2024-25

# Germantown Municipal School District

**2024 - 25 BENEFITS BOOKLET**

**Annual Enrollment:**

**School Based Employees: May 6 through May 17, 2024**

**District Office Employees: June 10 through June 14, 2024**

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## Enrollment will be in person with American Fidelity

All eligible employees will complete an in person enrollment with an American Fidelity representative. Health reform regulations have made it essential that every eligible employee enroll or waive coverage. American Fidelity is helping us achieve the 100% goal.

**ANNUAL ENROLLMENT FOR SCHOOL BASED EMPLOYEES WILL BEGIN MAY 6 THROUGH MAY 17, 2024.**

**ANNUAL ENROLLMENT FOR DISTRICT OFFICE EMPLOYEES WILL BEGIN JUNE 10 THROUGH JUNE 14, 2024.**

Benefits chosen during these enrollment periods will become effective September 1, 2024. When completing your in person enrollment you will need the following:

- Social Security numbers and birth dates of all family members you will enroll
- If applicable, a completed Spousal Affidavit Form (located on page 6 of this booklet). Once completed, the Spousal Affidavit Form will need to be submitted to Gina Eddleman at gina.eddleman@gmsdk12.org on or before June 17, 2024
- Birth dates, addresses, and telephone numbers on all primary and contingent beneficiaries for your Group Life Insurance policy

# 2024-2025
# 20 Pay Period Rates

| MEDICAL PLANS | | |
|---|---|---|
| **Lucent Health** | **COVERAGE TIER** | **PER PAY PERIOD RATES** |
| In-Network Plus | Employee | $109.43 |
| | Employee + 1 | $257.49 |
| | Family | $359.20 |
| | | |
| BASIC | Employee | $93.97 |
| | Employee + 1 | $221.50 |
| | Family | $308.98 |
| | | |
| HRA (Health Reimbursement Arrangement) | Employee | $67.47 |
| | Employee + 1 | $173.81 |
| | Family | $242.47 |
| | **DENTAL PLANS** | |
| **METLIFE DENTAL** | **COVERAGE TIER** | PER PAY PERIOD RATES |
| High Plan - $2000 (Dental PPO - Point of Service) | Employee | 24.31 |
| | Employee + 1 | 51.06 |
| | Family | 72.94 |
| | | |
| Low Plan - $1500 (Dental PPO - Point of Service) | Employee | $16.85 |
| | Employee + 1 | $35.38 |
| | Family | $50.55 |
| | **VISION PLAN** | |
| DAVIS VISION | COVERAGE TIER | PER PAY PERIOD RATES |
| VISION | Employee | 4.43 |
| | Employee + 1 | 8.48 |
| | Family | 13.75 |

## IMPORTANT BENEFIT VENDOR'S CONTACT INFORMATION

| COMPANY | TELEPHONE | DESCRIPTION |
|---|---|---|
| Lucent Health Customer Service http://www.mylucenthealth.com | 1-800-411-3650 | Medical Benefits |
| In-Network Providers/CIGNA PPO | www.mycigna.com | In-Network Providers |
| Prescription Drug Benefits: WellDyneRX Member Helpline: | 1-888-479-2000 | Prescription drug benefits |
| MetLife- nscrep@metlife.com | 1-800-GET-MET8 | Providers and benefits |
| Davis Vision - www.davisvision.com | 1-877-923-2847 | Providers and benefits |
| Concern - EAP | 1-800-445-5011 or 1-901-458-4000 | Employee Assistance Program |
| American Fidelity - www.americanfidelity.com | 1-800-662-1113, option #3 | FSA Administration |
| American Fidelity - www.americanfidelity.com | 1-800-662-1113, option #4 | Short-term Disability/accident/cancer |
| Dearborn Group | 1-800-721-7987 | Life and Long-Term Disability |
| Employee Benefits | Office: 752-7890 Fax: 757-6006 Email: gina.eddleman@gmsdk12.org | Gina Eddleman-Benefits |

Once you receive your ID cards, please show them to your providers the first time you are seen.

MEDICAL: Group Number: 300052

DENTAL: Group Number: 259919

VISION: Client Code Number: 8099

LIFE PRODUCTS Group Number: F020518

If a medical provider needs to verify medical coverage outside of Lucent Health Solutions's normal business hours, the provider can do so by going to mylucenthealth.com

GERMANTOWN
MUNICIPAL SCHOOL DISTRICT
Excellence Always

# Spousal Healthcare Eligibility Affidavit for Germantown Municipal School District

Employee Name _____ Employee ID _____

Spouse Name _____ Last four of SSN (Spouse) _____

**Section A: Must complete to enroll your spouse in Group Health Plan Coverage.**

**Your Spouse is:**

#1 ☐ Not employed or is Retired

#2 ☐ An employee of Germantown Municipal School District

#3 ☐ *Employed or Self-Employed ***WITHOUT*** access to coverage from his/her employer **(MUST COMPLETE SECTION B)**

#4 ☐ *Employed ***WITH*** access to coverage from his/her employer but employer pays less than 50% of the cost **(MUST COMPLETE SECTION B)**

**NOTE:** ***If none of the above applies then he or she is not eligible for the Group Health Plan. (He or she is eligible for other benefits such as dental, vision, life.)***

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit my employer to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Group Health Plan coverage.

**Employee Signature** _____ Date _____

**Spouse Signature** _____ Date _____

## Section B: Must be completed by spouse's employer or spouse if self-employed

Is the person named above as Spouse *eligible* for coverage with your company?

YES _____ NO _____

If yes, does the employee's share, **exceed 50%** of the total cost of premiums for your cheapest individual coverage?

YES ____ NO ____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Authorized Employer Name: _____ Title: _____

Authorized Employer Signature _____ Date: _____

Please return completed document to the HR Department

Email: gina.eddleman@gmsdk12.org, Fax: (901)757-6006

2024-25

# LUCENT HEALTH SOLUTIONS (LHS) MEDICAL COVERAGE

Make sure your physician's office calls LHS at 1-800-411-3650, not CIGNA, to verify your coverage.
GMSD's group number is 300052.

To gain access to your LHS Member Portal, go to mylucenthealth.com and click "Register Account".

# Medical Benefits Plan Design - Lucent Health Solutions

*GOOD NEWS - 10 YEARS IN A ROW WITH NO CHANGES IN PREMIUMS!*

| | HRA FUND | | IN-NETWORK PLUS | BASIC PLAN | |
|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | | IN-NETWORK | OUT-OF-NETWORK |
| **WELLNESS (Routine Care)** | | | | | |
| Physical Exams | 100% | Not Covered | 100% | 100% (No Ded) | Not Covered |
| Well Child Care (Including Immunizations) | 100% | Not Covered | 100% | 100% (No Ded) | Not Covered |
| Mammogram (Test and Reading) | 100% | 50% (Ded) | 100% | 100% (No Ded) | 50% (Ded) |
| Pap Smears (Test and Reading) | 100% | 50% (Ded) | 100% | 100% (No Ded) | 50% (Ded) |
| Prostate Blood Test (Test and Reading) | 100% | 50% (Ded) | 100% | 100% (No Ded) | 50% (Ded) |
| Fecal Occult Screening (Test and Reading) | 100% | 50% (Ded) | 100% | 100% (No Ded) | 50% (Ded) |
| Annual Health Fund Provided to Employees and Dependents.** | $500 Individual<br>$750 Individual plus one<br>$1,000 Family | | Not Applicable | Not Applicable | |
| **MAJOR MEDICAL** | | | | | |
| **Deductible (Ded)*** | **$1,500/Individual**<br>**$2,250/Individual plus one**<br>**$3,000/Family** | **$3,000/Individual**<br>**$4,500/Individual plus one**<br>**$6,000/Family** | **None**<br>**None**<br>**None** | **$500/Individual**<br>**$750/Individual plus one**<br>**$1,000/Family** | **$1,000/Individual**<br>**$1,500/Individual plus one**<br>**$2,000/Family** |
| Plan Payment (Coinsurance) | 80% | 50% | 100% | 80% | 50% |
| **Out-of-Pocket Maximum*** | **$4,500/Individual**<br>**$8,000/Individual plus one** | **$11,500/Individual**<br>**$22,500/Individual plus one** | **$2,500/Individual**<br>**$4,000/Indiv. plus one** | **$3,500/Individual**<br>**$6,000/Individual plus one** | **$8,500/Individual**<br>**$16,000/Individual plus one** |
| **(Including Deductible)** | **$11,500/Family** | **$32,500/Family** | **$5,500/Family** | **one $8,500/Family** | **$23,500/Family** |
| Lifetime Maximum per Family Member | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| **HOSPITAL BENEFITS** | | | | | |
| Hospital Copay | N/A | N/A | **$500 per admission** | N/A | N/A |
| Out-Patient | 80% (Ded) | 50% (Ded) | **$250 per visit** | 80% (Ded) | 50% (Ded) |
| Emergency Room | 80% (Ded)<br>(Waived If Admitted)<br>Medical Emergency | 80% (Ded)<br>(Waived If Admitted)<br>Medical Emergency | **$150 per visit**<br>Medical Emergency | **100% ($150 Copay &**<br>**Ded)** Medical Emergency<br>(Waived If Admitted) | 100% ($150 Copay &<br>Ded) Medical Emergency<br>(Waived If Admitted) |
| **SURGICAL BENEFITS** | | | | | |
| In-Patient | 80% (Ded) | 50% (Ded) | 100% | 80% (Ded) | 50% (Ded) |
| Out-Patient | 80% (Ded) | 50% (Ded) | 100% | 80% (Ded) | 50% (Ded) |
| **PHYSICIAN'S OFFICE VISIT** | 80% (Ded) | 50% (Ded) | **100%; $25 Copay** | **100%; $30 Copay** | 50% (Ded) |
| **SPECIALIST OFFICE VISIT** | 80%(Ded) | 50%(Ded) | **100%; $40 Copay** | **100%; $40 Copay** | |
| **DIAGNOSTIC X-RAY & LABORATORY SERVICES** | 80% (Ded) | 50% (Ded) | 100% | 100% (No Ded) | 50% (Ded) |
| **PRESCRIPTION DRUG CARD** | $10 Generic | 50% (Ded) | $10 Generic | $10 Generic | 50% (Ded) |
| **(Copay)** | $50 Brand | 50% (Ded) | $50 Brand | $50 Brand | 50% (Ded) |
| | $100 Specialty | 50% (Ded) | $100 Specialty | $100 Specialty | 50% (Ded) |
| **MENTAL/NERVOUS & SUBSTANCE ABUSE** | | | | | |
| **In-Patient** | 80% (Ded) | 50% (Ded) | **$500 per admission** | 80% (Ded) | 50% (Ded) |
| **Physician Office Visit** | 80% (Ded) | 50% (Ded) | **$40 copay per visit** | **100%; $40 Copay** | 50% (Ded) |
| **Out-Patient** | 80% (Ded) | 50% (Ded) | **$40 copay per visit** | 80% (Ded) | 50% (Ded) |
| **ADDITIONAL MEDICAL BENEFITS** | | | | | |
| Pre-Admission Testing | 80% (Ded) | 50% (Ded) | 100% | 100% (No Ded) | 100% (No Ded) |
| Physical Therapies including Chiropractic | 80% (Ded) | 50% (Ded) | 100%; $40 copay | **100%; $40 Copay** | 50% (Ded) |
| Home Health Care (Precertification) | 80% (Ded) | 50% (Ded) | 100%<br>60 Visits Cal. Yr. Max. | 80% (Ded) | 50% (Ded) |
| Extended Care Facility (Precertification) | 80% (Ded)<br>60 Days Cal. Yr. Max. | 50% (Ded)<br>60 Days Cal. Yr. Max. | 100%<br>60 Days Cal. Yr. Max. | 100% (No Ded)<br>60 Days Cal. Yr. Max. | 100% (No Ded)<br>60 Days Cal. Yr. Max. |
| Hospice (Precertification) | 80% (Ded) | 50% (Ded) | 100% | 80% (Ded) | 50% (Ded) |
| Urgent Care | 80% (Ded) | 50% (Ded) | **$75 per visit** | **100% ($75 Copay & Ded)** | **100% ($75 Copay & Ded)** |
| Ambulance Services | 80% (Ded) | 50% (Ded) | 100% | 80% (Ded) | 50% (Ded) |
| Medical Supplies and Durable Equipment | 80% (Ded) | 50% (Ded) | 100% | 80% (Ded) | 50% (Ded) |

*Deductibles and Out of Pocket Expenses Accumulate on a calendar year basis.
**The HRA Fund pays at the front end of the deductible and can be used beginning September 1 through August 31. Any funds remaining at the end of the Plan Year do not roll over to the new Plan Year. Please note that the fund cannot exceed 100% of the total deductible
The plan document is the governing document; therefore any discrepancies which may be found are not binding. The Plan Document may be found by going to your district's Employee Portal and looking under "Documents/Links"

Better value. Better together.

# Find a health care professional

With a growing nationwide PPO network of nearly 800,000 health care professionals and more than 6,000 facilities, Cigna offers you a range of quality choices to help you stay healthy.

## Three ways to find what you need

**There are three ways to find a network health care professional:**

- **If you're already enrolled, visit myCigna.com and log in using your User ID and Password.**
- **Visit Cigna.com and click "Find a Doctor." Be sure to select the "PPO, Choice Fund PPO" network.**
- **Call your Third Party Administrator during business hours.**

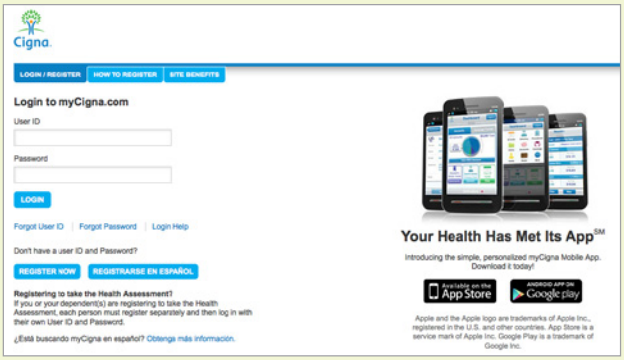
Special features allow you to:

- Narrow your results by distance, cost efficiency, specialty and more.
- Email a copy of your search results.
- Find doctors in 22 different medical specialties, who meet certain cost and quality measures and have been awarded the Cigna Care Designation.
- Estimate procedure costs based on Cigna's historical data.

Cigna's extensive PPO Network gives you access to qualified health care professionals. Your good health is important, and we're here to help.

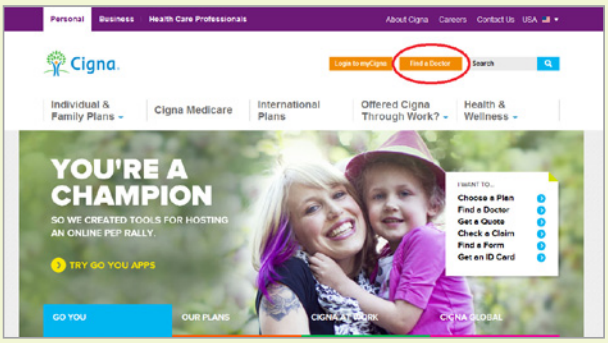
## Option 1

**Log in to myCigna.com**




## Option 2

**Visit Cigna.com – click on "Find a Doctor." On the next page, click on "Select a plan for your search" and then "PPO, Choice Fund PPO" in the pop-up box.**




Cigna®



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# METLIFE DENTAL

ID cards are not required for MetLife Dental plans. Beginning on September 1, 2024, if you wish to have an ID card they will be available online for members to download and print via the MetLifeMyBenefits website.

