RPS RICHMOND PUBLIC SCHOOLS

2023 Benefits Enrollment Guide

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Welcome

At Richmond Public Schools we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to your accomplishments and our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees. Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefits package that is easy to understand, easy to access and affordable for all employees.

Please review the information is this guide to fully understand the benefit options available to you. It's important that you correctly enroll in the coverage that is right for you and your family.

This brochure summarizes the benefit plans that are available to Richmond Public Schools eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

If you have any questions regarding the information contained in this guide, please contact the Talent Office (HR) – Benefits at (804) 780-1880.

Benefits at a Glance

Benefit	Options	Who Pays for Coverage	When Can I Enroll*
Medical	RPS offers three medical options: - Cigna Open Access Premier Plan - Cigna Open Access Classic Plan - Cigna Open Access High Deductible Plan with HSA	You and RPS share in the cost	NH, OE
Health Savings Account	Offered through HSA Bank - only applicable if the Cigna Open Access High Deductible Plan is selected	You and RPS fund your account	NH, OE
Vision	RPS offers vision coverage through Cigna	No additional cost - included with medical premiums	NH, OE
Dental	RPS offers two dental options: - Cigna DPPO - Cigna DHMO	You pay the full cost	NH, OE
Flexible Spending Accounts	Two options offered through PayFlex: - Health Care FSA - Dependent Care FSA	You fund your account with pre-tax dollars	NH, OE
Virginia Retirement System (VRS)	Your VRS retirement benefits are based on date of hire	You and RPS share in the cost	AE
Group Term Life Insurance	Basic Group Term Life Insurance provided by the Virginia Retirement System and Securian Financial	RPS pays the full cost	AE
Optional Supplemental Life Insurance	Supplemental employee, spousal, and child(ren) life insurance provided by the Virginia Retirement System and Securian Financial	You pay the full cost	NH, AT
Accidental Injury Insurance	Offered through Cigna	You pay the full cost	NH, OE
Critical Illness Insurance	Offered through Cigna	You pay the full cost	NH, OE
Hospital Care Insurance	Offered through Cigna	You pay the full cost	NH, OE
Short Term / Long Term Disability *VRS Plan 1 and Plan 2 Participants*	Offered through One America	You pay the full cost	NH, OE
Short Term / Long Term Disability *VRS Hybrid Plan Participants*	Offered through The Standard	RPS pays the full cost	AE
Universal Life Insurance	Offered through Trustmark	You pay the full cost	NH, OE
Optional Supplemental Retirement Program	403(b) offered through Lincoln Financial	You fund your account with pre-tax dollars	AT
School Board Match Program	Benefit-eligible employees receive matching funds deposited into the 403(b) account with Lincoln Financial when the minimal threshold is met	RPS funds the employer match	AT
Prepaid Legal	Legal Resources	You pay the full cost	NH, OE
Employee Assistance and Work Life Support Program (EAP)	Cigna	RPS pays the full cost	AE
Leave	Accrued paid leave: - Urgent Personal Business - Sick Leave - Vacation Leave (for 12 month employees only) - Paid Parental Leave	Leave paid by RPS	AE

*NH - New Hire; OE - Open Enrollment; AE - Auto Enrolled; AT - Can Enroll At Any Time

Eligibility and Enrollment

Who is Eligible for Benefits?

Active employees working at least 30 hours per week and their eligible dependents may participate in the Richmond Public Schools benefits program.

New Hires

New hires have 30 calendar days from date of hire to enroll in benefits. You will be able to enroll in your benefits on or after your hire date, but within 30 calendar days of your date of hire. You will receive an email in your RPS email inbox with the subject "RPS New Hire Benefits Enrollment" on your first day inviting you to enroll in your benefits. The Richmond Public Schools Benefits Service Center is also available Monday through Friday 8:00 am to 5:00 pm via phone to assist you with the enrollment process and answer any questions.

Eligible Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents.

- Spouse – a person to who you are legally married
- Dependent children – You or your spouse's biological, adopted, legal dependents (including grandchildren for who you have legal custody) up to age 26 regardless of student, financial, residential or marital status. Dependent coverage will be terminated at the end of the month in which they turn 26. If your dependent is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.
- Acceptable dependent verification – marriage certificate, birth certificate, signed federal tax return, court order, and adoption papers.

Employee and Spouse Both Work for Richmond Public Schools

If you and your spouse are benefits-eligible employees of Richmond Public Schools, you may be eligible for reduced premium rates for your medical benefits. You must take action by completing the Both Working Spouses Application found here and supplying the required documentation within 30 calendar days of your date of hire. The both working spouses designation must be recertified each plan year.

When Coverage Begins

The 2023 benefits for current employees are effective January 1, 2023. Benefits for newly hired employees and eligible dependents will be the first of the month following 30 days of employment. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a Qualifying Life Event.

Qualifying Life Events

You will not be able to make changes to your elections outside of Open Enrollment unless you, your spouse, or your dependent children experience qualifying life events, provided you properly notify the Talent Office (HR) - Benefits within 30 days of the event and provide documentation supporting the change. Examples of qualifying life events may include:

- Marriage, divorce or legal separation
- Birth, adoption, gain of legal custody of a child
- Death of your spouse or covered child
- Loss or gain of coverage by spouse or dependent children
- Loss or gain of coverage due to a change in employment status
- Loss of dependent child status (dependent has reached age 26)
- Loss or gain of eligibility under Medicaid
- Eligibility for Medicare
- Child support order

Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period.

What is Open Enrollment?

Open enrollment is the one time period during the year in which benefit eligible employees can make changes to their benefit elections for any reason for the upcoming year. The Open Enrollment period for 2023 begins on October 24th and ends November 4th with changes taking effect January 1st.

How Do I Enroll?

There are two convenient ways to enroll:

1. **Online – Available October 24th – November 4th**
    - Click https://trustmark.benselect.com/enroll/login.aspx?ReturnUrl=%2fenroll to log into the Richmond Public Schools enrollment system to begin your benefit selection process which is available 24/7.
    - You will be prompted to enter your Social Security Number **OR** Employee ID.
    - Next, enter your PIN. Your pin is a six digit number, consisting of the last four of your SSN, followed by the last two digits of your birth year.
    - Once your identity is confirmed, you will be brought to an **Introduction** page. Click **"Next"** to review your personal information and make sure it's correct.
    - On the following **Dependents** screen, you can add new dependents on this screen or verify existing ones.

- To review your employment information, click through to the **Employment** screen.
- Next, make a selection or waive coverage for each benefit.
- Review your benefits summary and use the back button to modify your selections.
- Sign and submit your benefits confirmation by entering your PIN. Remember, your PIN is a six digit number, consisting of the last four of your SSN followed by the last two digits of your birth year.
- Print a copy of your benefits summary for your records.

2. Phone – Available October 26th – November 4th

- The Richmond Public Schools Benefit Service Center is available Monday through Friday, 8:00 am to 5:00 pm by calling (844) 379-0069.
- The service center is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries.
- The representative are experienced professionals and their primary responsibility is to assist you.

Pre-Tax vs Post-Tax Benefits

Richmond Public Schools offers the following plans on either a pre-tax or post-tax basis:

Pre-Tax

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

vs.

Post-Tax

A "post-tax basis" means that the money you pay towards the cost of coverage comes out of your salary after you pay any taxes. Although you do not get any savings from taxes, you have the flexibility of dropping your coverage at any time. If your employer allows, you may also enroll any time during the year but, depending on the plan, you may be subject to waiting periods for pre-existing conditions, or you may have to furnish Evidence of Insurability (EOI).

Pre-Tax Plans Offered:

- Cigna Medical
- PayFlex Flexible Spending Accounts
- Cigna Dental

Post-Tax Plans Offered:

- Cigna Group Critical Illness
- Cigna Group Accident
- Cigna Group Hospital Indemnity
- One America Short-term Disability
- One America Long-term Disability
- Trustmark Universal Life
- Legal Resources

Medical Benefits Overview

The chart below and on the following page are a brief outline of the plans. For more information, please refer to the Open Enrollment presentation found here.

Benefit Coverage	CIGNA OAP Premier Plan 3333350		CIGNA OAP Classic Plan 3333350		CIGNA OAP HDHP with HSA 3333350	
	POS In-Network	POS Out-of-Network	POS In-Network	POS Out-of-Network	POS In-Network	POS Out-of-Network
Annual Deductible						
Individual	$250	$1,000	$500	$1,000	$1,500	$3,000
Family	$500	$2,000	$1,000	$2,000	$3,000	$6,000
Coinsurance	90%	50% of the Maximum Reimbursable Charge	80%	50% of the Maximum Reimbursable Charge	80%	50% of the Maximum Reimbursable Charge
Maximum Out-of-Pocket*						
Individual	$5,000	$10,000	$6,350	$10,000	$6,000	$13,100
Family	$10,000	$20,000	$12,700	$20,000	$12,000	$26,200
Physician Office Visit						
Primary Care	$20 copay	50% after deductible	$25 copay	50% after deductible	80% after deductible	50% after deductible
Specialty Care	$40 copay	50% after deductible	$50 copay	50% after deductible	80% after deductible	50% after deductible
Preventive Care						
Adult Periodic Exams	No	In-Network coverage only	No Charge	50% after deductible	No Charge	In-Network coverage only
Well-Child Care	No Charge	In-Network coverage only	No Charge	50% after deductible	No Charge	In-Network coverage only
Diagnostic Services						
X-ray and Lab Tests	Office: $20/$40 copay; Other: 90% after deductible	50% after deductible	Office: $25 / $50 copay; Facility: 80% after deductible	50% after deductible	80% after deductible	50% after deductible
Complex Radiology	Office: No Charge; OP Facility: 90% after deductible	50% after deductible	Office: No Charge; Facility: 80% after Deductible	50% after deductible	80% after deductible	50% after deductible
Urgent Care Facility	$40 copay	$40 copay	$50 copay	$50 copay	80% after deductible	80% after deductible
Emergency Room Facility Charges*	90% after $200 copay/visit	90% after $200 copay/visit	$250 copay, then 80%	$250 copay, then 80%	80% after deductible	80% after deductible
Inpatient Facility Charges	$500 copay/admission, then 90% after deductible	50% after deductible	$500 copay per admission, then 80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Facility and Surgical Charges	$250 copay, then 90% after deductible	50% after deductible	$300 copay, then 80% after deductible	50% after deductible	80% after deductible	50% after deductible

Medical Benefits Overview

For more information, please refer to the Open Enrollment presentation found here.

Benefit Coverage	CIGNA OAP Premier Plan 3333350		CIGNA OAP Classic Plan 3333350		CIGNA OAP HDHP with HSA 3333350	
Mental Health						
Inpatient	$500 copay per admission, then 90% after deductible	50% after deductible	$500 copay per admission, then 80% after deductible	50% after deductible	80% after deductible	80% after deductible
Outpatient	Office: $20 copay; Other: 90% after deductible	50% after deductible	Office: $25 copay; Facility: 80% after deductible	50% after deductible	80% after deductible	80% after deductible
Substance Abuse						
Inpatient	Same as Mental Health Benefits	Same as Mental Health Benefits	Same as Mental Health	Same as Mental Health	80% after deductible	80% after deductible
Outpatient	Same as Mental Health Benefits	Same as Mental Health Benefits	Same as Mental Health	Same as Mental Health	80% after deductible	80% after deductible
Other Services						
Chiropractic	$20/$40 copay (30 days maximum per CY)	50% after deductible	$50 copay (30-day CY maximum)	50% after deductible (30-day CY maximum)	80% after deductible (90 days maximum for all OP short-term rehabilitative therapies combined)	50% after deductible (90 days maximum for all OP short-term rehabilitative therapies combined)
Retail Pharmacy (30 Day Supply)						
Generic (Tier 1)	$10 copay	In-Network coverage only	$10 copay	In-network coverage only	$10 copay after deductible	50% after deductible
Preferred (Tier 2)	$30 copay	In-Network coverage only	$30 copay	In-network coverage only	$30 copay after deductible	50% after deductible
Non-Preferred (Tier 3)	$55 copay	In-Network coverage only	$55 copay	In-network coverage only	$55 copay after deductible	50% after deductible
Home Delivery or Cigna 90-Now (90 Day Supply)						
Generic (Tier 1)	$10 copay	In-Network coverage only	$10 copay	In-network coverage only	$10 copay after deductible	50% after deductible
Preferred (Tier 2)	$60 copay	In-Network coverage only	$60 copay	In-network coverage only	$60 copay after deductible	50% after deductible
Non-Preferred (Tier 3)	$165 copay	In-Network coverage only	$165 copay	In-network coverage only	$165 copay after deductible	50% after deductible

For medical and prescription drug benefit questions: Call Cigna OneGuide toll free hotline 1-888-806-5042

Medical Plan Vision Benefits

(included with all Cigna medical plans)

For more information, please refer to the Open Enrollment presentation found here..

Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered at 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances (once per pair per frequency period) **Single Vision** **Bifocal** **Trifocal** **Lenticular**	 Covered in Full Covered in Full Covered in Full Covered in Full	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lens Allowance (one pair of single purchase per frequency period) **Elective** **Therapeutic**	 Covered in Full up to $100 Covered in Full	 Up to $87 Up to $210	 12 months 12 months
Frame Retail Allowance (once per frequency period)	Covered in Full up to $100	Up to $55	24 months
Call to find a provider 1-877-478-7557			

For medical and prescription drug benefit questions: Call Cigna OneGuide toll free hotline 1-888-806-5042

2023 Medical Rates – 24 Pays

Employees must complete a biometric screening and health assessment each year to be eligible to pay the "With Health Assessment" rates. Newly eligible employees hired on or after July 1 are not eligible for the "With Health Assessment" rates until the next calendar year.

Employee Contributions (24 Pay)		
Premier Plan		
	With Health Assessment	**Without Health Assessment**
Employee	$51.03	$66.66
Employee & Child	$173.53	$226.67
Employee & Spouse	$237.04	$309.63
Employee & RPS Spouse	$102.06	$133.32
Employee & Family	$276.26	$360.85
Employee & RPS Spouse/Family	$182.89	$238.89

Employee Contributions (24 Pay)		
Classic Plan		
	With Health Assessment	**Without Health Assessment**
Employee	$31.49	$41.13
Employee & Child	$140.11	$183.01
Employee & Spouse	$191.40	$250.00
Employee & RPS Spouse	$62.98	$82.25
Employee & Family	$225.64	$294.74
Employee & RPS Spouse/Family	$133.43	$174.28

Employee Contributions (24 Pay)		
HDHP with HSA		
	With Health Assessment	**Without Health Assessment**
Employee	$14.44	$14.86
Employee & Child	$99.26	$129.65
Employee & Spouse	$135.59	$177.11
Employee & RPS Spouse	$28.88	$37.72
Employee & Family	$158.01	$206.40
Employee & RPS Spouse/Family	$93.43	$122.04

IMPORTANT!

THIS IS SUMMARY OF YOUR MEDICAL PLAN. PLEASE VIEW YOUR FULL SUMMARY OF BENEFITS AND COVERAGE (SBC) PRIOR TO CHOOSING YOUR HEALTH PLAN. THE SBC CAN BE FOUND ON YOUR GROUP BENEFITS WEBSITE FOUND HERE.

2023 Medical Rates – 20 Pays

Employees must complete a biometric screening and health assessment each year to be eligible to pay the "With Health Assessment" rates. Newly eligible employees hired on or after July 1 are not eligible for the "With Health Assessment" rates until the next calendar year.

Employee Contributions (20 Pay)		
Premier Plan		
	With Health Assessment	**Without Health Assessment**
Employee	$61.24	$79.99
Employee & Child	$208.23	$272.00
Employee & Spouse	$284.45	$371.56
Employee & RPS Spouse	$122.47	$159.98
Employee & Family	$331.51	$433.02
Employee & RPS Spouse/Family	$219.47	$286.67

Employee Contributions (20 Pay)		
Classic Plan		
	With Health Assessment	**Without Health Assessment**
Employee	$37.78	$49.36
Employee & Child	$168.13	$219.61
Employee & Spouse	$229.67	$300.00
Employee & RPS Spouse	$75.57	$98.70
Employee & Family	$270.77	$353.68
Employee & RPS Spouse/Family	$160.11	$209.14

Employee Contributions (20 Pay)		
HDHP with HSA		
	With Health Assessment	**Without Health Assessment**
Employee	$17.33	$22.63
Employee & Child	$119.11	$155.58
Employee & Spouse	$162.70	$212.53
Employee & RPS Spouse	$34.65	$45.26
Employee & Family	$189.61	$247.67
Employee & RPS Spouse/Family	$112.12	$146.44

IMPORTANT!

THIS IS SUMMARY OF YOUR MEDICAL PLAN. PLEASE VIEW YOUR FULL SUMMARY OF BENEFITS AND COVERAGE (SBC) PRIOR TO CHOOSING YOUR HEALTH PLAN. THE SBC CAN BE FOUND ON YOUR GROUP BENEFITS WEBSITE FOUND HERE.

Health Savings Account

A Health Savings Account (HSA) provides a tax-advantaged way to save for future medical expenses. The HSA is a component of a High Deductible Health Plan (HDHP). Under the RPS HDHP plan, the individual deductible is $1,500, and the family deductible is $3,000 with an out of pocket maximum of $6,000/$12,000. All eligible medical expenses are subject to the comprehensive, front-end deductible. Preventive benefits are covered at 100%.

It's your account and you can build on it over the years. It's portable. If you leave Richmond Public Schools, your HSA account still belongs to you. There is no "use it or lose it" rule as with an FSA.

Who Is Eligible to Enroll?

- You must be enrolled in a qualifying HDHP to be eligible to contribute to an HSA.
- You cannot be enrolled in Medicare (generally those over 65) and contribute funds to the account. However, HSA funds can be used when enrolled in Medicare for qualifying expenses not covered by Medicare.
- You cannot be covered by another health insurance program.
- You cannot be eligible to be claimed as a dependent on another's tax return (does not apply to joint filing).
- You cannot be enrolled in a medical Flexible Spending Account (you or spouse) and put funds in an HSA. However, you can be enrolled in the HDHP without the HSA.

If you or your spouse is currently enrolled in an FSA today, you must exhaust all money in your FSA account by the end of the plan year (December 31) to be eligible to open an HSA on January 1.

If your spouse is enrolled in an FSA plan, you cannot cover your spouse under RPS' plan and open an HSA account until the end of their plan year. For example, if their plan does not end until March 31, you are not able to open the HSA until then. If you have money remaining in the FSA and won't exhaust those funds until the end of the 3-month extension, you must wait until April 1 to open an HSA account.

Contributions

HSAs function much like an IRA, where employees can invest money on a pre-tax basis and reduce taxable income. You can use the funds without penalty for eligible medical expenses (similar to the FSA eligible list).

All contributions, including RPS contributions, are vested immediately. RPS contributes to your HSA account as follows:

- *Employee Only Participants:* RPS will contribute $750 annually* (Federal limits apply)
- *Dependent/Family Participants:* RPS will contribute $1,250 annually* (Federal limits apply)

**RPS contributions are adjusted based on your enrollment date.*

Contributions can be made up to the Federal limit ($3,850 individual or $7,750 family) in 2023. If you are age 55 or older, you can make an additional $1,000 contribution. Contributions can be made on a pre-tax basis or can be deducted on your tax return at filing time.

The maximum contribution is allowable for partial year participation in a qualified HDHP as long as you remain in the plan the following full year.

Plan Administrator

Our administrator is **HSA Bank** and you can access your account online here.

Eligible Expenses

Expenses that are eligible for reimbursement from an HSA are similar to those that are allowed under an FSA. You can refer to IRS Publication 502, Medical and Dental Expenses to identify eligible expenses. This publication can be found on the Internal Revenue Service's website found here.

Paying Claims and Reimbursements from Account

Show your Cigna ID card when you receive care. The provider will submit a claim to Cigna for the application of discounts and credit to your deductible. Most providers will not require a payment from you at time of service. They will bill you for the balance due after the insurance discount has been applied.

You pay the bill one of the following ways:

- HSA debit card
- Direct from HSA (check)
- From regular funds, then reimburse yourself from HSA
- From regular funds, don't reimburse yourself, but save the HSA funds for a rainy day

If you withdraw funds in an account after age 65 and use the fund for anything other than eligible medical expenses, you will be subject to a tax but a penalty does not apply.

Dental Insurance

The chart below and on the following page are a brief outline of the plans. For more information, please refer to the Open Enrollment presentation found here.

Benefit Coverage	Cigna DPPO 3333350	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50 per person per calendar year	$50 per person per calendar year Combined with In-Network
Family	$150 per person per calendar year	$150 per person per calendar year Combined with In-Network
Waived for Preventive Care	Yes	Yes
Annual Maximum		
Per Person / Family Progressive Maximum Benefit: When you or your family members receive preventive care in one plan year, the annual dollar maximum will increase in the following plan year.	Year 1: $1,500 per enrollee per calendar year Year 2: $1,600 per enrollee per calendar year Year 3: $1,700 per enrollee per calendar year Year 4: $1,800 per enrollee per calendar year	Year 1: $1,500 per enrollee per calendar year Year 2: $1,600 per enrollee per calendar year Year 3: $1,700 per enrollee per calendar year Year 4: $1,800 per enrollee per calendar year Combined with In-Network
Diagnostic & Preventive	100%	100%
Basic Restorative	80%	80%
Major Restorative	50%	50%
Orthodontia		
Benefit Percentage	50% No Deductible	50% No Deductible
Adult (and Covered Full-Time Students, if Eligible)	Covered	Covered
Dependent Child(ren)	Covered	Covered
Lifetime Maximum	$1,000 per person	$1,000 per person Combined with In-Network

Employee Contributions		
Cigna DPPO		
	24-Pay	**20-Pay**
Employee	$15.84	$19.01
Employee & 1 Dep	$32.19	$38.63
Employee & 2+ Deps	$51.50	$61.79

Dental Insurance

For more information, please refer to the Open Enrollment presentation found here.

Benefit Coverage	Cigna DHMO (G1-V9) 3333350	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	None	N/A
Family	None	N/A
Waived for Preventive Care	N/A	N/A
Annual Maximum		
Per Person / Family	Unlimited	N/A
Office Visit Copay per patient, per office visit	$5.00	N/A
Diagnostic & Preventive	100%	Not Covered
Basic Restorative	Copays vary based on service	Not Covered
Major Restorative	Copays vary based on service	Not Covered
Orthodontia		
Benefit Percentage	Copays vary based on service	Not Covered
Adult (and Covered Full-Time Students, if Eligible)	Covered	N/A
Dependent Child(ren)	Covered	N/A
Lifetime Maximum	Unlimited	N/A

Employee Contributions		
Cigna DHMO		
	24-Pay	**20-Pay**
Employee	$4.94	$5.92
Employee & 1 Dep	$8.18	$9.81
Employee & 2+ Deps	$11.15	$13.37

Cigna Group Insurance

HEALTH ADVOCACY SERVICES WHEN YOU NEED THEM

Help for you and your family is just a phone call away

Cigna Health Advocacy Services offers you expert assistance with a wide range of healthcare and health insurance issues. Let us help you – your spouse, dependents, parents and parents-in-law – get the answers you need, when you need them, 24/7, at no additional cost to you.

Don't know where to turn? We point the way.

- Find the right health care professionals based on your needs
- Locate specialists, schedule appointments, arrange medical tests or special treatments
- Answer questions about diagnoses, test results, treatments, medications and more

Want to maximize your benefit dollars? We can help you save.

- Get the estimated fees for services in your area
- Find options for non-covered and alternative health services
- Receive information about generic drug options
- Address questions and concerns related to your medical bills
- Get help negotiating discounts on medical or dental bills over $400 not covered by insurance

Need eldercare or special needs services? We're there for you.

- Find in-home care, adult day care, group homes, assisted living and long-term care
- Get access to a range of services for parents of children with special needs or autism spectrum disorders
- Clarify or get help applying for Medicare, Medicare Supplement plans and Medicaid
- Coordinate care among multiple providers
- Arrange transportation to appointments

cut and fold

CIGNA GROUP INSURANCE®

Health Advocacy Services

Access to help when you need it for all your health care, insurance or medical bill needs – for you and your family, including parents and parents-in-law.

24/7 support **866.799.2725**

Cigna

Health advocacy services are NOT health insurance or medical services, and this program does not provide either for health care services or for the reimbursement for financial losses of health care services. Health advocacy services are provided under a contract with Health Advocate, Inc. subject to all of the terms of that contract. Presented here are highlights of the program. Full terms, conditions and exclusions are contained in the Health Advocate service agreement. "Health Advocate" and "Medical Bill Saver" are trademarks of Health Advocate, Inc. used under license.

