5.50	$6.00
40-44	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$7.50	$8.25	$9.00
45-49	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$10.00	$11.00	$12.00
50-54	$1.65	$3.30	$4.95	$6.60	$8.25	$9.90	$16.50	$18.15	$19.80
55-59	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$27.00	$29.70	$32.40
60-64	$4.10	$8.20	$12.30	$16.40	$20.50	$24.60	$41.00	$45.10	$49.20
65-69	$6.80	$13.60	$20.40	$27.20	$34.00	$40.80	$68.00	$74.80	$81.60
70-74	$10.75	$21.49	$32.24	$42.98	$53.73	$64.47	$107.45	$118.20	$128.94
75+	$10.75	$21.49	$32.24	$42.98	$53.73	$64.47	$107.45	$118.20	$128.94

SPOUSE AMOUNT CANNOT EXCEED 100% OF EMPLOYEES AMOUNT
and $50,000 is the most that can be issued without answering health questions

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CHILD(REN)

	$5,000	$10,000
LIFE/AD&D	$0.91	$1.82

NOTE: FINAL RATES MAY VARY SLIGHTLY DUE TO ROUNDING.

THESE GRIDS ARE PRICES OF FREQUENTLY SELECTED AMOUNTS. YOU MAY CHOOSE ANY INCREMENT OF $10,000 UP T0 $500,000 FOR EMPLOYEES (EE) AND $5,000 UP TO $500,000 FOR YOUR SPOUSE (SP). TO PURCHASE AN AMOUNT OTHER THAN LEVELS INDICATED ABOVE, SIMPLY COMPLETE THE FOLLOWING:

EMPLOYEE	_____	X	_____	=	_____
CALCULATION	# OF 10,000(EE) UNITS		YOUR AGE COST PER 10,000 UNIT		EMPLOYEE MONTHLY COST
SPOUSE	_____	X	_____	=	_____
CALCULATION	# OF 5,000(SP) UNITS		YOUR AGE COST PER 5,000 UNIT		SPOUSE MONTHLY COST

*** Age = Actual age immediately prior to and including the anniversary/effective date.**

****Spouse age is determined using Employee's date of birth.**

VISION INSURANCE

ABOUT THIS BENEFIT:

The value of vision insurance goes beyond saving money on new glasses and contact lenses every year. Most plans provide coverage that pays for annual eye exams and a portion of the cost for frames and lenses.

Eye exams are also effective in detecting medical conditions like diabetes, thyroid disease, and cancer. If you are considering buying vision insurance, just ask yourself one question: *"How much do I value my vision?"*

LEARN MORE

**This benefit booklet highlights certain features from the different policies and riders but is not the insurance contract. Please refer to the group master application or your policy for a full disclosure of benefits.*

Vision plan benefits for Frankston ISD

Copays	
Exam[1]	$10
Eyewear[2]	$15

Monthly premiums	
Emp. only	$7.00
Emp. + spouse	$14.01
Emp. + children	$15.90
Emp. + family	$24.56

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

(Based on date of service)

Benefits through Superior Select Southwest network

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

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

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

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

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

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

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

Discount features

Non-covered eyewear discount: members may also receive a discount of 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens "extras" such as tints and coatings. Eyewear purchased from a Walmart Vision Center does not qualify for this additional discount because of Walmart's "Always Low Prices" policy.

The national LASIK network of laser vision correction providers, featuring LasikPlus, offers members special program pricing on services. The program pricing should be verified prior to service.

superiorvision.com

(800) 507-3800

The Plan discount features are not insurance.

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

Discounts are subject to change without notice.

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

GLOSSARY OF TERMS

ACCIDENT
an unexpected event or circumstance without deliberate intent.

ACCIDENTAL DEATH & DISMEMBERMENT
an insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

BENEFICIARY
an individual who may become eligible to receive payment due to will, life insurance policy, retirement plan, annuity, trust, or other contract.

CALENDAR YEAR DEDUCTIBLE
in health insurance, the amount that must be paid by the insured during a calendar year before the insurer becomes responsible for further loss costs.

CLAIM
a request made by the insured for insurer remittance of payment due to loss incurred and covered under the policy agreement.

COINSURANCE
A clause contained in most property insurance policies to encourage policy holders to carry a reasonable amount of insurance. If the insured fails to maintain the amount specified in the clause (Usually at least 80%), the insured shares a higher proportion of the loss. In medical insurance a percentage of each claim that the insured will bear.