GMSD's group number with MetLife Dental is 259919

# Plan Design – AAFTE High and Low Plans

| Voluntary Dental | | | | |
|---|---|---|---|---|
| **Class Description** | All Active Full Time Employees High Plan (30 Hours) | | All Active Full Time Employees Low Plan (30 Hours) | |
| | **In-Network** | **Out-of-Network*** | **In-Network** | **Out-of-Network*** |
| **Reimbursement** | Negotiated Fee Schedule | R&C 90th Percentile | Negotiated Fee Schedule | R&C 90th Percentile |
| **Type A – Preventive** | 100% | 100% | 100% | 100% |
| **Type B – Basic** | 80% | 80% | 80% | 80% |
| **Type C – Major** | 60% | 60% | 50% | 50% |
| **Calendar Year Deductible applies to:**<br>▪ **Individual**<br>▪ **Family** | B & C<br><br>$25<br>$75<br>Aggregate | B & C<br><br>$50<br>$150<br>Aggregate | B & C<br><br>$50<br>$150<br>Aggregate | B & C<br><br>$100<br>$300<br>Aggregate |
| **Calendar Year Maximum** ***(applies to A,B,C services)*** | $2,000 | $2,000 | $1,500 | $1,500 |
| **Orthodontia** | 50% | 50% | 50% | 50% |
| **Orthodontia Lifetime Maximum** | $2,000 | $2,000 | $1,500 | $1,500 |

* Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

2024-25

# DAVIS VISION

Once you receive your ID cards, please show them to your providers the first time you are seen.

Davis Vision's ID cards include your ID number, your name, our school district's name, and Davis Vision's phone number you can call with any questions.
GMSD's Client Code Number with Davis Vision is **8099**

DavisVision™

davisvision.com | 1 (877) 923-2847, 8099

# Germantown Municipal School District your vision plan

Client code: 8099

## Frequency

Exam: September 1
Lenses & lens upgrades: September 1
Frame: Every other September 1
Contacts, evaluation & fitting: September 1

## Sign up during open enrollment

For more details about the plan, visit davisvision.com/member and enter your Client Code or call 1 (877) 923-2847 and enter your Client Code when prompted.

### Exams & Services

Eye Exam copay:
**$10**

Contacts evaluation, fitting & follow-up:

| Collection lenses | Non-Collection lenses |
|---|---|
| **$20 copay** | **15% savings**[2] |

### Lenses

Lens copay:
**$20**

### Frame

Allowance:

| Other locations | Visionworks[1] |
|---|---|
| **$130** | **$180** |

+Additional 20% **off** any overage.[2]

or

The Exclusive Collection copay:

| Fashion | Designer | Premier |
|---|---|---|
| **Covered in full** | **Covered in full** | **$25** |

### Contacts[3] in lieu of glasses

Allowance:

**$150**

+Additional 15% **off** any overage.[2]

or

The Exclusive Collection of Contact Lenses:[4]

**Covered in full**

## Find a network provider...

Enter your client code in the “Member Sign In” section of our website at davisvision.com/member to locate a provider near you including Visionworks.

## Using your client code

Log in using your client code (listed above) at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

## The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S. Log in to browse frames, and find a Collection near you.

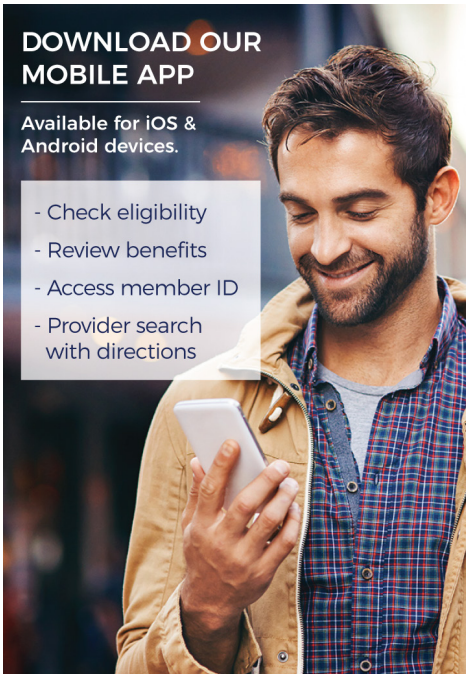
## Free breakage warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

# Options & upgrades

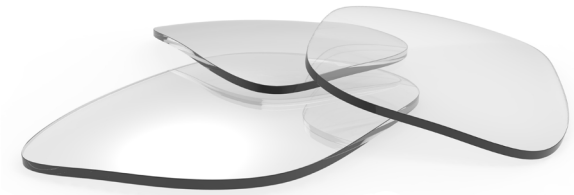
## Lens options

| | |
|---|---|
| Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX) | $0 |
| Polycarbonate Lenses (Children / Adults) | $0 or $30 |
| High-Index Lenses 1.67 | $55 |
| High-Index Lenses 1.74 | $120 |
| Polarized Lenses | $75 |
| Progressive Lenses (Standard / Premium / Ultra / Ultimate) | $0 / $40 / $140 / $175 |
| Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate) | $0 / $13 / $25 / $85 |
| Ultraviolet Coating | $12 |
| Tinting of Plastic Lenses (Solid / Gradient) | $0 |
| Plastic Photochromic Lenses (Transitions® Signature™) | $65 |
| Scratch-Resistant Coating | $0 |
| Premium Scratch-Resistant Coating | $30 |
| Scratch-Protection Plan (Single-Vision \| Multifocal) | $20 \| $40 |
| Digital Single Vision Lenses | $30 |
| Trivex Lenses | $50 |
| Blue Light Filtering | $15 |




## Additional savings

| | |
|---|---|
| Retinal imaging (Member charge) | $39 |
| Additional pairs of eyeglasses | 30% discount[2] |



## Out-of-network benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

| Out-of-network reimbursement schedule (up to) | |
|---|---|
| Eye Examination: $30 | Trifocal Lenses: $45 |
| Frame: $30 | Lenticular Lenses: $60 |
| Single-Vision Lenses: $25 | Elective Contact Lenses: $75 |
| Bifocal / Progressive Lenses: $35 | Visually Required Contacts: $225 |

1. Excludes Maui Jim® eyewear. 2. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. 3. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. 4. The Davis Vision Exclusive Collection of Contact Lenses is available at participating providers. Evaluation, fitting and follow-up care for Collection contacts are covered in full. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

2024-25

# DEARBORN NATIONAL

## Group Life & Voluntary Life coverage for employee, spouse, and child(ren)

Group Number: F020518

Dearborn Group™

## Group Benefit Program Summary for

# Germantown Municipal School District - #F020518

### Group Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With our Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

| | |
|---|---|
| Eligibility | All Active Full-time Employees excluding the Superintendent and including Employees whose in force Spouse benefit amounts in excess of 50% of the Employee's Amount. |
| Group Term Life Benefit: Employee | 2 times salary to a maximum of $300,000, rounded to the next higher $1,000, with a minimum of $1,000 |
| Guarantee Issue Amount - Employee | $300,000 |
| Group Term Life Age Reduction Schedule | Benefits reduce by 35% of the original amount at age 65; and further reduce by: 50% of the original amount at age 70. |
| Waiver of Premium | Elimination Period: 6 Months; Duration: To age 65 |
| Accelerated Death Benefit (ADB) | Benefit: Up to 75% of the employee's life insurance; Life expectancy: 12 months or less |
| Portability Feature (Life Coverage) | Included (employee) |
| Conversion | Included |
| Beneficiary Resource Service | Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents. |
| Travel Resource Services | Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet. |

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

| AD&D Schedule of Loss* | Principal Sum |
|---|---|
| Loss of life | 100% |
| Loss of both hands or both feet | 100% |
| Loss of one hand and one foot | 100% |
| Loss of speech and hearing | 100% |
| Loss of sight of both eyes | 100% |
| Loss of one hand and sight of one eye | 100% |
| Loss of one foot and sight of one eye | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Hemiplegia | 50% |
| Loss of sight of one eye | 50% |
| Loss of one hand or one foot | 50% |
| Loss of speech or hearing | 50% |
| Loss of thumb and index finger of same hand | 25% |
| Uniplegia | 25% |

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- ▲ Seatbelt and Airbag Benefits
- ▲ Repatriation Benefit
- ▲ Education Benefit

EXCLUSIONS

Unless specifically covered in the policy, or required by state law, we will not pay any AD&D benefit for any loss that directly or indirectly, results in any way from or is contributed to by:

1. disease of the mind or body, or any treatment thereof
2. infections, except those from an accidental cut or wound
3. suicide or attempted suicide
4. intentionally self-inflicted injury
5. war or act of war
6. travel or flight in any aircraft while a member of the crew
7. commission of, or participation in a felony
8. under the influence of certain drugs, narcotics, or hallucinogen unless properly used as prescribed by a physician or
9. intoxication as defined in the jurisdiction where the accident occurred
10. participation in a riot

Dearborn Group™

Group Benefit Program Summary for

# Germantown Municipal School District - F020518

## Supplemental Term Life/Accidental Death & Dismemberment (AD&D)

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Our Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

| | |
|---|---|
| Eligibility | All eligible, active full time employees |
| Group Term Life/AD&D Benefit: Employee | $10,000 - $500,000 in increments of $10,000 |
| Guarantee Issue Amount* Employee | 3 times Annual Salary<br>Special one-time open enrollment for 9/1/24. Employees can add or increase benefits up to the lesser of 3 times Annual Salary or $100,000 without EOI. |
| Group Term Life/AD&D Benefit: Spouse (Includes Domestic Partners) | $5,000 - $250,000 in increments of $5,000, not to exceed 100% of the employee benefit amount. |
| Guarantee Issue Amount - Spouse | $20,000 |
| Group Term Life/AD&D Benefit: Child(ren) | Birth to 14 days: $10,000<br>Age 15 days to 6 months: $10,000<br>Age 6 months to 25 years: $10,000 to $50,000 in increments of $10,000. Guarantee Issue Amount: $10,000 |
| Age Reduction Schedule | Life and AD&D benefits reduce by 35% of the original amount at age 65 and further reduce by 50% of the original amount at age 70. |
| Employee Contribution | 100 percent |
| Waiver of Premium | If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of six months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first. |
| Accelerated Death Benefit (ADB) | Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's life insurance, if diagnosed with a terminal illness and has a life expectancy of 12 months or less. Minimum: $7,500. Maximum $500,000. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB. |
| Portability Feature (Life Coverage) | Included (employee and spouse) |
| Conversion Privilege (Life Coverage) | Included |
| Beneficiary Resource Services | Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents. |
| Travel Resource Services | Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet. |
| Exclusions | **One-year suicide exclusion applies to Supplemental Group Term Life coverage. AD&D exclusions are the same as Basic AD&D exclusions.** |

For illustrative purposes only. May not be available in all jurisdictions. Coverage may be subject to limitations, exclusions and other coverage conditions contained in issued policy. Please consult the policy for the actual terms of coverage.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

| AD&D Schedule of Loss* | Principal Sum |
|---|---|
| Loss of life | 100% |
| Loss of both hands or both feet | 100% |
| Loss of one hand and one foot | 100% |
| Loss of speech and hearing | 100% |
| Loss of sight of both eyes | 100% |
| Loss of one hand and sight of one eye | 100% |
| Loss of one foot and sight of one eye | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Hemiplegia | 50% |
| Loss of sight of one eye | 50% |
| Loss of one hand or one foot | 50% |
| Loss of speech or hearing | 50% |
| Loss of thumb and index finger of same hand | 25% |
| Uniplegia | 25% |

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- ▲ Seatbelt and Airbag Benefits
- ▲ Repatriation Benefit
- ▲ Education Benefit

EXCLUSIONS

Unless specifically covered in the policy, or required by state law, we will not pay any AD&D benefit for any loss that directly or indirectly, results in any way from or is contributed to by:

1. disease of the mind or body, or any treatment thereof
2. infections, except those from an accidental cut or wound
3. suicide or attempted suicide
4. intentionally self-inflicted injury
5. war or act of war
6. travel or flight in any aircraft while a member of the crew
7. commission of, or participation in a felony
8. under the influence of certain drugs, narcotics, or hallucinogen unless properly used as prescribed by a physician or
9. intoxication as defined in the jurisdiction where the accident occurred
10. participation in a riot

## SUPPLEMENTAL GROUP LIFE AND AD&D

**PREMIUM RATE GRID**

Dearborn Group™

## Germantown Municipal School District- #F020518

### Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

### Supplemental Life/AD&D Insurance

Employee Benefit: **$10,000 to $500,000, in increments of $10,000**

Spouse Benefit: **$5,000 to $250,000, in increments of $5,000 (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

**Guarantee Issue - NEW HIRES ONLY**

| | |
|---|---|
| Employee | **Not To Exceed Three Times Salary** |
| Spouse | **$20,000** |
| Child(ren) | **$10,000** |

**Child Coverage**

| | |
|---|---|
| Age Birth to 14 days: | **$10,000** |
| Age 15 days to 6 months: | **$10,000** |
| Age 6 months to age 25 | **$10,000 to $50,000 in $10,000 increments** |

No Reduction Schedule

**EMPLOYEE**

**Supplemental Life**

10-Month rates per $1,000

| Age | Rates |
|---|---|
| Under 20 | $0.080 |
| 20-24 | $0.080 |
| 25-29 | $0.080 |
| 30-34 | $0.109 |
| 35-39 | $0.125 |
| 40-44 | $0.160 |
| 45-49 | $0.251 |
| 50-54 | $0.376 |
| 55-59 | $0.707 |
| 60-64 | $1.083 |
| 65-69 | $2.085 |
| 70+ | $3.386 |

**Supplemental AD&D**

10-Month rates per $1,000

| | |
|---|---|
| Employee | $0.029 |

**Dependent Life (Children)**

Premium Cost per Family Unit

| | Life | AD&D |
|---|---|---|
| $10,000 | $1.23 | $0.36 |
| $20,000 | $2.45 | $0.72 |
| $30,000 | $3.68 | $1.08 |
| $40,000 | $4.90 | $1.44 |
| $50,000 | $6.13 | $1.80 |