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Help is only a call away.
Call 866.799.2725

Together, all the way.®

Cigna®

Flexible Spending Accounts

Healthcare Expenses

The Healthcare Flexible Spending Account may be used to reimburse eligible expenses incurred by you or your dependents, as long as the expenses are not covered by insurance or any other source. The maximum amount that you may contribute to your Healthcare Account for each plan year is $3,050. You must use the amount in your FSA each plan year. Only $610 may be carried over into the next plan year. The Health Care Flexible Spending Account is advantageous when you have predictable healthcare expenses.

You can refer to IRS Publication 502, Medical and Dental Expenses to identify eligible expenses. This publication can be found on the Internal Revenue Service's website found here or by calling 1-800-TAX-FORM.

Dependent Care Expenses

The Dependent Care Spending Account may be used to care for a dependent in your home or someone else's home; childcare or dependent care facilities, including day care centers and nurseries; or Housekeeping services in your home that include day care.

However, you cannot claim payments for services provided by a dependent or one of your own children under the age of 19.

Dependent Care and the Federal Tax Credit

If you have eligible dependents, you may choose to use *either* or *both* the Dependent Care Flexible Spending Account and the Federal dependent care tax credit when you file your annual tax return. Whatever you contribute to the Dependent Care Spending Account will reduce the amount of the available Federal tax credit.

The annual maximum the IRS currently allows you to contribute to a Dependent Care Account is $5,000 for single individuals and married individuals filing jointly, and $2,500 for married individuals filing separately.

You are eligible for a Federal income tax credit of up to $3,000 of eligible dependent care expenses for one qualified dependent (up to $6,000 for two or more qualified dependents). The amount of your tax credit depends on your adjusted gross income reported on your Federal income tax return.

You must decide whether using the Dependent Care Flexible Spending Account or taking the Federal dependent care tax credit for your dependent care expenses will provide you with more tax savings. If you are uncertain as to which is best for you, we recommend that you check with a tax advisor before making your final decision.

Who May Participate in the Dependent Care Spending Account Plan?

If you are married, your spouse must work, be a full-time student or be mentally or physically unable to care for him or herself in order to be eligible to participate in this plan. You may also participate in this plan if you are not married and incur eligible dependent care expenses.

Plan Administrator

Our administrator is **PayFlex**.

IRS Publication 503 explains the child and dependent care tax credit in more detail. You can obtain a copy of this publication from the Internal Revenue Service's website found here or by calling 1-800-TAX-FORM.

If you choose to participate in the Healthcare and/or Dependent Care Spending Account, your contributions will be made through payroll deduction and will be made on a "before-tax" basis. This means that contributions to this plan will be deducted from your pay before taxes and are, therefore, tax-free. This will increase your net take-home pay since Federal, State and FICA taxes will be reduced.

Virginia Retirement System

RPS Retirement Benefits are administered through the Commonwealth of Virginia. The Virginia Retirement System (VRS) is an independent agency of the Commonwealth of Virginia. The VRS Board of Trustees administers and is trustee of the funds of the Virginia Retirement System Trust, including Plan 1, Plan 2, and the defined benefit component of the Hybrid Retirement Plan.

As a member, you contribute 5 percent of your compensation each month to your member contribution account through a pre-tax salary reduction. Your contributions are tax-deferred until you withdraw them as part of your retirement benefit or as a refund.

Your employer makes a separate contribution to VRS for all covered employees. VRS invests contributions to provide for your future benefit payment.

You will become vested when you have at least five years (60 months) of service credit. Vesting means you are eligible to qualify for retirement if you meet the age and service requirements for your plan. You also must be vested to receive a full refund of your member contribution account balance if you leave employment and request a refund.

VRS members are covered for Basic Group Life Insurance from the first day of employment through Securian Financial (Minnesota Life Insurance). The coverage is 2 times your salary for natural death and 4 times your salary for accident death. You are also eligible to purchase additional life insurance for yourself as well as your spouse and dependent children through the Optional Group Life Insurance Program. If you opt for this additional coverage you will be able to pay the premiums through payroll deductions.

VRS Plan Comparison Chart

PLAN 1	PLAN 2	HYBRID PLAN
VRS Plan 1 is a defined benefit plan where the benefit is based on the member's age, *creditable service* and *average final compensation* at retirement using a formula. **Members are in VRS Plan 1 if their membership date is before July 1, 2010, and they were** *vested* **as of January 1, 2013.**	**VRS Plan 2 is** a defined benefit plan where the benefit is based on the member's *age, creditable service and average final compensation* at retirement using a formula. **Members are in VRS Plan 2 if their membership date is from July 1, 2010, to December 31, 2013, or their membership date is before July 1, 2010, and they were not vested as of January 1, 2013.**	**VRS Hybrid Plan** combines the features of a defined benefit plan and a defined contribution plan. The plan applies to most members whose membership date is on or after **January 1, 2014.**
Disability Retirement	**Disability Retirement**	**Disability Benefits**
If you are eligible to be considered for disability retirement and retire on disability, the retirement multiplier will be 1.7 percent on all service credit, regardless of when it was earned, purchased or granted.	If you are eligible to be considered for disability retirement and retire on disability, the retirement multiplier will be 1.65 percent on all service credit, regardless of when it was earned, purchased or granted.	Members under the Hybrid Retirement Plan will be subject to a one-year waiting period before becoming eligible for non-work related disability benefits. Short-term and long-term disability benefits can be purchased while satisfying the one-year waiting period.
Purchase of Prior Service		
Members may be able to purchase service from previous public employment, active duty military service, an eligible period of leave or VRS refunded service as creditable service in their plan. Prior creditable service counts toward vesting, eligibility for retirement and the health insurance credit. Only active members are eligible to purchase prior service. When buying service, members must purchase their most recent period of service first. Members may also be eligible to purchase periods of leave without pay. Members are not eligible to purchase prior service if you are employed in a non-covered position, are a deferred member or are a retiree.		

Virginia Retirement System

Plan 1: State Employees, Teachers and General Political Subdivision Employees

Average Final Compensation	Your average final compensation is the average of your 36 consecutive months of highest creditable compensation as a covered employee.
Service Benefit Calculation	Your unreduced Basic Benefit is calculated using the following formula: Average final compensation × Retirement multiplier × Total years of service credit at retirement **Annual benefit amount** ÷ 12 months **Monthly benefit amount before taxes and other deductions** A reduction factor is applied to your monthly benefit amount if you retire with a reduced retirement benefit (see below) or a benefit payout option other than the Basic Benefit.
Cost-of-Living Adjustment (COLA)	A cost-of-living adjustment (COLA) allows your retirement benefit to keep pace with inflation. The COLA is based on the Consumer Price Index for all Urban Consumers (CPI-U), published by the U.S. Bureau of Labor Statistics and updated each July 1. During years of no inflation or deflation, the COLA will be 0%.
Death-in-Service Benefit	If you die while you are an active member ("in service"), your beneficiary or your spouse, minor child or parent may be eligible for a death-in-service benefit in addition to any life insurance benefits you may have.
Disability	If you are eligible to be considered for disability retirement and retire on disability, the retirement multiplier will be 1.7% on all service credit, regardless of when it was earned, purchased or granted, or you may be covered under the Virginia Sickness and Disability Program (VSDP). Learn more about VSDP at varetire.org/vsdp.
Unreduced Service Retirement Eligibility	Age 65 if you have at least five years (60 months) of service credit, or at age 50 if you have at least 30 years of service credit.
Reduced Service Retirement Eligibility	Age 55 if you have at least five years (60 months) of service credit, or age 50 if you have at least 10 years of service credit.
Employer Contribution	Your employer makes a separate contribution to VRS toward funding current and future benefits for all covered employees. Members are not eligible for a refund of the separate employer contribution.
Mandatory Retirement Distribution	If you defer retirement and do not apply for retirement by April 1 following the calendar year in which you turn age 72, VRS will pay you a retirement benefit (Basic Benefit option), as required by law. If you are not vested, you will receive a refund of your member contribution account balance, excluding any member contributions made by your employer to your account after July 1, 2010, and the interest on these contributions.

Member Contributions	You contribute 5% of your creditable compensation each month to your member contribution account on a pre-tax, salary-reduction basis. Contact your human resource office for more information. The *Code of Virginia* prohibits members from borrowing from their member contribution accounts.
Normal Service Retirement Age	Age 65.
Prior Service Credit	Eligible prior service includes federal and other public service, active duty military service, certain types of leave and VRS refunded service. If you have prior service, you may be eligible to purchase this service as credit in your plan. Prior service credit counts toward vesting, eligibility for retirement and eligibility for the health insurance credit, if offered by your employer. Visit myVRS.varetire.org to learn more.
Retirement Contributions	You contribute 5% of your creditable compensation each month to your member contribution account through a pre-tax salary reduction. Your contributions are tax-deferred until you withdraw them as part of your retirement benefit or as a refund. Your employer makes a separate contribution to VRS for all covered employees. VRS invests contributions to provide for your future benefit payment.
Service Retirement Multiplier	A service retirement multiplier is a factor that determines how much of your average final compensation will be used to calculate your retirement benefit. For service retirement, your retirement multiplier is 1.7%.
Service Credit	Service credit has monetary value when it is used to calculate your retirement benefit or if you take a refund of your member contributions and interest. You earn service credit for each month you are reported in a covered position. Service credit can include credit for prior service earned, purchased or granted.
Vesting	You become vested when you have at least five years (60 months) of service credit. Vesting means you are eligible to qualify for service retirement if you meet the age and service requirements for your plan. You also must be vested to receive a full refund of your member contribution account balance (contributions and interest accrued) if you leave employment and request a refund.

Virginia Retirement System

Plan 2: State Employees, Teachers and General Political Subdivision Employees

Average Final Compensation	Your average final compensation is the average of your 60 consecutive months of highest creditable compensation as a covered employee.
Service Benefit Calculation	Your unreduced Basic Benefit is calculated using the following formula: Average final compensation × Retirement multiplier × Total years of service credit at retirement **Annual benefit amount** ÷ 12 months **Monthly benefit amount before taxes and other deductions** A reduction factor is applied to your monthly benefit amount if you retire with a reduced retirement benefit (see below) or a benefit payout option other than the Basic Benefit.
Cost-of-Living Adjustment (COLA)	A cost-of-living adjustment (COLA) allows your retirement benefit to keep pace with inflation. The COLA is based on the Consumer Price Index for all Urban Consumers (CPI-U), published by the U.S. Bureau of Labor Statistics and updated each July 1. During years of no inflation or deflation, the COLA will be 0%.
Death-in-Service Benefit	If you die while you are an active member ("in service"), your beneficiary or your spouse, minor child or parent may be eligible for a death-in-service benefit in addition to any life insurance benefits you may have.
Disability	If you are eligible to be considered for disability retirement and retire on disability, the retirement multiplier will be 1.65% on all service credit, regardless of when it was earned, purchased or granted, or you may be covered under the Virginia Sickness and Disability Program (VSDP). Learn more about VSDP at varetire.org/vsdp.
Unreduced Service Retirement Eligibility	Normal Social Security retirement age with at least five years (60 months) of service credit or when your age (years) and service (years) equal 90.
Reduced Service Retirement Eligibility	Age 60 with at least five years (60 months) of service credit.
Mandatory Retirement Distribution	If you defer retirement and do not apply for retirement by April 1 following the calendar year in which you turn age 72, VRS will pay you a retirement benefit (Basic Benefit option), as required by law. If you are not vested, you will receive a refund of your member contribution account balance, excluding any member contributions made by your employer to your account after July 1, 2010, and the interest on these contributions.
Normal Service Retirement Age	Normal Social Security retirement age.