COORDINATION OF BENEFITS
provision to eliminate over insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan.

COPAY
a cost sharing mechanism in group insurance plans where the insured pays a specified dollar amount of incurred medical expenses and the insurer pays the remainder.

DEDUCTIBLE
Portion of the insured loss (in dollars) paid by the policy holder.

DENTAL INSURANCE
policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

DISABILITY INCOME
policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.

EFFECTIVE DATE
date at which an insurance policy goes into force.

FACE AMOUNT
the value of a policy to be provided upon maturity date or death.

GLOSSARY OF TERMS

HEALTH INSURANCE
a generic term applying to all types of insurance indemnifying or reimbursing for losses caused by bodily injury or illness including related medical expenses.

HEALTH MAINTENANCE ORGANIZATION (HMO)
a medical group plan that provides physician, hospital, and clinical services to participating members in exchange for a periodic flat fee.

HOSPITAL INDEMNITY COVERAGE
coverage that provides a pre-determined, fixed benefit or daily indemnity for contingencies based on a stay at a hospital or intensive care facility.

INCONTESTABILITY PROVISION
a life insurance and annuity provision limiting the time within which the insurer has the legal right to void the contract on grounds of material misrepresentation in the policy application.

INSURED
party(ies) covered by an insurance policy.

INSURER
an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state.

LAPSE
termination of a policy due to failure to pay the required premium.

LIVING BENEFITS RIDER
a rider attached to a life insurance policy providing long term care for the terminally ill.

LONG-TERM CARE
policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community based care, or any combination. The policy does not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated heath benefit-type products.

LONG-TERM DISABILITY INSURANCE
policy providing monthly income payments for insureds who become disabled for an extensive length of time, typically two years or longer.

MAJOR MEDICAL
a hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered.

MANAGED CARE
system of health care delivery that attempts to influence the utilization, quality, and cost of services provided.

GLOSSARY OF TERMS

PERMANENT LIFE INSURANCE
policy that remains active for the life of the insured.

PET INSURANCE PLANS
veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

POLICY
a written contract ratifying the legality of an insurance agreement.

POLICY PERIOD
time period during which insurance coverage is in effect.

POLICY RESERVE
the amount of money allocated specifically for the fulfillment of policy obligations by a life insurance company; reserves are in place to safeguard that the company is able to pay all future claims.

ORGANIZATION (PPO)
arrangement, insured or uninsured, where contracts are established by Health Plan Companies (typically, commercial insurers, and, in some circumstances, by self-insured employers) with health care providers. The Health Plans involved will often designate these contracted providers as "preferred" and will provide an incentive, usually in the form of lower deductibles or co-payments, to encourage covered individuals to use these providers. Members are allowed benefits for non-participating provider services on an indemnity basis with significant copayments and providers are often, but not always, paid on a discounted fee for service basis.

PREMIUM
Money charged for the insurance coverage reflecting expectation of loss.

PROVISIONS
contingencies outlined in an insurance policy.

RATE
value of insured losses expressed as a cost per unit of insurance.

RIDER
an amendment to a policy agreement.

SHORT-TERM DISABILITY
a company standard defining a period of time employees are eligible for short-term disability coverage, typically for 2 years or less.

SPECIFIED DISEASE COVERAGE
coverage that provides primarily pre-determined benefits for expenses of the care of cancer and/or other specified diseases.

TERM
period of time for which policy is in effect.

TERM INSURANCE
life insurance payable only if death of insured occurs within a specified time, such as 5 or 10 years, or before a specified age.

GLOSSARY OF TERMS

UNIVERSAL LIFE INSURANCE
adjustable life insurance under which premiums and coverage are adjustable, company expenses are not specifically disclosed to the insured but a financial report is provided to policyholders annually.

VARIABLE ANNUITY
an annuity contract under which the premium payments are used to purchase stock and the value of each unit is relative to the value of the investment portfolio.

VARIABLE LIFE INSURANCE
life insurance whose face value and/or duration varies depending upon the value of underlying securities.

VARIABLE UNIVERSAL LIFE
combines the flexible premium features of universal life with the component of variable life in which excess credited to the cash value of the account depends on investment results of separate accounts. The policyholder selects the accounts into which the premium payments are to be made.

VISION
limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.

WHOLE LIFE INSURANCE
life insurance that may be kept in force for the duration of a person's life and pays a benefit upon the person's death. Premiums are made for same time period.

Source:

Commissioners, March 2020

THE ADVANCED FINANCIAL GROUP

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