**Supplemental Life/AD&D Insurance**

**Premium Cost (Based on 20 payroll deductions per year)**

| Benefit Amount | EE AD&D | ATTAINED AGE <20 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| $10,000 | $0.15 | $0.40 | $0.40 | $0.40 | $0.55 | $0.63 | $0.80 | $1.26 | $1.88 | $3.54 | $5.42 | $10.43 | $16.93 |
| $20,000 | $0.29 | $0.80 | $0.80 | $0.80 | $1.09 | $1.25 | $1.60 | $2.51 | $3.76 | $7.07 | $10.83 | $20.85 | $33.86 |
| $30,000 | $0.44 | $1.20 | $1.20 | $1.20 | $1.64 | $1.88 | $2.40 | $3.77 | $5.64 | $10.61 | $16.25 | $31.28 | $50.79 |
| $40,000 | $0.58 | $1.60 | $1.60 | $1.60 | $2.18 | $2.50 | $3.20 | $5.02 | $7.52 | $14.14 | $21.66 | $41.70 | $67.72 |
| $50,000 | $0.73 | $2.00 | $2.00 | $2.00 | $2.73 | $3.13 | $4.00 | $6.28 | $9.40 | $17.68 | $27.08 | $52.13 | $84.65 |
| $60,000 | $0.87 | $2.40 | $2.40 | $2.40 | $3.27 | $3.75 | $4.80 | $7.53 | $11.28 | $21.21 | $32.49 | $62.55 | $101.58 |
| $70,000 | $1.02 | $2.80 | $2.80 | $2.80 | $3.82 | $4.38 | $5.60 | $8.79 | $13.16 | $24.75 | $37.91 | $72.98 | $118.51 |
| $80,000 | $1.16 | $3.20 | $3.20 | $3.20 | $4.36 | $5.00 | $6.40 | $10.04 | $15.04 | $28.28 | $43.32 | $83.40 | $135.44 |
| $90,000 | $1.31 | $3.60 | $3.60 | $3.60 | $4.91 | $5.63 | $7.20 | $11.30 | $16.92 | $31.82 | $48.74 | $93.83 | $152.37 |
| $100,000 | $1.45 | $4.00 | $4.00 | $4.00 | $5.45 | $6.25 | $8.00 | $12.55 | $18.80 | $35.35 | $54.15 | $104.25 | $169.30 |
| $110,000 | $1.60 | $4.40 | $4.40 | $4.40 | $6.00 | $6.88 | $8.80 | $13.81 | $20.68 | $38.89 | $59.57 | $114.68 | $186.23 |
| $120,000 | $1.74 | $4.80 | $4.80 | $4.80 | $6.54 | $7.50 | $9.60 | $15.06 | $22.56 | $42.42 | $64.98 | $125.10 | $203.16 |
| $130,000 | $1.89 | $5.20 | $5.20 | $5.20 | $7.09 | $8.13 | $10.40 | $16.32 | $24.44 | $45.96 | $70.40 | $135.53 | $220.09 |
| $140,000 | $2.03 | $5.60 | $5.60 | $5.60 | $7.63 | $8.75 | $11.20 | $17.57 | $26.32 | $49.49 | $75.81 | $145.95 | $237.02 |
| $150,000 | $2.18 | $6.00 | $6.00 | $6.00 | $8.18 | $9.38 | $12.00 | $18.83 | $28.20 | $53.03 | $81.23 | $156.38 | $253.95 |
| $200,000 | $2.90 | $8.00 | $8.00 | $8.00 | $10.90 | $12.50 | $16.00 | $25.10 | $37.60 | $70.70 | $108.30 | $208.50 | $338.60 |
| $250,000 | $3.63 | $10.00 | $10.00 | $10.00 | $13.63 | $15.63 | $20.00 | $31.38 | $47.00 | $88.38 | $135.38 | $260.63 | $423.25 |
| $300,000 | $4.35 | $12.00 | $12.00 | $12.00 | $16.35 | $18.75 | $24.00 | $37.65 | $56.40 | $106.05 | $162.45 | $312.75 | $507.90 |
| $350,000 | $5.08 | $14.00 | $14.00 | $14.00 | $19.08 | $21.88 | $28.00 | $43.93 | $65.80 | $123.73 | $189.53 | $364.88 | $592.55 |
| $400,000 | $5.80 | $16.00 | $16.00 | $16.00 | $21.80 | $25.00 | $32.00 | $50.20 | $75.20 | $141.40 | $216.60 | $417.00 | $677.20 |
| $450,000 | $6.53 | $18.00 | $18.00 | $18.00 | $24.53 | $28.13 | $36.00 | $56.48 | $84.60 | $159.08 | $243.68 | $469.13 | $761.85 |
| $500,000 | $7.25 | $20.00 | $20.00 | $20.00 | $27.25 | $31.25 | $40.00 | $62.75 | $94.00 | $176.75 | $270.75 | $521.25 | $846.50 |

## SUPPLEMENTAL GROUP LIFE AND AD&D

**PREMIUM RATE GRID**

Dearborn Group™

## Germantown Municipal School District- #F020518

### Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

### Supplemental Life/AD&D Insurance

Employee Benefit: **$10,000 to $500,000, in increments of $10,000**

Spouse Benefit: **$5,000 to $250,000, in increments of $5,000 (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

### Guarantee Issue - NEW HIRES ONLY

| | |
|---|---|
| Employee | **Not To Exceed Three Times Salary** |
| Spouse | **$20,000** |
| Child(ren) | **$10,000** |

### Child Coverage

| | |
|---|---|
| Age Birth to 14 days: | **$10,000** |
| Age 15 days to 6 months: | **$10,000** |
| Age 6 months to age 25: | **$10,000 to $50,000 in $10,000 increments** |

No Reduction Schedule

**SPOUSE**

**Supplemental Life**

10-Month rates per $1,000

| Age | Rates |
|---|---|
| Under 20 | $0.080 |
| 20-24 | $0.080 |
| 25-29 | $0.080 |
| 30-34 | $0.109 |
| 35-39 | $0.125 |
| 40-44 | $0.160 |
| 45-49 | $0.251 |
| 50-54 | $0.376 |
| 55-59 | $0.707 |
| 60-64 | $1.083 |
| 65-69 | $2.085 |
| 70+ | $3.386 |

**Supplemental AD&D**

10-Month rates per $1,000

| | |
|---|---|
| Spouse | $0.029 |

**Dependent Life (Children)**

Premium Cost per Family Unit

| | Life | AD&D |
|---|---|---|
| $10,000 | $1.23 | $0.36 |
| $20,000 | $2.45 | $0.72 |
| $30,000 | $3.68 | $1.08 |
| $40,000 | $4.90 | $1.44 |
| $50,000 | $6.13 | $1.80 |

**Supplemental Life/AD&D Insurance**

**Premium Cost (Based on 20 payroll deductions per year)**

| Benefit Amount | SP AD&D | ATTAINED AGE <20 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| $5,000 | $0.07 | $0.20 | $0.20 | $0.20 | $0.27 | $0.31 | $0.40 | $0.63 | $0.94 | $1.77 | $2.71 | $5.21 | $8.47 |
| $10,000 | $0.15 | $0.40 | $0.40 | $0.40 | $0.55 | $0.63 | $0.80 | $1.26 | $1.88 | $3.54 | $5.42 | $10.43 | $16.93 |
| $15,000 | $0.22 | $0.60 | $0.60 | $0.60 | $0.82 | $0.94 | $1.20 | $1.88 | $2.82 | $5.30 | $8.12 | $15.64 | $25.40 |
| $20,000 | $0.29 | $0.80 | $0.80 | $0.80 | $1.09 | $1.25 | $1.60 | $2.51 | $3.76 | $7.07 | $10.83 | $20.85 | $33.86 |
| $25,000 | $0.36 | $1.00 | $1.00 | $1.00 | $1.36 | $1.56 | $2.00 | $3.14 | $4.70 | $8.84 | $13.54 | $26.06 | $42.33 |
| $30,000 | $0.44 | $1.20 | $1.20 | $1.20 | $1.64 | $1.88 | $2.40 | $3.77 | $5.64 | $10.61 | $16.25 | $31.28 | $50.79 |
| $35,000 | $0.51 | $1.40 | $1.40 | $1.40 | $1.91 | $2.19 | $2.80 | $4.39 | $6.58 | $12.37 | $18.95 | $36.49 | $59.26 |
| $40,000 | $0.58 | $1.60 | $1.60 | $1.60 | $2.18 | $2.50 | $3.20 | $5.02 | $7.52 | $14.14 | $21.66 | $41.70 | $67.72 |
| $45,000 | $0.65 | $1.80 | $1.80 | $1.80 | $2.45 | $2.81 | $3.60 | $5.65 | $8.46 | $15.91 | $24.37 | $46.91 | $76.19 |
| $50,000 | $0.73 | $2.00 | $2.00 | $2.00 | $2.73 | $3.13 | $4.00 | $6.28 | $9.40 | $17.68 | $27.08 | $52.13 | $84.65 |
| $55,000 | $0.80 | $2.20 | $2.20 | $2.20 | $3.00 | $3.44 | $4.40 | $6.90 | $10.34 | $19.44 | $29.78 | $57.34 | $93.12 |
| $60,000 | $0.87 | $2.40 | $2.40 | $2.40 | $3.27 | $3.75 | $4.80 | $7.53 | $11.28 | $21.21 | $32.49 | $62.55 | $101.58 |
| $65,000 | $0.94 | $2.60 | $2.60 | $2.60 | $3.54 | $4.06 | $5.20 | $8.16 | $12.22 | $22.98 | $35.20 | $67.76 | $110.05 |
| $70,000 | $1.02 | $2.80 | $2.80 | $2.80 | $3.82 | $4.38 | $5.60 | $8.79 | $13.16 | $24.75 | $37.91 | $72.98 | $118.51 |
| $75,000 | $1.09 | $3.00 | $3.00 | $3.00 | $4.09 | $4.69 | $6.00 | $9.41 | $14.10 | $26.51 | $40.61 | $78.19 | $126.98 |
| $100,000 | $1.45 | $4.00 | $4.00 | $4.00 | $5.45 | $6.25 | $8.00 | $12.55 | $18.80 | $35.35 | $54.15 | $104.25 | $169.30 |
| $125,000 | $1.81 | $5.00 | $5.00 | $5.00 | $6.81 | $7.81 | $10.00 | $15.69 | $23.50 | $44.19 | $67.69 | $130.31 | $211.63 |
| $150,000 | $2.18 | $6.00 | $6.00 | $6.00 | $8.18 | $9.38 | $12.00 | $18.83 | $28.20 | $53.03 | $81.23 | $156.38 | $253.95 |
| $175,000 | $2.54 | $7.00 | $7.00 | $7.00 | $9.54 | $10.94 | $14.00 | $21.96 | $32.90 | $61.86 | $94.76 | $182.44 | $296.28 |
| $200,000 | $2.90 | $8.00 | $8.00 | $8.00 | $10.90 | $12.50 | $16.00 | $25.10 | $37.60 | $70.70 | $108.30 | $208.50 | $338.60 |
| $225,000 | $3.26 | $9.00 | $9.00 | $9.00 | $12.26 | $14.06 | $18.00 | $28.24 | $42.30 | $79.54 | $121.84 | $234.56 | $380.93 |
| $250,000 | $3.63 | $10.00 | $10.00 | $10.00 | $13.63 | $15.63 | $20.00 | $31.38 | $47.00 | $88.38 | $135.38 | $260.63 | $423.25 |

2024-25

# DEARBORN NATIONAL

## Long-Term Disability Insurance

Dearborn Group™

# Group Benefit Program Summary for
# Germantown Municipal School District - #F020518
## Group Voluntary Long-term Disability Insurance (LTD)

Without a steady income, most people would not be able to make payments on their homes or keep their family financially stable. LTD reduces the burden during these unstable times. It is a convenient, economical way of securing an income while out of work from an unexpected injury or illness. Your employer has made LTD coverage available for you to enroll in. Below are some of the major features of this program.

| | |
|---|---|
| Eligibility | All Active Full-time Employees |
| Group LTD Benefit Percentage | 60% |
| Maximum Monthly Benefit | $10,000 |
| Minimum Monthly Benefit | $100 or 10% of gross monthly earnings, whichever is greater |
| Elimination Period | 180 days |
| Maximum Period Payable | 5 year Reducing Benefit Duration |
| Social Security Offset Method | Primary and Family Integration |
| Mental Disorder Limitation | 24 Months |
| Substance Abuse Limitation | 24 Months |
| Special Conditions Limitation | 24 Months |
| Pre-Existing Condition Limitation | 3/12 - A Pre-Existing Condition is a Sickness or Injury for which you have received treatment within 3 months prior to your effective date. Any disability contributed to or caused by a Pre-Existing Condition within the first 12 months of your effective date will not be covered. |
| Rehabilitation Incentive Income (RII) | RII is offered to employees who agree to take part in a rehabilitation plan, structured to return them to gainful employment in another occupation because they cannot return to their regular occupation. During the first 12 months, RII is equal to the monthly benefit. If disability earnings during this period exceed 100% of indexed predisability earnings, the monthly benefit is reduced by the excess. After 12 months, RII is equal to the monthly benefit reduced by multiplying the monthly benefit by the adjusted loss of salary ratio. Includes Day Care Expense Benefit. |
| Disability Resource Service | In addition to the resource services available on-line at GuidanceResources.com, Disability Resource Services provides a 24-hour telephonic support for all LTD insureds for behavioral health issues. A staff of master's degree clinicians are available to provide each caller with assessment, counseling and referral advice for face-to-face counseling. Face-to-face counseling - Up to three face-to-face counseling sessions per year to address appropriate behavioral health issues. |
| Additional Features | Work Incentive Benefit, Survivor Benefit |

Dearborn Group™

## VLTD Definition of Disability:

| | |
|---|---|
| Total Disability | Total Disability means that during the first 24 consecutive months of benefits due to Injury or Sickness the employee is unable to perform all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any, are less than the percentage (20%) of the employee's pre-disability weekly earnings. |
| Partial Disability | Partial Disability means that during the elimination period the employee is able to perform some, but not all, of the material and substantial duties of the employee's regular occupation. After the elimination period, partial disability means that due to Injury or Sickness the employee is able to perform some but not all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any are at least the minimum percentage (20%), but less than the maximum percentage of the employee's pre-disability weekly earnings (60%). |

Dearborn Group™

## Voluntary Long-Term Disability - Percentage of Salary Program Premium Calculation

Group: **Germantown Municipal School District**

### Benefit Schedule

| | |
|---|---|
| Benefit Percentage: | 60% of Basic Monthly Earnings* |
| Benefit Maximum: | $10,000 |
| Maximum Monthly covered earnings: | $16,667 |
| Benefit Duration: | 5 Year Reducing Benefit Duration (RBD) |
| Elimination Period | 180 Days |
| Pre-Existing Conditions Limitation | 3/12 |

*Basic Monthly Earnings/Insured Salary means the monthly compensation you earn from your normal occupation with your employer. It includes total income before taxes, including deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include earnings from bonuses, overtime pay or any other extra compensation other than commissions. Commissions will be averaged over the 12-month period prior to the date death or disability begins.

**RATES BELOW ARE 10-MONTH BILLED**

| Age | Rate per $100 of Covered Payroll | Age | Rate per $100 of Covered Payroll |
|---|---|---|---|
| Under 20 | $0.062 | 45-49 | $0.258 |
| 20-24 | $0.062 | 50-54 | $0.258 |
| 25-29 | $0.078 | 55-59 | $0.566 |
| 30-34 | $0.078 | 60-64 | $0.566 |
| 35-39 | $0.114 | 65-69 | $0.649 |
| 40-44 | $0.114 | 70-74 | $0.649 |

### Sample Premium Calculation

(Sample assumes a 30-year-old employee with $2,500 in monthly earnings)

| Monthly Earnings (maximum $16,667) | x | Rate | Amount ÷ 100 | = | Monthly Premium | 20 Pay Periods* Premium |
|---|---|---|---|---|---|---|
| $2,500 | x | $0.078 | $195.00 ÷ 100 | = | $ 1.95 | $.98 |

### Your Premium Calculation

(Enter your salary and the rate for your current age from the table above)

| Monthly Earnings (maximum $16,667) | x | Rate | Amount ÷ 100 | = | Monthly Premium | 20 Pay Periods* Premium |
|---|---|---|---|---|---|---|
| $_____ | x | $_____ | $_____ ÷ 100 | = | $_____ | $_____ |

* To determine 20 pay period per year, take amount x 10 (months); then divide by 20.

This Premium Cost Chart is for illustrative purposes only; your premium cost may be slightly higher or lower due to rounding. This piece is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy has exclusions, conditions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. Refer to your certificate for complete details and limitations of coverage. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations.