Prior Service Credit	Eligible prior service includes federal and other public service, active duty military service, certain types of leave and VRS refunded service. If you have prior service, you may be eligible to purchase this service as credit in your plan. Prior service credit counts toward vesting, eligibility for retirement and eligibility for the health insurance credit, if offered by your employer. Visit myVRS.varetire.org to learn more.
Retirement Contributions	You contribute 5% of your creditable compensation each month to your member contribution account through a pre-tax salary reduction. Your contributions are tax-deferred until you withdraw them as part of your retirement benefit or as a refund. The *Code of Virginia* prohibits members from borrowing from their member contribution accounts. Your employer makes a separate contribution to VRS for all covered employees. VRS invests contributions to provide for your future benefit payment.
Service Retirement Multiplier	A service retirement multiplier is a factor that determines how much of your average final compensation will be used to calculate your retirement benefit. For service retirement, your retirement multiplier is 1.65% on service credit earned, purchased or granted on or after January 1, 2013, and 1.7% on service earned, purchased or granted before January 1, 2013.
Service Credit	Service credit has monetary value when it is used to calculate your retirement benefit or if you take a refund of your member contributions and interest. You earn service credit for each month you are reported in a covered position. Service credit can include credit for prior service earned, purchased or granted.
Vesting	You become vested when you have at least five years (60 months) of service credit. Vesting means you are eligible to qualify for service retirement if you meet the age and service requirements for your plan. You also must be vested to receive a full refund of your member contribution account balance (member contributions and interest accrued) if you leave employment and request a refund.

VRS HYBRID RETIREMENT PLAN
HYBRID CONTRIBUTIONS ILLUSTRATION

Virginia Retirement System

Hybrid Retirement Plan

Defined Benefit (DB) Component
Provides a lifetime monthly benefit based on a formula

- **Mandatory *Employee* Contribution** — 4%
- ***Employer* Contribution** — Varies based on contributions to the DC component

Employee contributions are placed into the Member Contribution Account and are used to provide a monthly retirement benefit.

The employer makes a separate contribution to VRS for all covered employees (not individuals).

VRS invests these contributions to provide a monthly retirement benefit once the member meets eligibility requirements.

Defined Contribution (DC) Component
Provides a balance to draw from in retirement based on contributions and investment performance

- **Mandatory *Employee* 401(a) Contribution** — 1%
  - Mandatory *Employer* 401(a) Contribution — 1%
- **Voluntary *Employee* 457 Contribution** — 0–4%
  - *Employer* Matching 401(a) Contribution — 0–2.5%

All mandatory contributions, along with any employer matching contributions, are placed into the Hybrid 401(a) Cash Match Plan. All voluntary contributions are placed into the Hybrid 457 Deferred Compensation Plan.

The employee should consider investment objectives, risks, fees and expenses carefully before investing.

This flyer provides general information regarding your retirement benefits, with a high-level overview of plan contributions. For further details, please refer to your VRS Hybrid Retirement Plan Handbook and additional resources at www.varetire.org/hybrid under Publications.

For help with defined benefit component hybrid questions:

- Call VRS at 1-855-291-2285
- Email: vrshybridsupport@varetire.org

For help with defined contribution component hybrid questions:

- Call Investor Services at 1-877-327-5261, option 1
- Email: InvestorServicesCommonwealthofVA@icmarc.org
- Contact your VRS Defined Contribution Plan Specialist

Visit www.varetire.org/hybrid for more resources.

AC: 33801-201710

Basic Group Life Insurance

Eligible employees are automatically enrolled in life insurance through the Virginia Retirement System (VRS) and administered by Securian Financial. Your basic group life insurance provides you with two kinds of life insurance during active employment – basic life insurance and accidental death and dismemberment insurance. Richmond Public Schools pays the total premium for group life insurance. Your coverage amount is determined by rounding your annual salary to the next highest thousand and then doubling that amount. In the event of accidental death or dismemberment, the amount doubles again. Your life insurance benefits include:

- Group life insurance without a medical examination
- Natural death benefits
- Double the natural death for an accidental death
- Dismemberment payments for accidental loss or one or more limbs or loss of sight in one or both eyes
- Accelerated death benefit for a terminal medical condition

Naming a Beneficiary

Who Can you Name as a Beneficiary?

You can name any living person or an entity such as an eligible trust or charity as your beneficiary.

Primary and Contingent Beneficiaries

You can name one primary beneficiary or multiple primary beneficiaries. Upon your death, each primary beneficiary receives a share of any retirement contributions and interest in your member contribution account and any life insurance benefits you may have, depending on how you designate your primary beneficiaries for each payment. If you name multiple primary beneficiaries, the proceeds will be split equally, unless you instruct otherwise on the form. You can name a contingent beneficiary or beneficiaries. If your primary beneficiary or beneficiaries are deceased at the time of your death, your contingent beneficiary or beneficiaries receive benefit payments.

Changing Your Beneficiary

VRS is required by law to pay benefits according to the latest beneficiary designation in your VRS record. Review your beneficiary designation after a personal milestone such as a change in marital status, the birth or adoption of a child, or as you near retirement. To change your beneficiary, log in to your myVRS account to make beneficiary updates as soon as possible. Should you need assistance, call 888-827-3847 (select option 3 for myVRS online assistance).

If There Is No Beneficiary

If there is no valid beneficiary designation on file or your beneficiary is deceased at the time of your death, VRS will pay benefits according to the following order of precedence, as required by law:

- First, to the spouse of the member;

- Second, if no surviving spouse, to the children of the member and descendants of deceased children, per stirpes;

- Third, if none of the above, to the parents of the member;
- Fourth, if none of the above, to the duly appointed executor or administrator of the estate of the member;
- Fifth, if none of the above, to other next of kin of the member entitled under the laws of the domicile of the member at the time of his death.

Defined Benefit Plans

Register or log in to your myVRS account to name or update beneficiaries for your defined benefit member contributions.

Defined Contribution Plans

If you participate in the Commonwealth of Virginia 457 Deferred Compensation Plan and Virginia Cash Match Plan, select your plan's website and log in to your account to name your beneficiary. Learn more about how to designate your beneficiary.

Optional Group Life Insurance

You may purchase additional life insurance at group rates for you, spouse, and your dependents up to age 21 (or age 25 if they are full time students). You may apply for coverage for:

- Yourself of 1, 2, 3, or 4 times your salary (rounded up to the next highest $1,000), up to a maximum of $800,000
- Spousal coverage for half of the amount of your coverage, up to a maximum of $400,000
- Coverage for your children over 14 days of age in increments of $10,000, $20,000, or $30,000, depending on the level of coverage you select for yourself.

VRS premiums for optional coverage for you and your spouse on each covered individual's age and the amount of coverage. Age-related premium rate changes occur once a year on July 1. Rate table can be found here.

Enrollment in optional life insurance for the employee is a guaranteed benefit (subject to maximums) if you enroll within 31 calendar days of your hire date. You may apply for optional coverage after 31 calendar days, but evidence of insurability will be required.

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid
ACCIDENTAL INJURY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Richmond Public Schools

Accidental Injury coverage provides a benefit according to the schedule below when a Covered Person suffers Covered Injuries or undergoes a broad range of medical treatments or care resulting from a Covered Accident. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active, Full-time Employees of the Employer who are regularly working in the United States a minimum of 20 hours per week and regularly residing in the United States who are United States citizens or permanent resident aliens and their Spouse and Dependent Children who are United States citizens or permanent resident aliens and are residing in the United States Employees hired 31 days or more before the Policy Effective Date are eligible for coverage immediately, employees hired after or less than 31 days before the Policy Effective Date will be eligible after 30 days of active service.

Your Spouse/Domestic Partner: Up to age 100, as long as you apply for and are approved for coverage yourself. Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage: This Accidental Injury plan provides 24 hour coverage.

The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred and are paid on a per day basis unless otherwise specified. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Benefit Percentage Amount (unless otherwise indicated)	Employee 100% of benefits shown	Spouse 100% of benefits shown	Children 100% of benefits shown
Initial & Emergency Care		Plan 1	
Emergency Care Treatment		$125	
Physician Office Visit		$125	
Diagnostic Exam (x-ray or lab)		$10	
Ground or Water Ambulance/Air Ambulance		$100/$500	
Hospitalization Benefits		Plan 1	
Hospital Admission		$1,000	
Hospital Stay		$200	
Intensive Care Unit Stay		$400	
Fractures and Dislocations		Plan 1	
Per covered surgically-repaired fracture		$200-$9,000	
Per covered non-surgically-repaired fracture		$100-$4,500	
Chip Fracture (percent of fracture benefit)		25%	
Per covered surgically-repaired dislocation		$200-$8,000	
Per covered non-surgically-repaired dislocation		$100-$4,000	
Follow-Up Care		Plan 1	
Follow-up Physician Office Visit		$25	
Follow-up Physical Therapy Visit		$25	

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

Available Coverage — continued

Enhanced Accident Benefits	Plan 1
Examples:	
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)	$100
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	$600
Concussion	$200
Coma (lasting 7 days with no response)	$10,000
Additional Accidental Injury benefits included - See certificate for details, including limitations & exclusions.	

Accidental Death and Dismemberment Benefit	Plan 1
Examples of benefits include (but are not limited to) payment for death from Automobile accident; total and permanent loss of speech or hearing in both ears. Actual benefit amount paid depends on the type of Covered Loss. The Spouse and Child benefit is 25% and 25% respective of the benefit shown.	Loss of Life: $50,000-$100,000 Dismemberment: $2,000-$30,000

Wellness Treatment, Health Screening Test, or Preventive Care Benefit*	Plan 1
Examples include (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests. Benefit paid for all covered persons is 100% of the benefit shown.	$75

Portability Feature: You can continue 100% of your coverage at the time your coverage ends. You must be under the age of 100 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Semi-Monthly Cost of Coverage:

Tier	Plan 1
Employee	$7.45
Employee and spouse	$10.65
Employee and child(ren)	$14.21
Family	$17.42

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

Important Definitions and Policy Provisions:

Coverage Type: Benefits are paid when a Covered Injury results, directly and independently of all other causes, from a Covered Accident.
Covered Accident: A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the Covered Person is insured under this Policy; is not contributed to by disease, sickness, mental or bodily infirmity; and is not otherwise excluded under the terms of this Policy.
Covered Injury: Any bodily harm that results directly and independently of all other causes from a Covered Accident. Covered Person: An eligible person who is enrolled for coverage under this Policy.
Covered Loss: A loss that is the result, directly and independently of other causes, from a Covered Accident suffered by the Covered Person within the applicable time period described in the Policy.
Hospital: An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of medical doctors; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis, and charges for its services. The term Hospital does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial, educational, or nursing care; the aged, treatment of drug or alcohol addiction.
When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if hospital, facility or home confined, disabled or receiving disability benefits or unable to perform activities of daily living.
When your coverage ends: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate.)

Important Definitions and Policy Provisions — continued

30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Benefit Conditions and Limitations: This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy.

Common Exclusions:* In addition to any benefit specific exclusions, no payments will be made for losses which directly or indirectly, is caused by or results from: · intentionally self-inflicted injury, including suicide or any attempted suicide; · committing an assault or felony; · bungee jumping; parachuting; skydiving; parasailing; hang-gliding; · declared or undeclared war or act of war; · aircraft or air travel, except as a commercial passenger or Aircraft used by the Air Mobility Command (unless owned, leased or controlled by Subscriber); · sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except bacterial infection from an accidental external cut or wound or accidental ingestion of contaminated food; · activities of active military duty, except Reserve or National Guard active duty training lasting 31 days or less; · operating any vehicle under the influence of alcohol or any drug, narcotic or other intoxicant; · voluntary use of drugs, unless taken as prescribed and under direction of a physician; · services or treatment rendered by a physician, nurse or any other person who is: employed by the subscriber, living with or immediate family of the Covered Person, or providing alternative medical treatments. Actual policy terms may vary depending on your plan design and location.

Specific Benefit Exclusions & Limitations:*

Emergency Care Treatment: Treatment must occur within 30 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person. Excludes: treatment provided by an immediate family member, clinic, or doctor's office. **Physician Office Visit**: Must be diagnosed and treated by a physician within 90 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; not payable if a Covered Person is eligible to receive a benefit under Emergency Treatment. Excludes: routine health examinations or immunizations for Covered Persons Age 60 and older, visits for mental or nervous disorders, and visits by a surgeon while confined to a Hospital. **Diagnostic Exam:** payable once per Covered Accident, per Covered Person. Treatment must occur within 90 days of the Covered Accident. **Ground or Water Ambulance/Air Ambulance:** Services must be provided from the scene of the Covered Accident or within 90 days of Covered Accident. Limits: payable once per Covered Accident, per Covered Person; only one benefit will be paid ground or water/air, whichever is greater. Hospital Admission: Inpatient admission must occur within 90 days of the Covered Accident due to such accident. Limits: payable once per Covered Accident. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Accident.