2024-25

# AMERICAN FIDELITY PRODUCTS

Accident Insurance
Cancer Insurance
Critical Illness Insurance
Flex Spending Accounts
Short-Term Disability Insurance

# Accident Insurance

AMERICAN FIDELITY
a different opinion

## Are you financially prepared for an accident?

Accidents can happen to anyone. And even though you can't plan for an accident, you can help prepare for unexpected medical costs. **Limited Benefit Accident Only Insurance** provides coverage to help with unforeseen accident costs.

### ACCIDENTAL INJURY

**Hypothetical Example** [1]

A bad fall from a ladder leads to a broken lower leg and head injury, resulting in a fractured tibia and concussion. Treatment is received within 3 days.

| | LEVEL 1 | LEVEL 2 | LEVEL 3 |
|---|---|---|---|
| Initial Treatment | $150 | $200 | $250 |
| X-Rays (two different days) | $100 | $200 | $300 |
| Anesthesia | $150 | $200 | $250 |
| Hospital Admission (day 1) | $500 | $1,000 | $1,500 |
| Hospital Confinement (days 2 through 4) | $300 | $600 | $900 |
| Concussion | $200 | $250 | $300 |
| Open Reduction Tibia Fracture Repair | $2,400 | $3,600 | $4,800 |
| Appliance - Crutches | $100 | $150 | $200 |
| Follow-up Treatment (3 visits) | $150 | $150 | $150 |
| **TOTAL** | **$4,050** | **$6,350** | **$8,650** |

### ACCIDENT SCREENING BENEFIT

This benefit is paid directly to you once per policy per calendar year and covers several tests, including, but not limited to:

- Routine Physical Exam
- Sports Physical Exam
- Bone Density Screening
- Stress Test

| LEVELS 1 & 2 | LEVEL 3 |
|---|---|
| $50 | $75 |

## Plan Benefit Highlights

| ACCIDENTAL DEATH & DISMEMBERMENT | | |
|---|---|---|
| **LEVEL 1** | **PRIMARY/SPOUSE** | **CHILD** |
| Common Carrier | $100,000 | $50,000 |
| Other Accident | $40,000 | $20,000 |
| Dismemberment | $2,800 to $40,000 | $1,400 to $20,000 |
| **LEVEL 2** | **PRIMARY/SPOUSE** | **CHILD** |
| Common Carrier | $150,000 | $75,000 |
| Other Accident | $60,000 | $30,000 |
| Dismemberment | $4,200 to $60,000 | $2,100 to $30,000 |
| **LEVEL 3** | **PRIMARY/SPOUSE** | **CHILD** |
| Common Carrier | $200,000 | $100,000 |
| Other Accident | $80,000 | $40,000 |
| Dismemberment | $5,600 to $80,000 | $2,800 to $40,000 |

[1] *Hypothetical example of a covered accident based on the AO22 policy.*

***Accident** is defined as an event which results in bodily Injury that is independent of disease or bodily infirmity or any other cause, and which occurs while the policy is active.*

# Plan Benefit Highlights

| BENEFITS | LEVEL 1 | LEVEL 2 | LEVEL 3 |
|---|---|---|---|
| **TREATMENTS** | | | |
| **Initial Treatment** | $150 | $200 | $250 |
| **Follow-up Treatment**<br>Up to six treatments | $50 | $50 | $50 |
| **MEDICAL IMAGING** | | | |
| **CT, CAT, MRI, PET, US, SPECT** | $200 | $200 | $200 |
| **X-Rays**<br>Up to two days | $50 | $100 | $150 |
| **HOSPITAL** | | | |
| **ICU Admission** | $1,000 | $1,500 | $2,000 |
| **Hospital Admission** | $500 | $1,000 | $1,500 |
| **ICU Confinement**<br>Up to 30 days | $400 | $800 | $1,200 |
| **Hospital Confinement**<br>Up to 365 days | $100 | $200 | $300 |
| **Rehabilitation**<br>Up to 30 days | $50 | $100 | $150 |
| **SURGICAL** | | | |
| **Anesthesia** | $150 | $200 | $250 |
| **Exploratory Surgery** | $250 | $300 | $350 |
| **Internal Injuries Surgery**<br>Open abdominal/thoracic surgery | $1,000 | $1,500 | $2,000 |
| **Miscellaneous Surgery** | $250 | $250 | $250 |
| **Outpatient Hospital or Ambulatory Surgical Center** | $150 | $250 | $350 |
| **Ruptured Disc or Torn Knee Cartilage Surgery** | $500 | $500 | $500 |
| **Tendons, Ligaments, and Rotator Cuff Surgery**<br>One tendon, ligament, or rotator cuff | $500 | $500 | $500 |
| More than one tendon, ligament, or rotator cuff | $750 | $750 | $750 |
| **AMBULANCE** | | | |
| **Ground/Water** | $500 | $500 | $500 |
| **Air** | $1,500 | $1,500 | $1,500 |
| **FAMILY SUPPORT** | | | |
| **Transportation**<br>Up to 3 round trips per Covered Person per Covered Accident | $300 | $300 | $300 |
| **Family Member Lodging and Meals**<br>Per day per accident; Up to 30 days per Covered Accident | $100 | $100 | $100 |

| BENEFITS | LEVEL 1 | LEVEL 2 | LEVEL 3 |
|---|---|---|---|
| **INJURY TREATMENTS** | | | |
| **Fractures**<br>Depending on open or closed reduction and bone involved<br>*Chip fracture*<br>*- 25% of closed reduction amount* | $150 to $4,000 | $225 to $6,000 | $300 to $8,000 |
| **Dislocations**<br>Depending on open or closed reduction and joint involved<br>*With local or no anesthesia*<br>*- 25% of closed reduction amount* | $150 to $4,000 | $225 to $6,000 | $300 to $8,000 |
| **Lacerations**<br>Not requiring sutures | $25 | $50 | $75 |
| Sutured lacerations less than two inches | $100 | $150 | $200 |
| Sutured lacerations totaling two but less than six inches | $200 | $250 | $300 |
| Sutured lacerations totaling six inches or more | $400 | $500 | $600 |
| **2nd & 3rd Degree Burns**<br>Skin grafts are 50% of benefit | $150 to $15,000 | $150 to $15,000 | $150 to $15,000 |
| **Appliances**<br>Crutches, leg braces, etc. | $100 | $150 | $200 |
| **Blood, Plasma, and Platelet** | $250 | $300 | $350 |
| **Concussion** | $200 | $250 | $300 |
| **Coma** | $5,000 | $10,000 | $15,000 |
| **Emergency Dental Work**<br>Broken teeth repaired with crown or extraction of a broken natural tooth | $150 | $200 | $250 |
| **Epidural Pain Management** | $100 | $150 | $200 |
| **Eye Injury**<br>Injury with surgical repair or removal of foreign body by physician, for one or both eyes | $200 | $250 | $300 |
| **Gunshot Wound** | $500 | $1,000 | $1,500 |
| **Paralysis**<br>Paraplegia/Uniplegia<br>Quadriplegia | $10,000<br>$20,000 | $15,000<br>$30,000 | $20,000<br>$40,000 |
| **Physical, Occupational, or Speech Therapy**<br>Per day of treatment up to eight days combined | $25 | $25 | $25 |
| **Prosthesis**<br>Up to two devices | $500 | $500 | $500 |
| **Traumatic Brain Injury** | $1,000 | $1,500 | $2,000 |

| MONTHLY PREMIUMS | LEVEL 1 | LEVEL 2 | LEVEL 3 |
|---|---|---|---|
| Individual | $19.90 | $26.10 | $33.40 |
| Individual & Spouse | $28.30 | $34.90 | $41.90 |
| Individual & Child(ren) | $31.50 | $41.00 | $51.30 |
| Family | $39.90 | $49.80 | $59.90 |

# Plan Benefit Highlights

A Covered Person (thereafter referred to as "Person") under AF™ **Limited Benefit Accident Only Insurance** policy may be eligible for the following benefits when a Covered Accident (thereafter referred to as "Accident") happens. All benefits are paid once per Person per Accident unless otherwise specified. All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is active. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. These references are not intended to change or modify any definitions in the AO22 policy series.

**Initial Treatment Benefit** Payable for the first treatment received within 30 days of the Accident. The initial treatment must be administered by a Physician or Medical Professional.

**Follow-Up Treatment Benefit** Payable for up to six follow-up treatments when initial medical treatment was received within 30 days of the Accident. Not payable for a visit in which a Physical, Occupational, or Speech Therapy benefit is paid.

**Accident Screening Benefit** Payable when a Person receives one of the following screenings rendered by a Physician: bone density screening; Epworth Sleepiness Scale for the purpose of diagnosing a sleeping disorder; hemoglobin A1C; routine physical exam; sports physicals; or stress test. This benefit is payable once per policy per Calendar Year. This benefit does not cover dental exams or eye exams. An Accident is not required for this benefit to be payable. This benefit is not payable for services performed as treatment for an Injury.

**Accidental Death and Dismemberment Benefit** The applicable benefits apply when an Accidental Death or Dismemberment occurs within 90 days of an Accident. In the event that Accidental Death and Dismemberment result from the same Accident, only the Accidental Death Benefit will be paid.

**Ambulance Benefit** If air and ground/water ambulance transportation is required for the same Accident, only the highest benefit will be paid.

**Anesthesia Benefit** Payable for the services of an anesthesiologist for a surgery performed due to an Accident. Hospital Confinement is not required to receive this benefit. We will only pay one Anesthesia Benefit per Person in a 24-hour period even if more than one surgical procedure is performed. This benefit is not payable for local anesthesia.

**Appliances Benefit** Payable for one of the following as prescribed by a Physician: wheelchair, motorized scooter, walker, walking boot, brace, cane, crutches, or any other medical device used for mobility. Not payable for Prosthetic Devices.

**Blood, Plasma and Platelets Benefit** Payable for blood, plasma and platelets. This benefit does not provide benefits for immunoglobulins.

**Burns Benefit** Payable for 2nd and 3rd degree burns when treated by a Physician within 3 days of the Accident.

**Coma Benefit** Must be diagnosed by a Physician and continue for at least 14 days. Coma does not include medically induced coma or a coma which results directly from alcohol or drug use.

**Concussion Benefit** Payable for a Person who sustains a concussion and is diagnosed by a Physician within 7 days of the Accident. If both a Concussion and a Traumatic Brain Injury occur in the same Accident, only the highest benefit will be paid.

**Dislocations Benefit** Amount payable varies by the joint involved, type of treatment, and type of anesthesia. If a Person receives more than one Dislocation in an Accident, we will pay for all Dislocations up to two times the amount shown in the Schedule of Benefits for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit. Benefits are payable only for the first dislocation of a joint which occurs while this policy is active.

**Emergency Dental Work Benefit** Payable for repair to natural teeth, free of decay, when treated by a Physician or dentist. Initial dental treatment must be received within 3 days of the Accident.

**Epidural Pain Management Benefit** Payable when a Person receives an epidural injection into the epidural space for management of pain due to an Injury. This benefit is not payable for an epidural administered before a surgical procedure.

**Exploratory Surgery Benefit** Payable when an exploratory surgical operation without surgical repair is performed.

**Eye Injury Benefit** Payable for one or both eyes requiring treatment by a Physician due to an Accident.

**Family Member Lodging and Meals Benefit** Payable for lodging and meals for a family member to be near a Person who is Hospital Confined in a non-local Hospital. The Hospital must be at least 50 miles away, one way, using the most direct route from the family member's residence.

**Fractures Benefit** Varies based on the bone involved, type of fracture and type of treatment. If the Person fractures more than one bone, payment is made for all fractures up to two times the amount for the bone involved that has the highest benefit amount.

**Gunshot Wound Benefit** Payable if gunshot wound does not cause Person to die; is caused by a shot from a Conventional Firearm; requires treatment by a Physician within 24 hours of Accident; and requires Confinement. If Dismemberment occurs, only the highest benefit will be paid. The Dismemberment must occur within 90 days after the Accident.

**Hospital Admission Benefit** Pays the first day a Person is Confined to a Hospital.

**Hospital Confinement Benefit** Pays a daily benefit for a Hospital Confinement up to 365 days. This benefit does not pay on the same day a Hospital Admission or ICU Admission benefit is paid.

**Intensive Care Unit (ICU) Admission Benefit** Pays the first day a Person is Confined to an ICU. If Hospital Admission and ICU Admission Benefits are payable for the same day, only the ICU Admission Benefit will be paid.

**Intensive Care Unit (ICU) Confinement Benefit** Pays a daily benefit for an ICU Confinement up to 30 days. This benefit does not pay on the same day a Hospital Admission or ICU Admission benefit is paid. This benefit is payable in addition to the Hospital Confinement Benefit.

**Internal Injuries Benefit** Payable for an open abdominal or thoracic surgery performed within 3 days of the Accident.

**Lacerations Benefit** This benefit varies based on the method of repair and total length of all lacerations due to an Accident.

**Medical Imaging Benefit** Payable for a Computerized Tomography (CT or CAT), Magnetic Resonance Imaging (MRI), Single-Photon Emission Computed Tomography (SPECT), Positron Emission Tomography (PET) or an ultrasound for diagnosing an Injury due to an Accident.

**Miscellaneous Surgery Benefit** Payable when a Person receives a surgery requiring general anesthesia due to an Accident that is not payable under any other benefit. Epidural injections are not paid under this benefit.

**Outpatient Hospital or Ambulatory Surgical Center Benefit** Pays when a surgical procedure is performed on an outpatient basis in a Hospital or Ambulatory Surgical Center. We will only pay one Outpatient Hospital or Ambulatory Surgical Center Benefit in a 24-hour period even if more than one surgical procedure is performed. This benefit will not be paid for surgery performed in an Emergency Room, Urgent Care Facility or in a Physician's Office.

**Paralysis Benefit** The duration of the Paralysis must be a minimum of 90 consecutive days. If more than one type of Paralysis occurs due to the same Accident, only the highest benefit will be paid. Paid once per lifetime per Person.

## Plan Benefit Highlights (cont.)

**Physical, Occupational, or Speech Therapy Benefit** Payable for one treatment per day for up to eight treatments by a licensed Physical, Occupational, or Speech Therapist for all therapies combined. If treatment in an Emergency Room, Physician's Office, or Urgent Care Facility occurs in the same visit, only the highest applicable benefit is payable.

**Prosthesis Benefit** Payable for up to two devices. This benefit is not payable for hearing aids; dental aids; eyeglasses; false teeth; cosmetic aids such as wigs; or joint replacements such as artificial hips or knees.

**Rehabilitation Benefit** Payable for each day a Person is an inpatient in a Rehabilitation Unit. The treatment must begin immediately after the date of discharge from the Hospital. This benefit is payable for up to 30 days. This benefit is not payable for any day for which a Hospital Admission, Hospital Confinement, ICU Admission, ICU Confinement, or Physical, Occupational, and Speech Therapy benefit is payable.

**Tendons, Ligaments and Rotator Cuff Benefit** Payable for the repair of one or more tendons, ligaments, or rotator cuffs. The tendons, ligaments, or rotator cuff must be repaired through surgery performed by a Physician, as a result of an Accident.

**Torn Knee Cartilage or Ruptured Disc Benefit** Payable for surgical repair as a result of an Accident.

**Transportation Benefit** Payable for the Person's transportation when specialized treatment and Hospital Confinement in a non-local Hospital is required. A non-local Hospital must be at least 50 miles away, one way, using the most direct route, from the Person's home. Travel must be by scheduled bus, plane, train, or by car. Ambulance service does not qualify for this benefit. The treatment must be prescribed by a Physician and not be available locally. This benefit is payable up to three round trips per Person per Accident. This benefit is not payable on any day that an Ambulance Benefit is payable.

**Traumatic Brain Injury (TBI) Benefit** Payable for a Person who is Confined for at least 48 hours as the result of a TBI. Diagnosis by a Physician and Confinement must occur within 3 days of the Accident. If both a TBI and Concussion occur in the same Accident, only the highest benefit will be paid.

**X-Ray Benefit** Payable once per day up to 2 days for an x-ray performed due to Injuries sustained in an Accident. The x-ray must be done at the request of a Physician. This benefit does not cover any tests payable under the Medical Imaging Benefit or any other screening or medical imaging tests.

## Limitations and Exclusions

No benefits will be provided for an Accident that is caused by or occurs as a result of:

(1) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
(2) participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft;
(3) any act that was caused by war, declared or undeclared, or service in any of the armed forces;
(4) participation in any activity or event while under the influence of any narcotic, drug, or controlled substance unless administered by a Physician or taken according to the Physician's instructions;
(5) voluntary ingestion, injection, inhalation or absorption of any narcotic, drug, controlled substance, poison, gas, or fume;
(6) participation in, or attempting to participate in, a felony, riot or insurrection. (A felony is as defined by the law of the jurisdiction in which the activity takes place.);
(7) participation in any sport for pay or profit; or sponsorship, in a professional or semi-professional capacity;
(8) treatment received outside the United States and its territories, Canada, or Mexico;
(9) participation in any contest of speed in a power driven vehicle for pay or profit;
(10) participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

Benefits will not be paid for services rendered by a member of the immediate family of a Person.

A Covered Accident is defined as an Injury caused by an Accident, for which benefits are provided, which is independent of any disease, illness, or bodily infirmity or any other cause and that takes place while the Person is covered under this policy.

A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Eligibility includes you, your lawful spouse and each natural, adopted or stepchild who is under 26 years of age.

**Guaranteed Renewable** You cannot be singled out for a rate increase for any reason. The Insurer has the right to increase premium rates only if rates for all policies in this class change.

**Termination Notice** Policy/rider(s) will terminate and coverage will end for all Covered Persons on the earliest of: the end of the grace period if the premium remains unpaid; or the end of the Policy/Rider(s) Month in which we receive a written request from you to terminate this policy/rider(s); or the date of your death, if this is an Individual Plan. If the plan is other than Individual, the remaining Covered Persons may have the right to continue or convert their coverage. Coverage for any Covered Person will terminate when they no longer meet the eligibility requirements.

*Underwritten by American Fidelity Assurance Company. This is a brief description of the coverage. This product contains limitations and exclusions. For complete benefits and other provisions, please refer to your policy, AO22. The premium and amount of benefits vary depending on the Plan level selected at the time of application. This coverage does NOT replace Workers' Compensation Insurance. Availability of riders may vary by employer.* ***This product is inappropriate for people who are eligible for Medicaid coverage.***


American Fidelity Assurance Company
**americanfidelity.com**

# Cancer C11 Individual Insurance

AMERICAN FIDELITY
a different opinion

## Focus on the fight.

A Cancer diagnosis may be both a physical and emotional drain. But thanks to advances in medicine and procedures to treat Cancer, more and more people are beating the disease. However, with the arrival of these advances also comes the continuing rise in the cost of Cancer treatment.

**Limited Benefit Individual Cancer Insurance** offers a solution to help you and your family focus on fighting the disease.

### Plan Highlights

- **Helps cover expenses**
  for the treatment of Cancer, transportation, hospitalization, and more.
- **Benefits paid directly to you**
  to be used however you see fit.
- **Portable to take with you**
  even if you leave employment.
- **Coverage options available**
  for you, your spouse, and your children under age 26.

## Cancer Insurance Benefits

With over 25 benefits specifically designed to help with the financial impact of being diagnosed, **Individual Cancer Insurance** may help pay for expenses not covered by your major medical insurance.

**Example Cancer insurance benefits include:**

### Experimental Treatment

This benefit may help pay for experimental treatment to give you alternatives in your healing. These treatment types may not be covered by major medical plans.

### Transportation and Lodging

This benefit may help pay for qualified transportation and lodging for the patient and family.

### SCREENING BENEFIT+

Receive a benefit for your annual internal Cancer screening test, including but not limited to mammogram, pap, prostate-specific antigen blood test (PSA), chest x-ray, flexible sigmoidoscopy, thinprep pap test, and colonoscopy.

| DIAGNOSTIC AND PREVENTION BENEFIT *(per calendar year)* | | |
|---|---|---|
| BASIC | ENHANCED | ENHANCED PLUS |
| $60 | $75 | $90 |

*+The premium and amount of benefits provided vary based upon the plan selected.*

# Benefits

| BENEFITS+ | BASIC | ENHANCED | ENHANCED PLUS |
|---|---|---|---|
| **SCREENING** | | | |
| **Diagnostic and Prevention Benefit** (one per calendar year) | $60 | $75 | $90 |
| **Cancer Screening Follow-Up Benefit** (one per calendar year) | $60 | $75 | $90 |
| **TREATMENT** | | | |
| **Radiation Therapy/Chemotherapy/ Immunotherapy Benefit** (per 12-month period) (Actual Charges) | up to $15,000 | up to $20,000 | up to $25,000 |
| **Medical Imaging Benefit** (per image - max 2 per calendar year) | $200 | $300 | $400 |
| **Hormone Therapy Benefit** (per treatment - max 12 treatments/ calendar year) | $50 | $50 | $50 |
| **Treatment Management/Lab Work Benefit** (per calendar month) | $75 | $100 | $125 |
| **Blood, Plasma, and Platelets Benefit** (per day)<br>(per calendar year max) | $150<br>$7,500 | $200<br>$10,000 | $250<br>$12,500 |
| **Experimental Treatment Benefit** | Paid as any non-experimental benefit | | |
| **Bone Marrow/Stem Cell Transplant Benefit**<br>**Autologous** (patient provided) (per calendar year)<br>**Non-autologous** (donor provided) (per calendar year) | <br>$1,000<br>$3,000 | <br>$1,500<br>$4,500 | <br>$2,000<br>$6,000 |
| **Donor Benefit** | $1,000 per donation | | |
| **Inpatient Special Nursing Services Benefit** (per day) | $150 | $150 | $150 |
| **Dread Disease Benefit**<br>(per day for the first 30 days per Hospital confinement)<br>(per day thereafter) | <br>$200<br>$400 | <br>$300<br>$600 | <br>$400<br>$800 |
| **HOSPITALIZATION** | | | |
| **Hospital Confinement Benefit*** (per day for the first 30 days)<br>(per day thereafter) | $200<br>$400 | $300<br>$600 | $400<br>$800 |
| **Drugs & Medicine Benefit**<br>**Hospital Confinement** (per confinement)<br>**Outpatient** (per prescription - $100 monthly max for basic; $150 for enhanced; $200 for enhanced plus per calendar month) | $200<br>$50 | $300<br>$50 | $400<br>$50 |
| **Attending Physician Benefit** (per day) | $40 | $50 | $60 |
| **U.S. Government/Charity Hospital or HMO Benefit** (per day in lieu of most benefits)<br>**Hospital Confinement**<br>**Outpatient Services** | <br>$200<br>$200 | <br>$300<br>$300 | <br>$400<br>$400 |

| BENEFITS+ | BASIC | ENHANCED | ENHANCED PLUS |
|---|---|---|---|
| **AMBULANCE, TRANSPORTATION, & LODGING** | | | |
| **Ambulance Benefit** (per trip - max 2 trips any combination per confinement)<br>**Ground**<br>**Air** | <br>$200<br>$2,000 | <br>$200<br>$2,000 | <br>$200<br>$2,000 |
| **Transportation & Lodging Benefit (Patient and/or Family)**<br>**Transportation** ($1,500 max per round trip; max 12 trips/calendar year) | Coach fare or $.50/mile by car | | |
| **Outpatient Lodging** (per day up to 90 days per calendar year) | $60 | $80 | $100 |
| **SURGICAL TREATMENT** | | | |
| **Surgical Benefit**<br>unit dollar amount (per surgical unit)<br>maximum per operation | <br>$30<br>$3,000 | <br>$40<br>$4,000 | <br>$50<br>$5,000 |
| **Anesthesia Benefit** | 25% of the amount paid for covered surgery | | |
| **Outpatient Hospital or Ambulatory Surgical Center Benefit** (per day) | $400 | $600 | $800 |
| **Second & Third Surgical Opinion Benefit** (per diagnosis) | $300 | $300 | $300 |
| **CONTINUING CARE** | | | |
| **Prosthesis Benefit**<br>**Non-Surgical** (per device - 1 per site, lifetime max of 3)<br>**Surgical Implantation** (per device, includes surgical fee - 1 per site, lifetime max of 2)<br>**Hair Prosthesis** (once per life) | <br>$150<br>$1,500<br>$150 | <br>$200<br>$2,000<br>$200 | <br>$250<br>$2,500<br>$250 |
| **Extended Care Facility Benefit** (per day for up to the same number of days of paid Hospital confinement) | $75 | $100 | $125 |
| **Physical or Speech Therapy Benefit** (per visit up to 4 per calendar month - lifetime max of $1,000) | $25 | $25 | $25 |
| **Hospice Care Benefit** (per day - $13,500 lifetime max for basic; $18,000 lifetime max for enhanced; $22,500 lifetime max for enhanced plus) | $75 | $100 | $125 |
| **Home Health Care Benefit** (per day for up to the same number of days of paid Hospital confinement) | $75 | $100 | $125 |
| **Waiver of Premium** (as long as the primary insured remains disabled) | after 90 continuous days of disability | | |

*Refer to Plan Benefit Highlights for more complete benefit descriptions and limits on the Individual Cancer insurance plan.*

*+The premium and amount of benefits provided vary based upon the plan selected.*

# Plan Benefit Highlights

| MONTHLY PREMIUMS+ | | | | |
|---|---|---|---|---|
| BASIC | Age 18-40 | Age 41-50 | Age 51-60 | Age 61+ |
| Individual | $16.30 | $23.60 | $32.60 | $44.20 |
| Single Parent Family | $24.40 | $35.20 | $48.70 | $65.90 |
| Family | $31.80 | $45.70 | $63.30 | $85.80 |

| ENHANCED | Age 18-40 | Age 41-50 | Age 51-60 | Age 61+ |
|---|---|---|---|---|
| Individual | $21.00 | $30.80 | $42.40 | $57.30 |
| Single Parent Family | $31.40 | $45.80 | $63.30 | $85.60 |
| Family | $40.80 | $59.50 | $82.30 | $111.30 |

| ENHANCED PLUS | Age 18-40 | Age 41-50 | Age 51-60 | Age 61+ |
|---|---|---|---|---|
| Individual | $25.80 | $38.10 | $52.70 | $71.00 |
| Single Parent Family | $38.50 | $56.80 | $78.60 | $106.00 |
| Family | $50.10 | $73.80 | $102.20 | $137.90 |

## Plan Benefit Highlights

**Only loss for Cancer or Dread Disease** The policy pays only for loss resulting from definitive Cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. The policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. The policy does not cover any other disease, sickness, or incapacity, even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically provided in the dread disease benefit.

**Cancer** means a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratosis; myelodysplastic and non–malignant myeloproliferative disorders; aplastic anemia; atypia; non–malignant monoclonal gammopathy; carcinoid; or pre–malignant lesions, benign tumors or polyps.

All diagnosis of Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. **Benefits under this policy pays the benefit amount shown per covered person due to a covered Cancer unless otherwise specified.**

**Diagnostic, Prevention and Cancer Screening Benefit** Pays for a generally medically recognized internal Cancer screening test when a charge is incurred for the test. Tests include but are not limited to mammogram, thinprep pap test, prostate-specific antigen blood test (PSA), colonoscopy, and chest x–ray. Refer to the policy for more examples. Screening tests payable under this benefit will ONLY be paid under this benefit and does not include any test payable under the medical imaging benefit. This benefit is available without a diagnosis of Cancer.

**Cancer Screening Follow-Up Benefit** Payable for one invasive follow–up screening test needed due to an abnormal result from a covered screening test. Diagnostic surgeries which result in a positive diagnosis of Cancer will be paid under the surgical benefit.

**Radiation/Chemotherapy/Immunotherapy Benefit** Pays the Actual Charges up to the maximum amount shown when radiation therapy, chemotherapy, or immunotherapy is received as defined in the policy, per 12-month period. The 12-month period begins on the first day the covered radiation therapy, chemotherapy, or immunotherapy is received. This benefit does not cover other procedures related to radiation/ chemotherapy/immunotherapy. This benefit does not include any drugs/ medicines covered under the drugs and medicine benefit or the hormone therapy benefit. Actual Charges means the amount actually paid by or on behalf of the insured person and accepted by the provider for services provided.

**Medical Imaging Benefit** Pays the indemnity amount for either an MRI; CT scan; CAT scan; or PET scan when performed at the request of a physician.

**Hormone Therapy Benefit** Drugs and medicines covered under the drugs and medicine benefit or the radiation/chemotherapy/immunotherapy benefit are not included. This benefit does not cover associated administrative processes.

**Treatment Management/Lab Work Benefit** Pays when procedures related to radiation therapy/chemotherapy/immunotherapy treatment occur and benefits are payable during the same calendar month as the radiation therapy/chemotherapy/immunotherapy benefit.

**Blood, Plasma and Platelets Benefit** Benefits for blood, plasma and platelets are only provided under this benefit. Laboratory processes and colony stimulating factors are not covered.

**Bone Marrow/Stem Cell Transplant Benefit** Harvesting of bone marrow or stem cells from a donor are not covered under this benefit.

**Hospital Confinement Benefit** Payable while confined to a Hospital for at least 18 continuous hours. *A Hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction. This benefit is not payable for outpatient treatment.

**Drugs and Medicine Benefit** Pays for anti-nausea and pain medication prescribed by a physician and administered while also receiving radiation therapy/chemotherapy/immunotherapy, a covered surgery, or a bone marrow/stem cell transplant. It does not include associated administrative processes or drugs or medicines covered under the radiation therapy/ chemotherapy/immunotherapy benefit or the hormone therapy benefit.

**Attending Physician Benefit** Pays for one physician's visit per day when the services of a physician, other than a surgeon, are required while confined in a Hospital.

**U.S. Government/Charity Hospital /HMO Benefit** Payable when an itemized list of services is not available due to confinement in a charity Hospital or a Hospital owned or operated by the U.S. government or covered under an HMO or diagnostic related group where no charges are made for treatment of Cancer or a covered dread disease. This benefit will be paid in lieu of most benefits covered under this policy.

**Ambulance Benefit** If air and ground ambulance services are both required on the same day, we will only pay the higher benefit amount. The covered person must be admitted as an inpatient and Hospital confined for at least 18 consecutive hours.

**Transportation and Lodging Benefits** Pays a benefit for transportation by scheduled bus, plane or train, or by car and outpatient lodging to receive radiation therapy, chemotherapy, or immunotherapy treatment, bone marrow or stem cell transplant, or surgery in a Hospital not available locally and at least 50 miles from the covered person's residence. Payable for the covered person and one adult family member. If traveling in the same car or lodging in the same room, the benefit is payable only for the covered person. Travel must be within the United States or its Territories.

**Surgical Benefit** Payable when a surgical operation is performed for covered diagnosed Cancer, skin Cancer, or reconstructive surgery due to Cancer. Benefits are calculated up to a maximum benefit by multiplying the surgical unit value assigned to the procedure, as shown in the most current physician's relative value table, by the unit dollar amount shown in the policy. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Bone marrow surgeries, surgeries to implant a permanent prosthetic device, are not covered under this benefit.