Hospital Stay per day: Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 365 days per Covered Accident; 1 stay per accident; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay. **Intensive Care Unit Stay per day**: Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 30 days per Covered Accident; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay. **Fracture/Dislocation**: If more than one fracture, only one benefit will be paid, whichever is the greater amount. Chip fracture not paid in addition to closed fracture. Limits: Both fractures and dislocations are limited to 1 per accident. Must be diagnosed and treated by a physician within 90 days of the Covered Accident.

Follow-up Physician Office Visit: Limits: 6 follow up visit(s) for each Covered Person per Covered Accident for follow up physician office visits. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident. **Follow-up Physical Therapy Visit**: Limits: 6 follow up visit(s) for each Covered Person per Covered Accident for follow up physical therapy visits. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident. **Large Lacerations**: Treatment by Physician must be received within 90 days of the Covered Accident. Limits: payable 1 time per Covered Person, Per Covered Accident; Multiple lacerations pay a maximum of 2 times the benefit.

Concussion: Must be diagnosed by a physician within 90 days of the Covered Accident. Limits: payable 1 times per Covered Accident. **Coma**: Limits: payable 1 times per Covered Accident. Must be unconscious for 7 days or more with no response to external stimuli and requiring artificial respiratory or life support. Excludes: medically induced coma. **Wellness Treatment, Health Screening Test or Preventive Care Benefit**: Limit: 1 per year per Covered Person. **Accidental Death and Dismemberment Rider**: To receive benefits, the death or loss must occur within 365 days of the covered accident. The exclusions that apply to this benefit are in the Common Exclusions Section. If a Covered Person dies as a result of an automobile accident other loss of life benefits will not be paid. If the driver, he/she must hold a current and valid driver's license. If total and permanent loss of speech or hearing in both ears is payable, no benefits will be paid under the dismemberment benefit and total benefits will not exceed the loss of life death benefit. This is not a complete list. See certificate for complete details, including limitations and exclusions that apply to this benefit.

***State Variations**

Spouse definition includes civil union partners in New Hampshire and Vermont. **Specific Benefit Exclusions and Limitations** The timeframe to obtain services following a covered accident is extended in SD and WA. **Common Exclusions** may vary for residents of MN, SC, SD, and WA. **Hospital/ICU Stay** requires a 31 day minimum for Idaho residents. See your Certificate for detail. **Wellness Treatment, Health Screening Test or Preventive Care Benefit i**s not available to residents of NH and ND. **Portability** in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage.

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid

CRITICAL ILLNESS INSURANCE

SUMMARY OF BENEFITS

Prepared for: Richmond Public Schools

Critical Illness insurance provides a cash benefit when a Covered Person is diagnosed with a covered critical illness or event after coverage is in effect. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active, Full-time Employees of the Employer who are regularly working in the United States a minimum of 20 hours per week and regularly residing in the United States who are United States citizens or permanent resident aliens and their Spouse and Dependent Children who are United States citizens or permanent resident aliens and are residing in the United States.

Employees hired 31 days or more before the Policy Effective Date are eligible for coverage immediately, employees hired after or less than 31 days before the Policy Effective Date will be eligible after 30 days of active service. Your Spouse/Domestic Partner: Up to age 100, as long as you apply for and are approved for coverage yourself. Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage:

The benefit amounts shown will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions and limitations applicable to these benefits. Please read all of the information in this Summary and your Certificate of Insurance for more information. All Covered Critical Illness Conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	$10,000, $20,000, $30,000	Up to $30,000
Spouse	100% of employee amount	Up to $30,000
Children	50% of employee amount.	All guaranteed issue

See "Guaranteed Issue" section below for more information.

Covered Conditions	Benefit Amount
Cancer Conditions	
Skin Cancer*	$250 1x per lifetime

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions		
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Other Specified Conditions		
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	100%	100%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Loss of Hearing	100%	Not Available
Loss of Speech	100%	Not Available
Systemic Lupus	25%	25%
Systemic Sclerosis	25%	25%

Wellness Treatment, Health Screening Test & Preventive Care Benefit*	Benefit Amount
Examples includes (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests.	$100 per day, limited to 1 per year

Benefits	
Initial Critical Illness Benefit	Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person, subject to the Maximum Lifetime Limit. A 180 days separation period between the dates of diagnosis is required.*
Recurrence Benefit	Benefit for the diagnosis of a subsequent and same Covered Condition for which an Initial Critical Illness Benefit has been paid, payable after a 6 month separation period from diagnosis of a previous Covered Condition, subject to the Maximum Lifetime Limit.
Skin Cancer Benefit	Pays benefit stated above.
Maximum Lifetime Limit	The maximum benefit payable per Covered Person is the lesser of 5 times the elected Benefit Amount or $150,000. The following benefits are not subject to this limit: Skin Cancer.

Portability Feature: You can continue 100% of coverage for all Covered Persons at the time Your coverage ends. You must be covered under the policy and be under the age of 100 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Semi-Monthly Cost of Coverage:

Benefit Amount: $10,000

	Employee (EE)	Employee + Spouse (EE+SP)	Employee + Children (EE+CH)	Employee + Family (EE+F)
Age				
<29	$4.87	$7.59	$4.87	$7.59
30 to 39	$6.73	$10.28	$6.73	$10.28
40 to 49	$11.09	$16.84	$11.09	$16.84
50 to 59	$15.97	$25.49	$15.97	$25.49
60 to 69	$20.82	$33.72	$20.82	$33.72
70 to 79	$32.96	$53.04	$32.96	$53.04
80 to 89	$52.46	$83.66	$52.46	$83.66
90+	$52.46	$83.66	$52.46	$83.66

Benefit Amount: $20,000

	Employee (EE)	Employee + Spouse (EE+SP)	Employee + Children (EE+CH)	Employee + Family (EE+F)
Age				
<29	$9.74	$15.18	$9.74	$15.18
30 to 39	$13.46	$20.56	$13.46	$20.56
40 to 49	$22.18	$33.68	$22.18	$33.68
50 to 59	$31.94	$50.98	$31.94	$50.98
60 to 69	$41.64	$67.44	$41.64	$67.44
70 to 79	$65.92	$106.08	$65.92	$106.08
80 to 89	$104.92	$167.32	$104.92	$167.32
90+	$104.92	$167.32	$104.92	$167.32

Semi-Monthly Cost of Coverage — continued

Benefit Amount: $30,000

	Employee (EE)	Employee + Spouse (EE+SP)	Employee + Children (EE+CH)	Employee + Family (EE+F)
Age				
<29	$14.61	$22.77	$14.61	$22.77
30 to 39	$20.19	$30.84	$20.19	$30.84
40 to 49	$33.27	$50.52	$33.27	$50.52
50 to 59	$47.91	$76.47	$47.91	$76.47
60 to 69	$62.46	$101.16	$62.46	$101.16
70 to 79	$98.88	$159.12	$98.88	$159.12
80 to 89	$157.38	$250.98	$157.38	$250.98
90+	$157.38	$250.98	$157.38	$250.98

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.
Premiums on coverage you first elect will be based on your age as of the first effective date of coverage and will not increase. Thereafter, premium rates may change if coverage is later increased or decreased. When increases occur, premiums on the increased amount only will be based on Your age of the effective date of such increase. Premiums for existing coverage amounts will continue to be based on your age as of the first effective date of that coverage. In addition, should rates increase for all individuals, your established age for premium purposes will remain unchanged while the rate for that age increases. If You continue coverage upon termination of employment with the employer, or when You are no longer eligible for coverage as an active employee premium rates will remain in effect at the age you were as of the effective dates of coverage with Us when active service or eligibility ends.

Important Policy Provisions and Definitions:

Covered Person: An eligible person who is enrolled for coverage under the Policy.
Covered Loss: A loss that is specified in the Policy in the Schedule of Benefits section and suffered by the Covered Person within the applicable time period described in the Policy.
When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received, or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing, unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home, disabled or receiving disability benefits or unable to perform activities of daily living.
When your coverage ends: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate about when coverage may continue.)
30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate of Insurance for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Benefit Reductions, Common Exclusions and Limitations:

Exclusions: In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss that is caused directly or indirectly, in whole or in part by any of the following: • intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane; • commission or attempt to commit a felony or an assault; • declared or undeclared war or act of war; • a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization (upon our receipt of proof of service, we will refund any premium paid for this time; Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days); • voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant (''Under the influence of alcohol'', for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred) • a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

Specific Definitions, Benefit Exclusions and Limitations:

The date of diagnosis must occur while coverage is in force and the condition definition must be satisfied.
Only one Initial Benefit will be paid for each Covered Condition per person and benefits will be subject to separation periods and Maximum Lifetime Limits.
Skin Cancer, basal cell/squamous cell carcinoma or certain forms of melanoma.

Specific Definitions, Benefit Exclusions and Limitations — continued

Invasive Cancer, uncontrolled/abnormal growth or spread of invasive malignant cells. Excludes pre-malignant conditions or conditions with malignant potential, carcinoma in situ, basal cell carcinoma, squamous cell carcinoma of the skin, unless metastatic disease develops, melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ, or prostate tumor that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale. Also excludes the recurrence or metastasis of an original Cancer that was diagnosed prior to the coverage effective date if the Insured has undergone treatment for such cancer within 12 months of being diagnosed with cancer while under this coverage.
Carcinoma in Situ, non-invasive malignant tumor. Excludes premalignant conditions or conditions with malignant potential, skin cancers (basal/squamous cell carcinoma or melanoma / melanoma in situ).
Heart Attack, includes the following that confirms permanent loss of heart muscle function: 1) EKG changes; 2) elevation of cardia enzyme.
Stroke, cerebrovascular event–for instance, cerebral hemorrhage–confirmed by neuroimaging studies or with neurological deficits lasting 96 hours or more. Excludes transient ischemic attack (TIAs), brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting eye or optic nerve or ischemic disorders of the vestibular system.
Coronary Artery Disease, heart disease/angina requiring coronary artery bypass surgery, as prescribed by a Physician. Excludes angioplasty (percutaneous coronary intervention) and stent implantation.
Advanced Alzheimer's Disease, progressive degenerative disorder that attacks the brain's nerve cells resulting in the inability to perform 3 or more of the Activities of Daily Living.
Amyotrophic Lateral Sclerosis (ALS aka Lou Gehrig's Disease), motor neuron disease resulting in muscular weakness and atrophy. **Parkinson's Disease**, progressive, degenerative neurologic disease with indicated signs of the disease.
Multiple Sclerosis, disease involving damage to brain and spinal cord cells with signs of motor or sensory deficits confirmed by MRI. Benign **Brain Tumor**, non-cancerous abnormal cells in the brain.
Blindness, irreversible sight reduction in both eyes; Best corrected single eye visual acuity less than 20/200 (E-Chart) or 6/60 (Metric) or with visual field reduction (both eyes) to 20 degrees or less. May require loss be due to specific illness.
Coma, unconscious state lasting at least 96 continuous hours. Excludes any state of unconsciousness intentionally or medically induced from unconsciousness intentionally which the Covered Person is able to be aroused.
End-Stage Renal (Kidney) Disease, chronic, irreversible function of both kidneys. Requires hemo or peritoneal dialysis.
Major Organ Failure, includes: liver, lung, pancreas, kidney, heart or bone marrow. Happens when transplant is prescribed or recommended and placed on UNOS registry. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable. Recurrence Benefit not payable for same organ for which a benefit was previously paid.
Paralysis, complete, permanent loss of use of two or more limbs due to a disease. Excludes loss due to Stroke and Multiple Sclerosis. **Loss of Hearing**, permanent hearing loss in both ears; loss greater than 90dB HL. May require loss be due to specific illness.
Loss of Speech, permanent loss of speech which is irrecoverable by other means excludes loss due to specified conditions (i.e. Alzheimer's). **Systemic Lupus**, chronic, inflammatory, auto-immune disease with indicated signs of the disease.
Systemic Sclerosis, chronic, degenerative, auto-immune disease with indicated signs of the disease.

Guaranteed Issue:

If you are a new hire you are not required to provide proof of good health if you enroll during your employer's eligibility waiting period and you choose an amount of coverage up to and including the Guaranteed Issue Amount. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. Guaranteed Issue coverage may be available at other specified periods of time. Your employer will notify you when these periods of time are available. Your Spouse must be age 18 or older to apply if evidence of insurability is required.

*State Variations

Spouse definition includes civil union partners in New Hampshire and Vermont. **Portability** in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage. **Exclusions** may vary for residents of ID, MN, NC, SC, SD, VT and WA. **Wellness Treatment, Health Screening Test & Preventive Care Benefit** is referred to as Health Screening Test and Preventive Care Benefit in WA. The Wellness Treatment or Preventive Care benefit is not available to ID residents. The Preventative Care Benefit is not available to NC residents.

THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

Series 2.0/2.1

Cigna

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid

HOSPITAL CARE COVERAGE

SUMMARY OF BENEFITS

Prepared for: Richmond Public Schools

Hospital Care coverage provides a benefit according to the schedule below when a Covered Person incurs a Hospital stay resulting from a Covered Injury or Covered Illness. *See State Variations (marked by *) below.*

Who Can Elect Coverage:

You: All active, Full-time Employees of the Employer who are regularly working in the United States a minimum of 20 hours per week and regularly residing in the United States who are United States citizens or permanent resident aliens and their Spouse and Dependent Children who are United States citizens or permanent resident aliens and are residing in the United States.

Employees hired 31 days or more before the Policy Effective Date are eligible for coverage immediately, employees hired after or less than 31 days before the Policy Effective Date will be eligible after 30 days of active service.

Your Spouse/Domestic Partner: Up to age 100, as long as you apply for and are approved for coverage yourself**. Your Child(ren)**: Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage:

The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand the terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Benefit Waiting Period:* 0 days following the effective date, unless otherwise stated. No benefits will be paid for a loss which occurs during the Benefit Waiting Period.

Hospitalization Benefits	Plan 1	Plan 2
Hospital Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$500 per day	$1,500 per day
Hospital Chronic Condition Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.	$50 per day	$100 per day
Hospital Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$100 per day	$150 per day
Hospital Intensive Care Unit (ICU) Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.	$200 per day	$400 per day
Hospital Observation Stay 24 hour Elimination Period. Limited to 72 hours.	$100 per 24-hour period	$200 per 24-hour period

Additional Benefits	Plan 1	Plan 2
Wellness Treatment Benefit* Examples include routine gynecological exams and general health exams.	$50 per day, limited to 1 per year	$50 per day, limited to 1 per year

Portability Feature:* You can continue 100% of your coverage at the time your coverage ends. You must be covered under the policy and be under the age of 100 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

Employee's Semi-Monthly Cost of Coverage:

Tier	Plan 1	Plan 2
Employee Only	$6.93	$14.72
Employee & Spouse	$14.22	$30.21
Employee & Child(ren)	$12.04	$25.91
Employee & Family	$19.33	$41.40

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

NOTE: The following are some of the important policy provisions, terms and conditions that apply to benefits described in the policy. This is not a complete list. See your Certificate of Insurance for more information.

Benefit Amounts Payable: Benefits for all Covered Persons are payable at 100% of the Benefit Amounts shown, unless otherwise stated. Late applicants, if allowed under this plan, may be required to provide medical evidence of insurability.

Benefit-Specific Conditions, Exclusions & Limitations (Hospital Care):

- **Hospital Admission:** Must be admitted as an Inpatient due to a Covered Injury or Covered Illness. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness.
- **Hospital Chronic Condition Admission**: Must be admitted as an Inpatient due to a covered chronic condition and treatment for the covered chronic condition must be provided by a specialist in that field of medicine. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness (including chronic conditions).
- **Hospital Stay**: Must be admitted as an Inpatient and confined to the Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the ICU Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is greater. Hospital stays within 30 days for the same or a related Covered Injury or Covered Illness is considered one Hospital Stay.
- **Intensive Care Unit (ICU) Stay**: Must be admitted as an Inpatient and confined in an ICU of a Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the Hospital Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is greater. ICU stays within 30 days for the same or a related Covered Injury or Covered Illness is considered one ICU stay.
- **Hospital Observation Stay**: Must be receiving treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or ambulatory surgical center, for more than 24 hour on a non-inpatient basis and a charge must be incurred. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit.

Common Exclusions and Limitations:

Exclusions:* In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following (unless otherwise provided for in the policy):

- (1) intentionally self-inflicted injury, suicide or any attempted threat while sane or insane;
- (2) commission or attempt to commit a felony or an assault;
- (3) declared or undeclared war or act of war;
- (4) a Covered Injury or Covered Illness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
- (5) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage (excludes WA residents);
- (6) operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred. (excludes WA residents)
- Those not necessary, as determined by Us in accordance with generally accepted standards of medical practice, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician.
- Elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect.
- Dental surgery, unless the surgery is the result of an accidental injury;
- In addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
  - Employed or retained by the Subscriber;
  - providing homeopathic, aroma-therapeutic or herbal therapeutic services;
  - living in the Covered Person's household;
  - a parent, sibling, spouse or child of the Covered Person.

Important Definitions:

Covered Illness: A physical or mental disease or disorder including pregnancy and complications of pregnancy that results in a covered loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.

Covered Injury: Any bodily harm that results in a covered loss.

Important Definitions — continued

Covered Person: An eligible person, as defined in the Schedule of Benefits, who is enrolled and for whom Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due, and coverage under this Policy remains in force.
Elimination Period: The continuous period of time that must be satisfied before a benefit shown in the Schedule of Benefits is payable. An Elimination Period may be satisfied during the Policy's Benefit Waiting Period.
Hospital:* An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of physicians; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis. The term Hospital does not include a clinic, facility, or unit of a Hospital for: (1) rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; (2) the aged, drug addicts or alcoholics; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients.

Policy Provisions:

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home; disabled or receiving disability benefits or unable to perform activities of daily living.
When your coverage ends: Coverage for any Covered Person ends on the earliest of the date they are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your Spouse and Dependent Child(ren), if applicable, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the *Continuation of Insurance* provisions in your Certificate.)
30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned to us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.
*State Variations
Spouse definition includes civil union partners in New Hampshire and Vermont. Portability in VT is referred to as Continuation due to loss of eligibility. VT residents are not subject to the age limit to continue coverage. Exclusions may vary for residents of MN, SC, SD, and WA. Important Definitions (Hospital) includes stays in substance abuse and mental nervous facilities in VT. Wellness, Health Screen Test and Preventive Care Benefit will not include preventive care in NC.
Series 1.0/1.1

THIS POLICY PAYS LIMITED BENEFITS ONLY. IT DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT A MEDICAID OR MEDICARE SUPPLEMENT POLICY.

This is not intended as a complete description of the insurance coverage offered. This is not a contract. Full terms and conditions of coverage are defined by and governed by Group Policy No.HC 960608. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence. Product availability, costs, benefits, riders and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form GHIP-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

EASY WAYS TO SUBMIT A CLAIM.

Cigna Accidental Injury, Critical Illness and Hospital Care (indemnity) insurance.

When a serious illness or injury occurs, Cigna Accidental Injury (AI), Critical Illness (CI) and Hospital Care (HC) insurance can help you bounce back to your best, body and mind. That's why it's important to submit your claims as soon as possible. There are five easy ways to file. Simply choose the option that's easiest for you.

Phone
Call **800.754.3207** to speak with one of our dedicated customer service representatives

Online
Visit **SuppHealthClaims.com**

Fax
Send documents to **1.866.304.3001**

Email
Send scanned documents to **SuppHealthClaims@Cigna.com**

Mail
Send documents to:
Cigna Supplemental Health Solutions
P. O. Box 188028
Chattanooga, TN 37422

CIGNA SIMPLE FILE®

If you forget to file your claim, we will send you a reminder to help you receive all of the benefits you are entitled to.*

After you file

A designated claim manager will be assigned to your claim. If they have any questions or need additional information, they will contact you, the beneficiary, or provider to obtain the needed information.

- Once all requested information is submitted, Cigna will pay your claim quickly – in days, not weeks.
- Benefits are paid directly to you,** for a covered critical illness, accidental injury or hospitalization.***

Together, all the way.®

Cigna®

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Short Term Disability Plan

You insure your home, car, and other valuable possessions, so why not also protect what pays for all of those things? Your income. Without it, think about how your mortgage/rent, groceries, or credit card bills would get paid. That's where disability insurance can help.

- Choose from 2 different plans to insure 60% of covered basic monthly earnings to a maximum monthly benefit of $6,000, then reduced by Other Income Benefits as outlined in the certificate
- 7 day elimination period for **Plan 1** or 30 day elimination period for **Plan 2**
- Benefit duration if continually disabled is 12 weeks for **Plan 1** or 9 weeks for **Plan 2**
- Coverage for non-occupational only
- 3/12 Pre-Existing Condition Exclusion
- Maternity coverage subject to applicable pre-existing condition exclusion
- Recurrent disability. If you resume work for 30 consecutive workdays, additional disability is considered a new period
- Guaranteed Issue if elected during Initial Enrollment
- Plan is portable. You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
- The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career)

Employees may benefit from the voluntary disability plan who are enrolled in the VRS Plan 1 or Plan 2. Employees enrolled in the VRS Hybrid will need to contact the Human Resources Department to see if they may benefit from the disability plan before applying for coverage.

ONEAMERICA®

Long Term Disability Plan

You insure your home, car, and other valuable possessions, so why not also protect what pays for all of those things? Your income. Without it, think about how your mortgage/rent, groceries, or credit card bills would get paid. That's where disability insurance can help. Long Term Disability kicks in after 90 consecutive days out of work for a sickness or injury.

Plan Features

- Choose from 2 different plans to insure 60% of covered basic monthly earnings to a maximum monthly benefit of $6,000, then reduced by Other Income Benefits as outlined in the certificate
- 90 day elimination period for both Plans
- Benefit duration if continually disabled is 2 years to age 70 for **Plan 3** and SSFRA (Social Security Full Retirement Age) for **Plan 4**
- 24 hour coverage on or off the job
- 3/12 Pre-Existing Condition Exclusion
- Guaranteed Issue if elected during Initial Enrollment
- Plan is portable. You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
- The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career)

Employees may benefit from the voluntary disability plan who are enrolled in the VRS Plan 1 or Plan 2. Employees enrolled in the VRS Hybrid will need to contact the Human Resources Department to see if they may benefit from the disability plan before applying for coverage.

AUL/OneAmerica Employee Benefits

Voluntary Disability Insurance- Based on Employee's Age as of 1/1

VOLUNTARY DISABILITY	Rates		Benefit %	Max Monthly Benefit	Elimination Period	Benefit Duration	Pre-Existing Period	Max Covered Monthly Payroll
	Age	Rate*						
STD Plan 1	<30	1.30	60%	$6,000	7 Days	12 Weeks	3/12	$10,000.00
	30-34	1.24						
	35-39	0.92						
	40-44	0.76						
	45-49	0.81						
	50-54	0.94						
	55-59	1.16						
	60 +	1.38						
STD Plan 2	Age	Rate*	60%	$6,000	30 Days	9 Weeks	3/12	$10,000.00
	<30	0.68						
	30-34	0.64						
	35-39	0.46						
	40-44	0.38						
	45-49	0.40						
	50-54	0.46						
	55-59	0.57						
	60 +	0.68						
LTD Plan 3	Age	Rate*	60%	$6,000	90 Days	2 yrs to Age 70	3/12	$10,000.00
	<30	0.08						
	30-34	0.14						
	35-39	0.18						
	40-44	0.25						
	45-49	0.31						
	50-54	0.42						
	55-59	0.56						
	60 +	1.30						
LTD Plan 4	Age	Rate*	60%	$6,000	90 Days	SSFRA	3/12	$10,000.00
	<30	0.16						
	30-34	0.31						
	35-39	0.43						
	40-44	0.62						
	45-49	0.81						
	50-54	1.07						
	55-59	1.32						
	60 +	1.49						

* per $100 of monthly covered payroll

To calculate the Semi-Monthly premium, do the following:

1. Enter the lesser of:
   a) Employee's Monthly Salary or
   b) Maximum Covered Monthly Payroll for the chosen plan: =
2. Divide step 1 by 100 =
3. Enter appropriate rate from "Age Band" above. =
4. Multiply step 2 times step 3 for monthly premium =
5. Multiply step 4 times 12 and divide by 24 for Semi-Monthly payroll deductions. =

Rates Effective 11/01/2013
Anniversary Date 08/01

Benefits at a Glance for Hybrid Disability Coverage

Hybrid Disability Coverage with The Standard provides some income protection if you can't work because of physical disease, mental disorder, injury or pregnancy. You are enrolled in this program because your employer opted out of the state disability program. Hybrid Disability Coverage with The Standard is comparable coverage and meets all requirements of Title 51.1 of the Code of Virginia.