## Plan Benefit Highlights (cont.)

**Anesthesia Benefit** Services of an anesthesiologist for bone marrow transplants, skin Cancer or surgical prosthesis implantation are not covered.

**Outpatient Hospital or Ambulatory Surgical Center Benefit** Surgical procedures for skin Cancer are not covered.

**Second and Third Surgical Opinion Benefit** Payable once per diagnosis of Cancer for a second surgical opinion, and a third if the second disagrees with the first. Surgical opinions for reconstructive, skin Cancer, or prosthesis surgeries are not covered.

**Prosthesis Benefit** Payable for a prosthetic device and, if surgery required, its surgical implantation. Prosthetic related supplies such as special bras or ostomy pouches and supplies are not covered. **Hair Prosthesis Benefit** is payable once per covered person per lifetime when a hair prosthesis is needed.

**Extended Care Facility Benefit** Pays for physician authorized confinement that begins within 14 days after a Hospital confinement.

**Physical or Speech Therapy Benefit** Therapy must be provided by a caregiver licensed in physical or speech therapy.

**Hospice Care Benefit** Payable when a physician determines terminal illness with life expectancy of 6 months or less and approves hospice care at home or in a hospice facility. This benefit does not include well baby care, volunteer services, meals, housekeeping services, or family support after the death.

**Home Health Care Benefit** Pays for physician authorized private nursing care that begins within 14 days of a hospital confinement. This benefit does not include nutrition counseling, medical social services, medical supplies, prosthesis or orthopedic appliances, rental or purchase of durable medical equipment, drugs or medicines, child care, meals or housekeeping services, or physical or speech therapy. The service must be provided by a nurse or home health nurse's aid and can not be a family member.

**Waiver of Premium Benefit** If the primary insured becomes disabled due to Cancer and remains so for more than 90 continuous days, we will pay all premiums for policy and rider(s) due after the 90th day so long as the primary insured remains disabled. "Disabled" means the primary insured's inability because of Cancer: to work at any gainful job for which (s)he is qualified by education, training or experience; and under the care of a physician for the treatment of Cancer. The policy must be in force at the time disability begins and the primary insured must be under age 65.

**Experimental Treatment Benefit** Benefits for experimental treatment prescribed by a physician for treatment of Cancer will be provided the same as non-experimental treatment. Coverage for treatments received outside of the United States or its territories is not provided.

**Donor Benefit** Pays if a donor incurs expenses on behalf of a covered person for a covered surgery due to organ transplant or a bone marrow/ stem cell transplant. Blood donor expenses are not covered under this benefit.

**Dread Disease Benefit** Covered dread diseases are: addison's disease; amyotrophic lateral sclerosis; cystic fibrosis; diphtheria; encephalitis; grand mal epilepsy; legionnaire's disease; meningitis; multiple sclerosis; muscular dystrophy; myasthenia gravis; niemann-pick disease; osteomyelitis; poliomyelitis; reye's syndrome; rheumatic fever; rocky mountain spotted fever; sickle cell anemia; systemic lupus erythematosus; tay-sach's disease; tetanus; toxic epidermal; toxic shock syndrome; tuberculosis; tularemia; typhoid fever; whipple's disease.

**Inpatient Special Nursing Services Benefit** Pays when Hospital confined and receiving physician authorized special nursing care (other than that regularly furnished by a Hospital) of at least 8 consecutive hours during a 24 hour period.

*See your policy for more information regarding the benefits listed above.*

**Eligibility** The policy/rider(s) will be issued only to those persons who meet American Fidelity's insurability requirements, which includes satisfactory responses to medical questions. You, your lawful spouse and each natural, adopted or step child who is under 26 years of age are eligible to apply for coverage.

**Limitations and Exclusions** The policy does not cover any other disease, sickness or incapacity even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically stated in the dread disease benefit.

**Pre-Existing Condition** A Pre-Existing Condition is a Cancer or dread disease for which, within 12 months prior to the effective date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession; or which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice, or treatment. Pre–Existing Conditions specifically named or described as excluded in any part of the policy are never covered. No benefits are payable for any covered person for any loss incurred during the first year of the policy as a result of a Pre–Existing Condition.

**Termination of Insurance** Policy/rider(s) will terminate and coverage will end on the earliest of: the end of the grace period if the premium remains unpaid; or the end of the policy/rider(s) month in which we receive a written request from you to terminate the policy/rider(s); or the date of your death, if this is an Individual Plan. If the plan is other than individual the remaining covered persons may have the right to continue or convert their coverage. Coverage will terminate when they no longer meet the eligibility requirements.

For the spouse, policy/rider(s) will terminate and coverage will end on the earliest of: The end of the policy/rider(s) month in which we receive a written request from you to delete the spouse from the policy/rider(s); the end of the premium term in which a divorce, annulment, legal separation is obtained; or upon their death.

For the child(ren), policy/rider(s) will terminate and coverage will end the earliest of: The end of the policy/rider(s) month in which we receive a written request from you to delete the child(ren) from the policy/rider(s); or upon their death.

**Guaranteed Renewable** You are guaranteed the right to renew your policy/rider(s) during your lifetime as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

*This product may contain limitations, exclusions, and waiting periods.* ***This product is inappropriate for people who are eligible for Medicaid coverage****.*

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SB-30641(TN)(AFES)-0723

Policy Form Series C11
Plan Codes 013-746, 013-747, 013-748

# Enhance Your Plan+,++

## Critical Illness Rider

| SCHEDULE OF BENEFITS | |
|---|---|
| **Cancer Benefit**<br>*per unit - maximum $10,000* | $2,500 |
| **Heart Attack/Stroke Benefit**<br>*per unit - maximum $10,000* | $2,500 |

### Summary of Critical Illness Rider Benefits:

- Pays when diagnosed by a Physician after a 30-day Critical Illness Waiting Period with Internal Cancer or Heart Attack/ Stroke, depending upon the Critical Illness coverage elected at time of application.
- Pays the specified Maximum Benefit Amount per Covered Critical Illness, as defined under this rider.
- Each benefit is a one-time paid benefit.
- All Critical Illness amounts reduce by 50% at age 70.

# Optional Benefit Rider Monthly Premiums++

## Critical Illness Rider Monthly Premiums

| CANCER ONLY | $2,500 | | | $5,000 | | | $7,500 | | | $10,000 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family |
| Age 18-40 | $1.50 | $2.20 | $2.90 | $3.00 | $4.40 | $5.80 | $4.50 | $6.60 | $8.70 | $6.00 | $8.80 | $11.60 |
| Age 41-50 | $3.00 | $4.50 | $5.80 | $6.00 | $9.00 | $11.60 | $9.00 | $13.50 | $17.40 | $12.00 | $18.00 | $23.20 |
| Age 51-60 | $4.90 | $7.30 | $9.40 | $9.80 | $14.60 | $18.80 | $14.70 | $21.90 | $28.20 | $19.60 | $29.20 | $37.60 |
| Age 61+ | $7.10 | $10.60 | $13.80 | $14.20 | $21.20 | $27.60 | $21.30 | $31.80 | $41.40 | $28.40 | $42.40 | $55.20 |

| HEART ATTACK/ STROKE ONLY | $2,500 | | | $5,000 | | | $7,500 | | | $10,000 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family | Ind | 1 Parent Family | 2 Parent Family |
| Age 18-40 | $0.80 | $1.20 | $1.50 | $1.60 | $2.40 | $3.00 | $2.40 | $3.60 | $4.50 | $3.20 | $4.80 | $6.00 |
| Age 41-50 | $2.10 | $3.10 | $4.10 | $4.20 | $6.20 | $8.20 | $6.30 | $9.30 | $12.30 | $8.40 | $12.40 | $16.40 |
| Age 51-60 | $3.10 | $4.60 | $6.00 | $6.20 | $9.20 | $12.00 | $9.30 | $13.80 | $18.00 | $12.40 | $18.40 | $24.00 |
| Age 61+ | $4.60 | $6.90 | $8.90 | $9.20 | $13.80 | $17.80 | $13.80 | $20.70 | $26.70 | $18.40 | $27.60 | $35.60 |

*+Availability of riders may vary by state and employer. Optional benefit rider are subject to our general underwriting guidelines and coverage is not guaranteed.*
*++The premium and amount of benefits provided vary based upon the plan selected.*

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## Critical Illness Rider

**Limitations and Exclusions** Benefits will only be paid for a Covered Critical Illness as shown on the Policy Schedule page in the policy. No benefits will be provided for any loss caused by or resulting from: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; or intentional self-injury; or alcoholism or drug addiction; or any war or act of war or any act related to war; or military service for any country at war; or a Pre-Existing Condition during the 12 month period following the Covered Person's Effective Date under the rider; or a Covered Critical Illness when the Date of Diagnosis occurs during the Waiting Period; or participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.) Critical Illness Waiting Period will not exceed 30 days. All Critical Illness amounts reduce by 50% at age 70.

**Pre-Existing Condition** As used in the rider means any sickness or condition for which, within 12 months prior to the Effective Date of coverage under the rider, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or for which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice or treatment. Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: Acquired immune deficiency syndrome (AIDS); or Actinic keratosis; or Myelodysplastic and non-malignant myeloproliferative disorders; or Aplastic anemia; or Atypia; or Non-malignant monoclonal gammopathy; or Pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or Cancer in situ or any skin Cancer other than invasive malignant melanoma into the dermis or deeper. Heart Attack does not include congestive heart failure, atherosclerotic heart disease, angina, including unstable angina, coronary disease or any other dysfunction of the cardiovascular system. Stroke does not mean a head injury, transient ischemic attack, multi-infarct dementia, or chronic cerebrovascular insufficiency.

**Waiting Period** Pays when diagnosed by a Physician after a 30-day Critical Illness Waiting Period with Internal Cancer or Heart Attack/Stroke, depending upon the Critical Illness coverage elected at time of application.

**Termination** Each Covered Person's coverage will terminate when the maximum benefit amount for the Covered Critical Illness(es) has been paid for him/her.

This insert must be used in conjunction with SB-30643 or SB-30641 and any state specific deviations thereof.

*This is a brief description of the coverage. For complete benefits and other provisions, please refer to the policy and rider. This coverage does not replace Workers' Compensation Insurance.* ***These products are inappropriate for people who are eligible for Medicaid Coverage.***

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SB-32507(TN)(AFES)-1219

Policy Form Series AMDI239
Plan Code 013-776 and 013-777

# Limited Benefit Critical Illness Insurance

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## Surviving a critical illness may come at a high price.

If you experience a critical illness—like a heart attack or stroke—you shouldn't have to worry about the financial impact. But co-pays, transportation expenses, out-of-pocket medical costs, and lost income can add up quickly.

**Limited Benefit Critical Illness Insurance** can help provide financial protection so you can focus on recovery.

**Approximately every 40 seconds, someone in the United States will have a heart attack.[1]**

## How It Works

If you're diagnosed with a covered critical illness, this plan is designed to pay a lump sum benefit amount to help cover expenses. In addition, certain specified critical illnesses that reoccur will allow for an additional benefit.

**Features:**

- Benefits paid directly to you, to be used however you see fit
- No required medical exams as part of the application process
- Guaranteed issue benefit amounts may be available for first-time eligible employees and spouse
- Coverage extended to dependent children at no additional cost
- Compatible with a Health Savings Account
- Option to add an infectious disease rider in select states

Coverage is available for you, and your children, and your lawful spouse at determined benefit amounts.

## HEALTH SCREENING BENEFIT

**This benefit covers several qualified tests, including, but not limited to:**

- Stress Test
- Echocardiogram
- Electrocardiogram (EKG)
- Blood Glucose Testing
- Neuroimaging Studies

| SCREENING BENEFIT *(per calendar year per covered person)* | $50 |
|---|---|

***Policy provisions and benefits may vary if you reside in a state other than your employer's state of domicile.***

*[1]American Heart Association: 2022 Heart Disease and Stroke Statistics Update Fact Sheet At-a-Glance; January 24, 2022, p2.*

# Plan Benefit Highlights

## Schedule of Benefits

Depending on the plan selected by your employer, the following benefit amounts may be available. The employee benefit amounts can range from $10,000, $20,000 or $30,000. Eligible children will be automatically covered at 25% of the employee's benefit amount at no additional cost. If elected, spousal benefit amounts will be 50% of the employee benefit amount.

### CRITICAL ILLNESS BENEFITS

**Pays once per covered person for each critical illness shown below.**

| | Benefit Percentage | Recurrent Diagnosis Benefit |
|---|---|---|
| **Heart Attack Benefit**<br>Pays full lump sum benefit amount. | 100% | 50% |
| **Coronary Artery Bypass Surgery Benefit**<br>Pays 25% of benefit amount. Payment will reduce the Heart Attack Benefit. No payment if the Heart Attack Benefit has been paid. | 25% | - |
| **Stroke Benefit (Permanent damage due to a Stroke)**<br>Pays full lump sum benefit amount. | 100% | 50% |
| **Paralysis Benefit (Permanent due to a covered accident)**<br>Pays full lump sum benefit amount. | 100% | - |
| **Major Organ Failure Benefit**<br>Pays full lump sum benefit amount. | 100% | 50% |
| **End Stage Renal Failure Benefit**<br>Pays full lump sum benefit amount. | 100% | - |

### EMPLOYEE MONTHLY PREMIUMS*

| | $10,000 | | $20,000 | | $30,000 | |
|---|---|---|---|---|---|---|
| *AGE* | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| *18-29* | $3.78 | $5.98 | $6.14 | $10.54 | $8.50 | $15.10 |
| *30-39* | $5.94 | $9.42 | $10.46 | $17.42 | $14.98 | $25.42 |
| *40-49* | $10.82 | $17.06 | $20.22 | $32.70 | $29.62 | $48.34 |
| *50-59* | $17.78 | $28.18 | $34.14 | $54.94 | $50.50 | $81.70 |
| *60 & Over* | $29.14 | $46.14 | $56.86 | $90.86 | $84.58 | $135.58 |

### SPOUSE MONTHLY PREMIUMS*

| | $5,000 | | $10,000 | | $15,000 | |
|---|---|---|---|---|---|---|
| *AGE* | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| *18-29* | $2.28 | $3.96 | $3.14 | $6.50 | $4.00 | $9.04 |
| *30-39* | $3.56 | $6.24 | $5.70 | $11.06 | $7.84 | $15.88 |
| *40-49* | $6.50 | $11.36 | $11.58 | $21.30 | $16.66 | $31.24 |
| *50-59* | $10.74 | $18.74 | $20.06 | $36.06 | $29.38 | $53.38 |
| *60-69* | $17.58 | $30.70 | $33.74 | $59.98 | $49.90 | $89.26 |

**The premium and benefits vary depending upon the amount selected at the time of application.*

# Plan Benefit Highlights

**Effective Date**

Certificates will become effective on the requested effective date following the date we approve the application, providing you are on active employment and premium has been paid.

**Health Screening Benefit**

Pays $50 when a covered employee or covered spouse receives a covered Health Screening Test. This benefit covers several qualified tests, including, but not limited to: blood test for triglycerides, doppler ultrasound, echocardiogram, electrocardiogram (EKG), fasting blood glucose test, serum cholesterol test to determine HDL and LDL levels, exercise or pharmacologic stress test, and neuroimaging studies. This policy pays for one test per covered employee and one test per covered spouse per calendar year, regardless of the number of tests received during the calendar year. This benefit is available without a diagnosis of a critical illness. This benefit does not reduce the critical illness lump sum benefit amount.