The hyperlinks provided below will take you directly to important documents regarding your Hybrid Disability Coverage with The Standard, including an Employee Handbook, FAQ, Benefits at a Glance, Employee Assistance Program Flyer and Certificates of Coverage. We encourage you to save this email that includes the hyperlinks so you will have direct access to current contractual information.

If you think you need to file a claim or have questions, please contact your Benefit Administrator.

Hybrid Disability Coverage with The Standard	
Document Name	Click Below for Document
Employee Handbook	Employee Handbook
Employee FAQ	Employee FAQ
STD Benefits at a Glance	Short Term Disability Benefits at a Glance
STD Certificate of Coverage	STD Certificate of Coverage
LTD Benefits at a Glance	Long Term Disability Benefits at a Glance
LTD Certificate of Coverage	LTD Certificate of Coverage
Employee Assistance Program Flyer	Employee Assistance Program Flyer

Trustmark Universal LifeEvents® Insurance with Long-Term Care Benefit

Two important coverages for when you need them the most.

Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal LifeEvents can help.**

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a benefit amount that provides the **right protection for you.**

Universal LifeEvents insurance can mean those left behind can still pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

Universal LifeEvents sample rates

Sample ranges of weekly rates for employee-only, non-smoker coverage. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	$25,000 policy
30	from **$3.49 – $4.59**
40	from **$5.05 – $6.71**
50	from **$7.84 – $10.71**

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC) benefit** that can help pay for these services at any age. This benefit **never reduces due to age**, so the full amount is always available when you most need it.

Here's how it works:

4% You can **collect 4% of the face amount of your Universal LifeEvents policy per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

2x **PLUS:** If you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

3x **PLUS:** You can collect your LTC benefit for an **extra 25 months**, as much as **tripling** your benefit.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA, where the LTC benefit is Long-Term Care Insurance.) It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Benefits may not be available in all states or may be named differently. Your policy will contain complete details.

Universal LifeEvents is **flexible permanent** life insurance designed to last a lifetime.

The younger you are when you enroll, the **more benefit** you receive for the same premium.

No medical exams or blood work – just answer a few simple questions.

See reverse for more information on Universal LifeEvents insurance from Trustmark Insurance Company.

What would happen if you weren't around?

1 In 3 households would have immediate trouble paying for living expenses if they lost their primary earner.[1]

40% **40% of Americans** live paycheck to paycheck. Could your family afford to stay in your home?[2]

56% of Americans have less than $10,000 saved for retirement – **1 In 3** have $0 saved. Wouldn't it be nice to have some protection?[3]

How Universal LifeEvents Works

- A **higher death benefit** during working years.
- **Full LTC benefits** when you're most likely to need them.

Example: $25,000 policy

Before age 70	
Death benefit	**$25,000**
LTC benefits	**$25,000**

After age 70	
Death benefit	**$8,333**
LTC benefits	**$25,000**

Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 18-64.

Benefit for terminal illness

- **Use part of your death benefit** if you're diagnosed with a terminal illness to help manage costs.

Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.
- **Convenient payroll deduction;** pay via direct bill, bank draft or credit card if you leave your employer.

More flexible features

- **Buy term life insurance for your children.** They can later simply convert it to a permanent Universal Life policy.
- **Waive your policy payments** if your doctor says you're totally disabled.

You care.
We listen.

This is a brief description of benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state. This policy guarantees against lapsing for 15 years as long as planned premiums are paid. If you make changes during this period, or pay only the minimum amount, your cash value may not accumulate, or your death benefit may reduce. If there is negative cash value at the end of your no-lapse period, you must make up the premium to establish positive cash value. You may need to pay more premium to maintain your policy than the rate you paid to keep the no-lapse guarantee, or coverage may end before age 100. An illustration will be delivered with your policy. For costs and coverage detail, including exclusions, reductions, limitations and terms, see your agent or write the company. Underwriting conditions may vary, and determine eligibility for the offer of insurance. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/(A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/.

[1]2016 Insurance Barometer Study LIMRA/Life Happens, lifehappens.org/industryresources/agent/barometer2016. [2]nielsen.com/us/en/insights/news/2015/saving-spending-and-living-paycheck-to-paycheck-in-america.html. [3]gobankingrates.com/retirement/1-3-americans-0-saved-retirement. [4]An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

Underwritten by Trustmark Insurance Company
Rated A- (EXCELLENT) A.M. Best
trustmarksolutions.com

Trustmark
benefits beyond benefits

ULELTC_BRR-EOB-CTR-W

A112-2224 (3-18)

Trustmark Universal Life Insurance with Long-Term Care Benefit

Two important coverages in one to help protect you for life.

Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal Life can help**.

Whether you are married, a parent or single and starting out, Universal Life **helps take care** of the people important to you if tragedy happens. You can choose a benefit amount that provides the **right protection for you**.

Universal Life insurance can mean those left behind can still pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

Universal Life sample rates

Sample ranges of weekly rates for employee-only, non-smoker coverage. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	$25,000 policy
30	from **$5.06 – $6.27**
40	from **$7.42 – $9.44**
50	from **$11.92 – $15.44**

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal Life includes a **long-term care (LTC) benefit** that can help pay for these services at any age.

Here's how it works:

4% You can **collect 4% of your Universal Life benefit per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

2x **PLUS:** If you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

3x **PLUS:** You can collect your LTC benefit for an **extra 25 months**, as much as **tripling** your benefit.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA, where the LTC benefit is Long-Term Care Insurance.) It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Benefits may not be available in all states or may be named differently. Your policy will contain complete details.

Universal Life is **flexible permanent** life insurance designed to last a lifetime.

The younger you are when you enroll, the **more benefit** you receive for the same premium.

No medical exams or blood work - just answer a few simple questions.

See reverse for more information on Universal Life insurance from Trustmark Insurance Company.

What would happen if you weren't around?

1 in 3 households would have immediate trouble paying for living expenses if they lost their primary earner.[1]

40% **40% of Americans** live paycheck to paycheck. Could your family afford to stay in your home?[2]

56% of Americans have less than $10,000 saved for retirement - **1 in 3** have $0 saved. Wouldn't it be nice to have some protection?[3]

What can Universal Life benefits help pay for?

- Funeral and burial costs
- Rent or mortgage payments
- Tuition and loans
- Credit card bills
- Medical expenses
- Retirement savings

Benefit for terminal illness

- **Use part of your death benefit** if you're diagnosed with a terminal illness to help manage costs.

Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.
- **Convenient payroll deduction:** pay via direct bill, bank draft or credit card if you leave your employer.

More flexible features

- **Buy term life insurance for your children.** They can later simply convert it to a permanent Universal Life policy.
- **Waive your policy payments** if your doctor says you're totally disabled.

You care.
We listen.

This is a brief description of benefits under GUL.205/IUL.205 and applicable riders HOA/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, exclusions, form numbers and limitations may vary by state. This policy guarantees against lapsing for 10 years as long as planned premiums are paid. If you make changes during this period, or pay only the minimum amount, your cash value may not accumulate, or your death benefit may reduce. If there is negative cash value at the end of your no-lapse period, you must make up the premium to establish positive cash value. You may need to pay more premium to maintain your policy than the rate you paid to keep the no-lapse guarantee, or coverage may end before age 100. An illustration will be delivered with your policy. For costs and coverage detail, including exclusions, reductions, limitations and terms, see your agent or write the company. Underwriting conditions may vary, and determine eligibility for the offer of insurance. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/.

[1]2016 Insurance Barometer Study LIMRA/Life Happens, lifehappens.org/industryresources/agent/barometer2016. [2]nielsen.com/us/en/insights/news/2015/saving-spending-and-living-paycheck-to-paycheck-in-america.html. [3]gobankingrates.com/retirement/1-3-americans-0-saved-retirement. [4]An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

Underwritten by Trustmark Insurance Company
Rated A- (EXCELLENT) A.M. Best[4]
trustmarksolutions.com
ULLTC BRR-E OB-CTR-W

Trustmark
benefits beyond benefits

PLAN HIGHLIGHTS

Richmond Public Schools 403(b) Retirement Plan

Your employer-sponsored retirement plan is a powerful way to save for the future. Learn more about the benefits of your plan, and get the answers to any questions you have.

How can I contribute to my retirement plan?

You can control your contributions in the following ways:

- You can contribute up to 100% of your salary to your retirement savings, not to exceed the maximum allowed by the IRS.
- You can increase or decrease your contribution rate at any time.
- You can discontinue contributions to your retirement savings plan at any time. The effective date of the changes occurs as soon as administratively possible.
- You can enroll by logging in to LincolnFinancial.com/Retirement.

Will my employer contribute to my retirement savings plan?

Your employer will contribute to your retirement savings through:

- A discretionary matching contribution: Each year, your employer may match some or all of your contributions.
- If you are not a full-time contracted salaried employee, you are not eligible for employer contributions.

When am I fully vested in my retirement plan?

"Fully vested" means you have 100% ownership of the assets in your retirement account (your plan).

- You always have 100% ownership of any money you contribute to the plan, including any earnings and/or assets consolidated from another retirement plan.
- After three years of service, you will have 100% ownership of your employer's discretionary matching contributions, including any earnings.

What are my investment options?

You can choose from a wide variety of investment options to meet your retirement savings goal.

- **MAKE AN ALL-IN-ONE CHOICE** if you want one diversified portfolio managed for you.
- **WORK WITH A PROFESSIONAL** to manage your retirement account. Fees may apply.
- **MANAGE IT YOURSELF** and select your own portfolio of investments.
  You may use a Self-Directed Brokerage Account (SDBA) and choose from thousands of investment options. Fees may apply.
- **STILL UNDECIDED?** If you participate in the plan without selecting investment options, your money will be directed to the Default Investment Alternative (DIA) selected by your employer.

Can I consolidate accounts from my previous retirement plans?

You can consolidate assets from a previous retirement plan (or plans) to create an integrated savings strategy. With this option, you have the ability to:

- Manage all of your assets in one place.
- Get a single consolidated quarterly statement.
- Access account information with a single toll-free number or a single website.
- Get help and educational assistance for all of your accounts.
- Get a potentially broader array of investment choices and account types.

Contact your financial professional for assistance in determining the course of action appropriate to your situation.

Can I access balances in my retirement savings account prior to retirement?

Your retirement plan will have the greatest potential to grow if you stay invested for the long term, rather than withdrawing money from it. For that reason, the IRS limits what you can do with your account prior to retirement by imposing certain penalties for early distributions. However, you do have access to your savings—and may avoid penalties—under certain circumstances.

Loans

You can take a loan from certain account balances for:

- General purposes
- Purchase a primary residence

Check with your financial professional for information about loan fees, repayment, and the pros and cons of borrowing from your retirement plan.

Withdrawals of pretax balances

You may take a distribution from **certain available accounts** upon:

- Severance from employment
- Financial hardship
  (Distribution may be subject to the premature 10% distribution penalty if taken prior to age 59 ½.)

Withdrawals of Roth balances

If you have a Roth account, your distribution will be a qualified distribution (tax-free) if your Roth deferral or Roth rollover account has been in place for five (5) taxable years (from the year the first Roth contribution or the Roth rollover was made to the plan, whichever was first) and the distribution is made after one of the following:

- Attainment of age 59 ½
- Disability
- Death

If the distribution conditions above are not met, the earnings may be taxable and may be subject to a 10% early distribution penalty on the taxable portion of the distribution.

Consult with your tax advisor before withdrawing any money from your account. You may wish to confirm with your plan sponsor the distributions available under your plan.

How can I access my account?

You can access and manage your retirement account any time:

LincolnFinancial.com/Retirement
800-234-3500

These highlights are a brief overview of the Richmond Public Schools 403(b) Retirement Plan and not a legally binding document. Please read these materials carefully and contact your Human Resources department if you have further questions.

For any investment option in the plan, including an option that is part of an asset allocation portfolio, you may obtain a prospectus or a similar document by requesting one from your employer, visiting your plan's website, or calling a Lincoln Financial representative at 800-234-3500.

LEGAL RESOURCES

QUALITY.
VALUE.
SERVICE.
PEACE OF MIND.

RICHMOND PUBLIC SCHOOLS

A SPECIAL LOW RATE OF $8.00 PER PAYCHECK

As a member, you are covered for expected and unexpected legal needs, including real estate closings, will preparation, traffic matters, divorce and much more. Most attorneys charge between $200-400 per hour, but as a Legal Resources member, you and your family are covered for $8.00 per pay period.