**Critical Illness Benefit**

Pays once per covered person for each critical illness. Each critical illness must be separated by at least 30 days following the first critical illness occurrence date.

**Heart Attack Benefit**

Pays following a Heart Attack due to coronary artery disease. Any previous amounts paid for a coronary artery bypass surgery will be deducted from the amount payable under this benefit.

***Heart Attack*** means an acute myocardial infarction due to coronary artery disease resulting in the death of a portion of the heart muscle. Diagnosis must be supported by the onset of new symptoms and any of the following: EKG changes, the elevation of biochemical markers, or imaging studies consistent with acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation, or death certificate identifying Heart Attack will be acceptable. Heart Attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system.

**Coronary Artery Bypass Surgery Benefit**

Pays following open heart surgery performed by a physician to correct coronary artery disease with bypass grafts. Coronary artery bypass surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than coronary artery bypass surgery.

**Stroke Benefit (Permanent Damage Due To A Stroke)**

Pays following permanent neurological damage to the brain due to a stroke that results from an acute or sub-acute interruption of blood flow to brain tissue as defined in the policy. Permanent damage due to a stroke does not include transient ischemic attacks (TIA).

**Paralysis Benefit (Permanent Due To A Covered Accident)**

Injuries to the spinal cord due to a covered accident, which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

**Major Organ Failure Benefit**

Pays following the date the covered person is placed on the United Network for Organ Sharing (UNOS) list for a transplant of the heart, liver, lung, or entire pancreas.

**End Stage Renal Failure Benefit**

Pays following the occurrence date of end stage renal failure resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

**Recurrent Diagnosis Benefit**

Upon a second occurrence of certain specified critical illnesses, this benefit pays 50% of the amount previously paid under the policy. Covered critical illness events include Heart Attack, permanent damage due to a stroke, and major organ failure. The second occurrence date must be separated by at least 180 days following the first occurrence date of that same critical illness. Once a Recurrent Diagnosis Benefit has been paid for a critical illness, no further benefits for that same critical illness will be payable.

## Limitations and Exclusions

### Pre-Existing Condition Limitation

No Critical Illness Benefit will be payable for a critical illness caused by or resulting from a Pre-Existing Condition when the critical illness occurrence date occurs before a covered person has been continuously covered under the policy for 12 consecutive months.

***Pre-Existing Condition*** means a disease, accident, sickness, physical condition or mental illness for which a covered person has experienced any of the following: (a) treatment; (b) incurred expense; (c) took medication; (d) received care or services including diagnostic testing or related measures; or (e) received a diagnosis or advice from a physician, during the 12-month period immediately before the covered person's effective date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, accident, sickness, physical condition or mental illness.

### Exclusions

We will not pay benefits for any critical illness resulting from or caused, directly or indirectly, by: (a) an intentionally self-inflicted accident or sickness; (b) suicide or attempted suicide while sane or insane; (c) participating in riots, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss while acting lawfully within the scope of authority; (d) being intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions. Intoxication is determined and defined by the laws and jurisdiction of the geographical area where the event that caused the critical illness occurred; (e) committing or attempting to commit a felony; (f) being incarcerated in any type of penal institution; (g) alcoholism or drug addiction; (h) a diagnosis received outside the United States, or its territories, that cannot be confirmed by a physician licensed and practicing in the United States.

### Portability

Upon becoming no longer eligible for coverage, you will have 30 days to request continuation of coverage. Providing you pay premiums when due, you may be provided coverage under your certificate upon leaving employment until the earliest of these dates: (a) your 75th birthday; (b) 10 years from the portability effective date; (c) the date the policy is terminated; or (d) the date you fail to pay the required premium. You must have been continuously covered for 12 consecutive months before the date your coverage under the policy ends. Portability is not applicable to dependents.

### Leave of Absense

Your coverage may be continued for up to one year during a leave of absence approved in writing by your employer.

### Termination of Coverage

Coverage will continue as long as the group policy remains in force, the premiums are paid, and you remain eligible for coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, or your employment terminates. Coverage for any dependent children will end when your coverage terminates or they no longer meet the definition of a dependent child. Coverage for your covered spouse will end on the earliest of: the date your coverage terminates, the end of the premium term in which they no longer meet the definition of a covered spouse, or the date you or your spouse turn 75. Your coverage can be terminated, or premiums may be increased on any premium due date with 31 days advance notice.

*This product contains limitations, exclusions, and waiting periods.* ***This product is inappropriate for people who are eligible for Medicaid coverage.*** *This brochure highlights important features of the policy. Please refer to your certificate for complete details.*


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# Protection for the Unexpected

Being diagnosed with an infectious disease can be unsettling, but you might rest a little easier knowing you have coverage with the **Infectious Disease Benefit Rider**. Benefits are paid directly to you and may help ease the financial pressures from a diagnosis.

## How It Works

If diagnosed with one of the covered infectious diseases below and hospitalized for a minimum of 7 days with that disease, the following benefits may be payable:

- Your Infectious Disease Benefit is **50%** of your Critical Illness Benefit. Coverage extends to your eligible children at **25%** of your Infectious Disease Benefit amount.
- Your spouse's Infectious Disease Benefit, if covered, will be **50%** of their Critical Illness Benefit amount.

## Did you know?


**47,039,749 COVID cases** were reported in the U. S. during 2022.[1]

*[1] CDC Centers for Disease Control and Prevention: COVID Data Tracker; Accessed from covid.cdc.gov on January 5, 2023.*

## What's Covered

This benefit is paid to you based on a diagnosis of any of the following infectious diseases:

- Anthrax
- Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Bacterial Cerebrospinal Meningitis
- Osteomyelitis
- Botulism
- Pertussis (Whooping Cough)
- Cholera
- Poliomyelitis
- COVID-19
- Q Fever
- Dengue Fever
- Rabies
- Diphtheria
- Rocky Mountain Spotted Fever
- Encephalitis
- Sepsis
- Hansen's Disease
- Tetanus
- Hepatitis B or C
- Trichinosis
- Histoplasmosis
- Tuberculosis
- Human Immunodeficiency Virus (HIV)
- Tularemia
- Legionnaire's Disease
- Typhoid Fever
- Malaria

*Availability of this rider may vary by state. Refer to your policy for complete details.* ***This flyer must be used in conjunction with a G925 brochure.*** *The rider will terminate on the same date as the policy or certificate to which it is attached.*

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## Limitations

For benefits to be payable, the covered person must be admitted as a patient to a Hospital and charged for room and board facilities. ***Hospital*** shall not include an institution used by the covered person as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

- The covered infectious disease must be diagnosed after the covered person's effective date.
- The Infectious Disease Benefit will only be paid once per covered infectious disease, per covered person, per lifetime.
- Any infectious disease not explicitly listed in your policy document isn't payable under this rider.
- If two or more covered infectious diseases are diagnosed at the same time, benefits will only be paid for the disease that occurred first.
- The benefit amount will be paid after diagnosing a covered infectious disease, and a minimum hospitalization of 7 consecutive days with that infectious disease.
- The benefit amount will be paid to your beneficiary if:
  - You are diagnosed with a covered infectious disease, and you are hospitalized as an inpatient but pass away from the diagnosed infectious disease before the minimum hospitalization period of 7 consecutive days.

## Pre-Existing Conditions

No Infectious Disease Benefit will be payable for an infectious disease caused by or resulting from a Pre-Existing Condition when the infectious disease occurrence date occurs before the covered person has been continuously covered under this rider for 12 consecutive months.

***Pre-Existing Condition*** means a disease, accident, sickness, physical condition or mental illness for which a covered person has experienced any of the following: treatment; incurred expense; took medication; received care or services including diagnostic testing or related measures; or received a diagnosis or advice from a physician, during the 12-month period immediately before the covered person's effective date of coverage under this rider.

The term Pre-Existing Condition also includes conditions related to such disease, accident, sickness, physical condition, or mental illness.

| | Monthly Premiums |
|---|---|
| Individual per **$1000** benefit amount<br>Children per **$250** benefit amount | **$1** |
| Spouse per **$1000** benefit amount | **$1** |

## Termination

Your coverage will end on the earliest of these dates.

- The end of the last period for which premium has been paid.
- The date you notify us in writing to terminate coverage.
- The end of the month following your 75th birthday.
- The date the rider is discontinued.
- The date the policy is discontinued.
- The date your employment terminates.

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AF-1761-0223

# Plan Today for Tomorrow's Costs

With medical costs continuing to rise, you may be looking for options to help manage out-of-pocket medical expenses.

One option is a Healthcare Flexible Spending Account (HCFSA). HCFSAs allow you set aside money, tax free, for eligible medical costs like doctor visits, prescription drugs, prescription contact lenses, and dental procedures. Additionally, the entire amount you choose to contribute will be available to you at the beginning of your plan year.

## Savings Example

In the example to the right, Jane makes $4,000 per month. By participating in an HCFSA, she would save $82.96 a month.

**That's a savings of $995.52 a year.**

To calculate your possible savings, visit:
**americanfidelity.com/s125-calculator**

| Earnings & Taxes | Without FSA | With FSA |
|---|---|---|
| ***Gross Pay*** | $4,000 | $4,000 |
| Health Insurance | -$300 | -$300 |
| HCFSA Contribution | *N/A* | -$300 |
| ***Taxable Income*** | ***$3,700*** | ***$3,400*** |
| Estimated Taxes (Federal & State @ 20%) | -$740 | -$680 |
| Estimated FICA (7.65%) | -$283.05 | -$260.10 |
| Out-of Pocket Medical Expenses | -$300 | *N/A* |
| ***Take Home Pay*** | ***$2,376.95*** | ***$2,459.90*** |

*Example is for illustrative purposes only. Please consult your tax advisor for actual tax savings.*

## How It Works

### Paying Out of Pocket


**Make** an eligible medical purchase

**Snap** a photo of itemized document(s)

**Submit** claim and documentation via AFmobile or your online account

**Receive** funds via direct deposit*

### Paying with your Benefits Debit Card**


**Make** an eligible purchase with card

**Snap** a photo of itemized document(s)

**Submit** documentation electronically, if requested

**americanfidelity.com/fileaclaim**

** Funds deposit within 3-5 business days after claim approval.*
*** If your employer has elected to provide a Benefits Debit Card, you may use this card to pay for eligible medical expenses or pay out of pocket and file a claim for reimbursement.*

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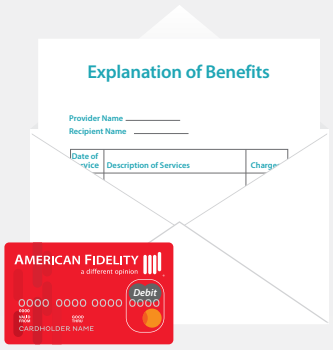
## Using Your Benefits Debit Card

A Benefits Debit Card allows you to pay for eligible medical expenses using the funds in your HCFSA. The card may be used at locations that accept Mastercard® and have been identified as authorized medical merchants.

If you receive a documentation request letter, submit a picture of your itemized document or Explanation of Benefits (EOB) through your online account at **americanfidelity.com/submit-fsa** or through our mobile app, AFmobile®.

Learn more about your debit card at:
**americanfidelity.com/debit-card**




### Documentation must include:

1. Provider Name
2. Recipient Name
3. Date of Service
4. Description of Service
5. Charges

## Internal Revenue Code (IRC) Requirements: What You Need to Know

IRC guidelines are strict when tax breaks are provided. As your plan provider, we are required to follow IRC rules.

### First, the money you set aside operates under a "use or lose" system.

That means you'll want to use all of your funds prior to the next plan year or you will lose whatever amount is left.

Ask if your employer's plan includes a Runoff Period and Carryover Provision or Grace Period.

- **Runoff Period**
  A period typically up to 90 days after the plan year ends when you can submit claims incurred during the previous plan year that have not already been submitted for reimbursement.
- **Carryover Provision**
  For 2023, this provision allows you to carry over up to $610 of unused contributions from one plan year to the next.
- **Grace Period**
  An additional two and a half months following the end of the plan year in which you can incur and submit claims to receive reimbursement.

### Second, the IRC requires proof for eligible expenses.

An itemized document or EOB must be submitted to prove eligibility for medical expenses when they aren't verified when filing a claim or at the time of debit card swipe. Submitting documentation through AFmobile is the easiest way to validate a claim.

## Spend Smart & Save on Eligible Medical Expenses

| | | | |
|---|---|---|---|
| Copays/Co-insurance | Prescription contacts | Chiropractic care | Deductibles |
| Physical exams | Asthma treatments | Eye exams/eyeglasses | Over-the-counter medicine |
| Prenatal care | Laser eye surgery | Physical therapy | Menstrual products |

**Discover more ways to spend at americanfidelity.com/eligible-expenses**

American Fidelity Assurance Company
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AF-1473-1022

# AF™ Short-Term Disability Income Insurance

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EMPLOYER BENEFIT SOLUTIONS
FOR YOUR INDUSTRY

## Focus on Recovery, Not Expenses

How would you cover your everyday expenses if you experienced an Injury or Sickness and couldn't work for a period of time? AF™ **Short-Term Disability Income Insurance** provides a steady benefit to cover everyday expenses while you are unable to work due to a covered Disability.

## Plan Highlights

### Benefits are Payable Directly to You

You have the freedom to use the funds for your daily expenses such as: groceries, mortgage, daycare, etc.

### Customized to Meet Your Individual Needs

You can select a benefit amount and elimination period that best meets your financial needs.

## Choose the Right Plan for You

| BENEFITS BEGIN | |
|---|---|
| Plan I | On the 1st day of Disability due to a covered Injury and on the 8th day of Disability due to a covered Sickness. |

***Injury*** means physical harm or damage to the body you sustained which results directly from an accidental bodily Injury, is independent of disease or bodily infirmity; and takes place while your coverage is active.

***Sickness*** means a disease or illness (including pregnancy). Disability must begin while your coverage is active.

***Hospital*** - the term "Hospital" shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

***Disability*** or disabled means that you are unable to perform the material and substantial duties of your regular occupation.