THE LEGAL RESOURCES PLAN TRULY DELIVERS IN ALL THE RIGHT WAYS

100% COVERAGE

pay no attorney fees
Covers a broad range of legal services and includes coverage for qualifying dependents

select your own law firm
Call them directly anytime you have a legal need

it's comprehensive
No waiting periods, annual usage limits, deductibles or co-payments

exceptional law firm network
Over 13,000 attorneys nationwide

it's valuable
Annual cost = less than what an attorney typically charges for just one hour

superior customer service
Award-winning certified paralegals answer your calls and questions

HOW THE PLAN WORKS

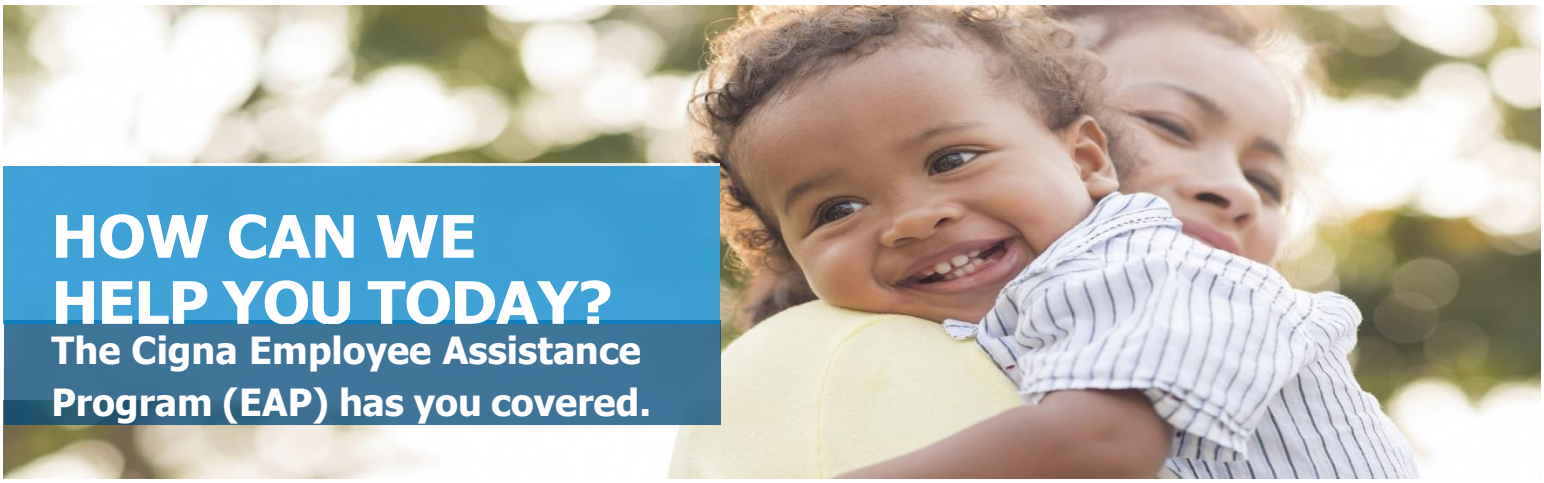
1 Choose a law firm that best suits your needs from our highly rated law firm network. Use our Law Firm Finder at LegalResources.com to find a firm near you. If you need to transfer to another Plan Law Firm, call Member Services.

2 Certified paralegals in our Member Services Department provide you with dedicated, ongoing support and assist you with any coverage or attorney-related concerns.

Participating employees agree to a 12 month commitment and cancellation may only occur during open enrollment. The plan provides coverage for you, your spouse and qualifying dependents.

If you become non-benefits eligible or leave employment with Richmond Public Schools, you may continue coverage by setting up direct billing with Legal Resources. Coverage remains exactly the same.

Please visit **LegalResources.com** for more information or call Member Services at **800.728.5768.** We look forward to serving you and your family.



HOW CAN WE HELP YOU TODAY?

The Cigna Employee Assistance Program (EAP) has you covered.

As an employee you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

- **5** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 877-622-4327

Or log in to myCigna.com.

Employer ID: rps

(Needed for initial registration only)

If already registered on myCigna.com, simply log in and go to the EAP link under Coverage.

Together, all the way.®

Cigna®

*Employment-related legal issues are not covered.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna contracted third-party vendor.

Leave

Personal Leave

Three (3) urgent personal business days are granted to less-than-twelve month employees at the beginning of each school year with full pay for personal reasons. Unused urgent personal business days will be credited to sick leave accrual at the end of each fiscal year. Absence for religious reasons shall be included in the category of urgent personal business reasons.

Sick Leave

Less than twelve month and twelve month employees accrue sick leave. Sick leave may be used for personal illness or disability not of a permanent nature, including quarantine, maternity reasons, and necessary appointments with physicians or dentists.

HOURS WORKED PER DAY	SICK HOURS ACCRUED PER PAY PERIOD	SICK HOURS ACCRUED PER MONTH
6	3	6
7	3.5	7
8	4	8

Accumulated sick leave earned in other school divisions in Virginia and any other VRS institution will be accepted at full value upon presentation of appropriate proof of such leave by an instructional or administrative employee transferring to Richmond City Schools.

Vacation

Only twelve-month employees accrue vacation leave.

YEARS OF SERVICE	VACATION HOURS ACCRUED PER PAY PERIOD	VACATION HOURS ACCRUED PER MONTH	MAXIMUM ACCUMULATION
Less than ten	5	10	240 hours
Ten or more	6	12	400 hours

Any excess accumulation greater than 240 hours or 400 hours will be transferred to the employee's sick leave balance at the beginning of each calendar year.

Paid Parental Leave

Richmond Public Schools (RPS) provides its eligible employees with paid parental leave to allow employees to care for and bond with a newborn or child under the age of eighteen (18) newly-placed for adoption, foster or custodial care. RPS also provides paid parental leave for birthing parents in the event of stillbirth.

Paid parental leave will be available for eligible employees in conjunction with the Family Medical Leave Act (FMLA). Employees eligible for FMLA have been employed at least 12 months by Richmond Public Schools and have at least 1,250 hours of service with Richmond Public Schools during the previous 12-month period.

Contact Information

Benefit	Provider	Contact	Web
Medical	Cigna	(800) 244-6224	www.mycigna.com
Health Savings Account	HSA Bank	(800) 357-6246	www.hsabank.com
Vision	Cigna	(800) 244-6224	www.mycigna.com
Dental	Cigna	(800) 244-6224	www.mycigna.com
Flexible Spending Accounts	PayFlex	(844) 729-3539	www.payflex.com
Virginia Retirement System (VRS) *Plan 1 and Plan 2 Participants*	Virginia Retirement System	(888) 827-3847	www.varetire.org
Virginia Retirement System (VRS) *Hybrid Plan Participants*	Virginia Retirement System	(855) 291-2285 (Defined Benefit)	www.varetire.org/hybrid
	ICMA-RC	(877) 327-5261 (Defined Contribution)	
Group Term Life Insurance	Securian Financial	(800) 843-8358	https://www.varetire.org/members/benefits/life-insurance/basic-group-life-insurance.asp
Optional Supplemental Life Insurance	Securian Financial	(800) 843-8358	https://www.varetire.org/members/benefits/life-insurance/optional-group-life-insurance.asp
Accidental Injury Insurance	Cigna	(800) 754-3207	www.cigna.com/customer-forms
Critical Illness Insurance	Cigna	(800) 754-3207	www.cigna.com/customer-forms
Hospital Care Insurance	Cigna	(800) 754-3207	www.cigna.com/customer-forms
Short Term and Long Term Disability *VRS Plan 1 and Plan 2 Participants*	One America	(800) 553-5318 or (855) 517-6365	www.oneamerica.com
Short Term and Long Term Disability *VRS Hybrid Plan Participants*	The Standard	(800) 628-9797	www.standard.com
Universal Life Insurance	Trustmark	(800) 918-8877 or (877) 201-9373	https://www.trustmarkbenefits.com/Voluntary-Benefits
Optional Supplemental Retirement Program	Lincoln Financial	(717) 585-5356	Carolyn.Robinson@lfg.com
		(800) 234-3500	www.lfg.com
Prepaid Legal	Legal Resources	(804) 897-1700	www.legalresources.com
Employee Assistance Program (EAP)	Cigna	(877) 622-4327	www.mycigna.com

Talent Office (HR) – Benefits

301 North Ninth Street – 15th Floor
Richmond, Virginia 23219
Phone: (804) 780-1880
Fax: (804) 780-7899
Email: benefits@rvaschools.net

Alyson Davis
Director of Benefits and Compensation
(804) 780-7007
amiddlet@rvaschools.net

Letitia Lampley
Senior HR Retirement & Benefits Specialist
(804) 780-7878
llampley2@rvaschools.net

Sherrie Brown
Senior HR Leave Specialist
(804) 780-7881
sbrown18@rvaschools.net

If you have questions about your benefits and/or need assistance enrolling, you can call the Richmond Public Schools Benefit Service Center at 1-844-379-0069 Monday – Friday from 8:00 a.m. – 5:00 p.m.

Continuation of Benefits

Health and Dental Plans

Under Health and Dental Plans, you and your covered dependents are eligible to continue coverage through COBRA according to the "qualifying events".

If you and your dependents are enrolled in the dental or health plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plans, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you may contact the Talent Office (HR) – Benefits at 804-780-1880.

Cigna Accident, Critical Illness, and Hospital Care Plans

You may continue your Cigna Accident, Critical Illness, and Hospital Care plans by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. For more information contact Cigna at 1-800-754-3207.

OneAmerica Disability

You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time. For more information, call 1-800-553-5318.

Trustmark Universal Life

When you leave employment, you may continue your Trustmark Universal Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting customer service at 1-800-918-8877.

Getting Ready to Retire and Need Information Regarding the Following:

- Retiree Medical Options
- Affordable Care Act
- Medicare
- COBRA Options

Leigh Battle Hometeam

Leigh Battle
4905 Radford Ave., Suite 110
Richmond, VA 23230
804-516-4822
leighbattlerva@gmail.com

Virginia Senior Services

Dave Fitzgerald
804-334-6835
davefitzgerald23@gmail.com

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Talent Office (HR) – Benefits

804-780-1880

benefits@rvaschools.net

OMB 0938-0990

Important Notice from Richmond Public Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Richmond Public Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Richmond Public Schools has determined that the prescription drug coverage offered by the Richmond Public Schools is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

OMB 0938-0990

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Richmond Public Schools coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Richmond Public Schools coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Richmond Public Schools changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/10/2022
Name of Entity/Sender:	Letitia Lampley
Contact--Position/Office:	RPS Benefits Department
Address:	301 N. 9th Street, Richmond, VA 23219
Phone Number:	804-780-7878

CMS Form 10182-CC **Updated April 1, 2011**

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Richmond Public Schools	4. Employer Identification Number (EIN) 54-1689909	
5. Employer address 301 N. Ninth Street	6. Employer phone number 804-780-7881	
7. City Richmond	8. State Virginia	7. City Richmond
10. Who can we contact about employee health coverage at this job? Sherrie Brown		
11. Phone number (if different from above)	12. Email address sbrown18@rvaschools.net	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Active employees that work at least 30 hours per week on average

  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Lawful spouses and dependents to age 26

  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986

RPS RICHMOND PUBLIC SCHOOLS

A Publication of Richmond Public Schools
Richmond, Virginia

In accordance with federal laws, the laws of the Commonwealth of Virginia and the policies of the School Board of the City of Richmond, the Richmond Public Schools does not discriminate on the basis of sex, race, color, age, religion, disabilities or national origin in the provision of employment and services. The Richmond Public Schools operates equal opportunity and affirmative action programs for students and staff. The Richmond Public Schools is an equal opportunity/affirmative action employer. The School Board also supports equal opportunities and treatment of all individuals regardless of sexual orientation. The Section 504 Coordinator is Dr. Anthony Walker, Director of Exceptional Education, 301 North 9th Street, Richmond, Virginia 23219, (804) 780-7911. The ADA Coordinator is Mr. Timothy Williams, Ombudsman Manager, 301 North 9th Street, Richmond, Virginia 23219, (804) 780-7864. The Title IX Officer is Mr. Timothy Williams, Ombudsman Manager, 301 North 9th Street, Richmond, Virginia 23219, (804) 780-7864. The United States Department of Education's Office of Civil Rights may also be contacted at 400 Maryland Avenue, SW, Washington, DC 20202, (202) 401-2000 or 1-800-872-5327.