# Benefit Policy Schedule

Several benefit options are available to you. You may participate in the plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 60% of your monthly compensation.

| | | | | Monthly Premiums |
|---|---|---|---|---|
| Monthly Salary | Monthly Disability Benefit | Hospital Confinement Benefit | Accidental Death Benefit | 1st/8th |
| $334.00 - $499.99 | $200.00 | $400.00 | $10,000.00 | $7.00 |
| $500.00 - $666.99 | $300.00 | $600.00 | $10,000.00 | $10.50 |
| $667.00 - $833.99 | $400.00 | $800.00 | $10,000.00 | $14.00 |
| $834.00 - $999.99 | $500.00 | $1,000.00 | $10,000.00 | $17.50 |
| $1,000.00 - $1,166.99 | $600.00 | $1,200.00 | $10,000.00 | $21.00 |
| $1,167.00 - $1,333.99 | $700.00 | $1,400.00 | $10,000.00 | $24.50 |
| $1,334.00 - $1,499.99 | $800.00 | $1,600.00 | $10,000.00 | $28.00 |
| $1,500.00 - $1,666.99 | $900.00 | $1,800.00 | $10,000.00 | $31.50 |
| $1,667.00 - $1,833.99 | $1,000.00 | $2,000.00 | $10,000.00 | $35.00 |
| $1,834.00 - $1,999.99 | $1,100.00 | $2,200.00 | $10,000.00 | $38.50 |
| $2,000.00 - $2,166.99 | $1,200.00 | $2,400.00 | $10,000.00 | $42.00 |
| $2,167.00 - $2,333.99 | $1,300.00 | $2,600.00 | $10,000.00 | $45.50 |
| $2,334.00 - $2,499.99 | $1,400.00 | $2,800.00 | $10,000.00 | $49.00 |
| $2,500.00 - $2,666.99 | $1,500.00 | $3,000.00 | $10,000.00 | $52.50 |
| $2,667.00 - $2,833.99 | $1,600.00 | $3,200.00 | $10,000.00 | $56.00 |
| $2,834.00 - $2,999.99 | $1,700.00 | $3,400.00 | $10,000.00 | $59.50 |
| $3,000.00 - $3,166.99 | $1,800.00 | $3,600.00 | $10,000.00 | $63.00 |
| $3,167.00 - $3,333.99 | $1,900.00 | $3,800.00 | $10,000.00 | $66.50 |
| $3,334.00 - $3,499.99 | $2,000.00 | $4,000.00 | $10,000.00 | $70.00 |
| $3,500.00 - $3,666.99 | $2,100.00 | $4,200.00 | $10,000.00 | $73.50 |
| $3,667.00 - $3,833.99 | $2,200.00 | $4,400.00 | $10,000.00 | $77.00 |
| $3,834.00 - $3,999.99 | $2,300.00 | $4,600.00 | $10,000.00 | $80.50 |
| $4,000.00 - $4,166.99 | $2,400.00 | $4,800.00 | $10,000.00 | $84.00 |
| $4,167.00 - $4,333.99 | $2,500.00 | $5,000.00 | $10,000.00 | $87.50 |
| $4,334.00 - $4,499.99 | $2,600.00 | $5,200.00 | $10,000.00 | $91.00 |
| $4,500.00 - $4,666.99 | $2,700.00 | $5,400.00 | $10,000.00 | $94.50 |
| $4,667.00 - $4,833.99 | $2,800.00 | $5,600.00 | $10,000.00 | $98.00 |
| $4,834.00 - $4,999.99 | $2,900.00 | $5,800.00 | $10,000.00 | $101.50 |
| $5,000.00 - $5,166.99 | $3,000.00 | $6,000.00 | $10,000.00 | $105.00 |
| $5,167.00 - $5,333.99 | $3,100.00 | $6,200.00 | $10,000.00 | $108.50 |
| $5,334.00 - $5,499.99 | $3,200.00 | $6,400.00 | $10,000.00 | $112.00 |
| $5,500.00 - $5,666.99 | $3,300.00 | $6,600.00 | $10,000.00 | $115.50 |
| $5,667.00 - $5,833.99 | $3,400.00 | $6,800.00 | $10,000.00 | $119.00 |
| $5,834.00 - $5,999.99 | $3,500.00 | $7,000.00 | $10,000.00 | $122.50 |
| $6,000.00 - $6,166.99 | $3,600.00 | $7,200.00 | $10,000.00 | $126.00 |
| $6,167.00 - $6,333.99 | $3,700.00 | $7,400.00 | $10,000.00 | $129.50 |
| $6,334.00 - $6,499.99 | $3,800.00 | $7,600.00 | $10,000.00 | $133.00 |

# Benefit Policy Schedule (continued)

| | | | | Monthly Premiums |
|---|---|---|---|---|
| Monthly Salary | Monthly Disability Benefit | Hospital Confinement Benefit | Accidental Death Benefit | 1st/8th |
| $6,500.00 - $6,666.99 | $3,900.00 | $7,800.00 | $10,000.00 | $136.50 |
| $6,667.00 - $6,833.99 | $4,000.00 | $8,000.00 | $10,000.00 | $140.00 |
| $6,834.00 - $6,999.99 | $4,100.00 | $8,200.00 | $10,000.00 | $143.50 |
| $7,000.00 - $7,166.99 | $4,200.00 | $8,400.00 | $10,000.00 | $147.00 |
| $7,167.00 - $7,333.99 | $4,300.00 | $8,600.00 | $10,000.00 | $150.50 |
| $7,334.00 - $7,499.99 | $4,400.00 | $8,800.00 | $10,000.00 | $154.00 |
| $7,500.00 - $7,666.99 | $4,500.00 | $9,000.00 | $10,000.00 | $157.50 |
| $7,667.00 - $7,833.99 | $4,600.00 | $9,200.00 | $10,000.00 | $161.00 |
| $7,834.00 - $7,999.99 | $4,700.00 | $9,400.00 | $10,000.00 | $164.50 |
| $8,000.00 - $8,166.99 | $4,800.00 | $9,600.00 | $10,000.00 | $168.00 |
| $8,167.00 - $8,333.99 | $4,900.00 | $9,800.00 | $10,000.00 | $171.50 |
| $8,334.00 - $8,499.99 | $5,000.00 | $10,000.00 | $10,000.00 | $175.00 |
| $8,500.00 - $8,666.99 | $5,100.00 | $10,200.00 | $10,000.00 | $178.50 |
| $8,667.00 - $8,833.99 | $5,200.00 | $10,400.00 | $10,000.00 | $182.00 |
| $8,834.00 - $8,999.99 | $5,300.00 | $10,600.00 | $10,000.00 | $185.50 |
| $9,000.00 - $9,166.99 | $5,400.00 | $10,800.00 | $10,000.00 | $189.00 |
| $9,167.00 - $9,333.99 | $5,500.00 | $11,000.00 | $10,000.00 | $192.50 |
| $9,334.00 - $9,499.99 | $5,600.00 | $11,200.00 | $10,000.00 | $196.00 |
| $9,500.00 - $9,666.99 | $5,700.00 | $11,400.00 | $10,000.00 | $199.50 |
| $9,667.00 - $9,833.99 | $5,800.00 | $11,600.00 | $10,000.00 | $203.00 |
| $9,834.00 - $9,999.99 | $5,900.00 | $11,800.00 | $10,000.00 | $206.50 |
| $10,000.00 - $10,166.99 | $6,000.00 | $12,000.00 | $10,000.00 | $210.00 |
| $10,167.00 - $10,332.99 | $6,100.00 | $12,200.00 | $10,000.00 | $213.50 |
| $10,333.00 - $10,499.99 | $6,200.00 | $12,400.00 | $10,000.00 | $217.00 |
| $10,500.00 - $10,666.99 | $6,300.00 | $12,600.00 | $10,000.00 | $220.50 |
| $10,667.00 - $10,832.99 | $6,400.00 | $12,800.00 | $10,000.00 | $224.00 |
| $10,833.00 - $10,999.99 | $6,500.00 | $13,000.00 | $10,000.00 | $227.50 |
| $11,000.00 - $11,166.99 | $6,600.00 | $13,200.00 | $10,000.00 | $231.00 |
| $11,167.00 - $11,332.99 | $6,700.00 | $13,400.00 | $10,000.00 | $234.50 |
| $11,333.00 - $11,499.99 | $6,800.00 | $13,600.00 | $10,000.00 | $238.00 |
| $11,500.00 - $11,666.99 | $6,900.00 | $13,800.00 | $10,000.00 | $241.50 |
| $11,667.00 - $11,832.99 | $7,000.00 | $14,000.00 | $10,000.00 | $245.00 |
| $11,833.00 - $11,999.99 | $7,100.00 | $14,200.00 | $10,000.00 | $248.50 |
| $12,000.00 - $12,166.99 | $7,200.00 | $14,400.00 | $10,000.00 | $252.00 |
| $12,167.00 - $12,332.99 | $7,300.00 | $14,600.00 | $10,000.00 | $255.50 |
| $12,333.00 - $12,499.99 | $7,400.00 | $14,800.00 | $10,000.00 | $259.00 |
| $12,500.00 - And Over | $7,500.00 | $15,000.00 | $10,000.00 | $262.50 |

# Plan Benefit Highlights

## Maximum Benefit Period

Benefits are payable up to 180 days for a covered Injury or Sickness.

### When Coverage Begins

Certificates will become effective on the requested effective date following the date we approve the application, provided you are on active employment and premium has been paid.

### Physician Expense Benefit

Injury - $150.00 per Injury

If you need personal treatment by a physician due to an Injury, we will pay the amount shown above provided no other claim has been paid under the policy. You are not required to miss one full day of work in order to receive the Injury Benefit. This benefit will be limited to 8 payments per calendar year.

### Accidental Death Benefit

A lump sum of $10,000 will be paid to your designated beneficiary if you die as the direct result of an Injury within 90 days after the Injury.

### Hospital Confinement Benefit

A Hospital Confinement Benefit will be paid each day you are confined as a patient in a Hospital due to an Injury or Sickness, for up to 60 days. The amount payable is 2 times the Disability Benefit which will be pro-rated on a daily basis. This benefit will not be reduced by Deductible Sources of Income. The Hospital confinement must be at least 18 continuous hours in duration. This benefit will begin after you've met your elimination period.

### Donor Benefit

If you are Disabled as a result of being an organ or tissue donor, we will pay your benefit as any other Sickness under the terms of the plan.

### If You Are Disabled Due to a Covered Disability and Not Working

We will pay the Disability Benefit described in the benefit schedule. No Disability payment will be provided for any period in which you are not under the regular and appropriate care of a physician.

### Alcoholism and Drug Addiction Limited Benefit

If you are Disabled due to alcoholism or drug addiction, a limited benefit of up to 30 days for each Disability will be paid. Benefits will not be paid beyond the maximum benefit period. If drug addiction is sustained at the hands of, or while under the regular and appropriate care of a physician in the course of treatment for Injury or Sickness, it will be covered the same as any other Sickness.

### Pre-Existing Condition Limitation

No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before you have been continuously covered under the policy for 12 months. This provision will not apply if you have: gone treatment-free; incurred no expense; taken no medication; and received no diagnosis or advice from a physician, for 12 consecutive months for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after you have been continuously covered under the policy for 12 months.

Any increase in benefits will be subject to this Pre-Existing Condition limitation. A new Pre-Existing Condition period must be met with respect to any increase applied for and approved by us.

***Pre-Existing Condition*** means a disease, Injury, Sickness, physical condition or mental illness for which you: had treatment; incurred expense; took medication; received care or services including diagnostic testing or related measures; or received a diagnosis or advice from a physician, during the 12 month period immediately before your effective date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition, or mental illness.

# Benefit Riders and Limitations

## Spousal Accident Only Disability Benefit Rider

This rider is designed to provide a monthly benefit if your Spouse suffers a Disability due to a non-occupational accident.

Pays a monthly benefit amount to you for your Spouse who is Disabled as a result of a non-occupational accident. Benefits begin on the 31st consecutive day after the Injury and will continue for up to two years.

| Monthly Benefit Amount | Annual Salary | Monthly Premium |
|---|---|---|
| $500.00 | up to $10,000.00 | $4.00 |
| $1,000.00 | $10,001.00 - $20,000.00 | $8.00 |
| $1,500.00 | $20,001.00 - $30,000.00 | $12.00 |
| $2,000.00 | $30,001.00 and over | $16.00 |

## Critical Illness Benefit Rider

This rider is designed to provide a lump sum benefit based on diagnosis of a certain Critical Illness.

Benefits are payable at a one-time lump sum benefit amount based on diagnosis of the following conditions heart attack, stroke, kidney failure, paralysis, or major organ failure. In the case of heart attack, a physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms.

| Benefit Amount | Monthly Premium |
|---|---|
| $10,000.00 | $9.80 |
| $15,000.00 | $13.18 |
| $20,000.00 | $16.56 |
| $25,000.00 | $19.94 |

# Benefit Rider Limitations and Exclusions

## Critical Illness Benefit Rider

The Critical Illness Benefit rider will not be payable for any loss caused by or resulting from: a Critical Illness when the date of diagnosis occurs during the waiting period; a Critical Illness diagnosed outside of the United States; or a Sickness or Injury not specifically defined in this Rider.

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness date of diagnosis occurs before you have been continuously covered under this rider for 12 consecutive months. Following 12 consecutive months this exclusion does not apply.

Pre-Existing Condition means a disease, Injury, Sickness, physical condition or mental illness for which you have experienced any of the following: treatment; incurred expense; took medication; received care or services including diagnostic testing or related measures; or received a diagnosis or advise from a physician, during the 12-month period immediately before the effective date of this rider. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness. Benefits reduce by 50% at age 70. No benefits will be paid for a Critical Illness when the date of diagnosis occurs during the Critical Illness waiting period. The waiting period is 30 days from the effective date of this rider. Waiting period will be waived for Major Organ Failure and Paralysis if the cause is due to an Injury.

## Spousal Accident Only Disability Benefit Rider

This rider does not provide benefits for your Spouse for any Disability, fatal or non-fatal, which results from any of the following: intentionally self-inflicted Injury while sane or insane; an act of war, declared or undeclared; Injury sustained or contracted while in the service of the armed forces of any country; committing a felony; penal incarceration. American Fidelity will not pay benefits during any period for which your Spouse is incarcerated in a penal or correctional institution or for any Injury that occurs while your Spouse is incarcerated in a penal or correctional institution; Injury arising out of and in the course of any occupation for wage or profit or for which your Spouse is entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this policy for any period during which your Spouse is entitled to Workers' Compensation benefits; participation in any sport for wage or profit; participation in any contest of speed in a power driven vehicle for wage or profit.

Spouse means the person you are lawfully married to who is less than age 70. Your spouse must be engaged in Full Time Employment for benefits to be payable. Full Time Employment means your spouse is employed an average of 25 or more hours per week for pay or benefits. Full Time Employment does not include any hours your spouse is working while self-employed. No benefits are payable for your Spouse under this rider for a Disability from an Injury that occurred outside of the United States or its territories. No benefit will be provided for any period in which your Spouse is not under the regular and appropriate care of a physician. No benefits will be paid for any Injury to your Spouse which is caused by or resulting from Spousal abuse.

Your coverage with respect to the riders listed above will end on the earliest of these dates: the end of the last period for which premium has been paid; the date you notify us in writing to terminate coverage; the date the rider is discontinued; the date the policy is discontinued; or the date your employment terminates.

Availability of riders may vary by state, employer and short-term coverage with a benefit period of less than 12 months. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed. Riders have limitations, exclusions, and waiting periods. Refer to your policy for complete details. These riders will terminate on the same date as the policy or certificate to which it is attached.

## Policy Exclusions

The policy does not cover any loss, fatal or non-fatal, resulting from:

- Intentionally self-inflicted Injury while sane or insane.
- An act of war, declared or undeclared.
- Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- Committing a felony.
- Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

Your coverage may be extended for up to 1 year during a leave of absence approved in writing by your employer. Coverage will continue as long as the group policy remains in force, the premiums are paid and you remain eligible for the coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, or your employment terminates. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

**Your benefits, all in one place.**

Manage your American Fidelity benefits and reimbursement accounts through your online account or the AFmobile® app.

*Policy provisions and benefits may vary if you reside in a state other than your employer's state of domicile.*

*Pre-Existing Conditions may apply.*

*This brochure highlights important features of the policy. Please refer to your certificate for complete details.*

American Fidelity Assurance Company
800-662-1113 • **americanfidelity.com**

2024-25

# EMPLOYEE ASSISTANCE PROGRAM

# CONCERN

CONCERN
EMPLOYEE ASSISTANCE PROGRAM

**What is Concern, your Employee Assistance Program (EAP)?**

CONCERN Employee Assistance Program (EAP) is a workplace program designed to identify and resolve production or operational problems associated with employees who are affected by personal problems such as stress, health, marital, family, financial, alcohol and drug, legal, gambling, emotional and other problems.

CONCERN EAP serves a wide range of customers in the Memphis metro and Mid-South region that represent manufacturing, distribution, government, health care, education, legal, transportation, hi-tech, law enforcement, retail sales, gaming and banking work sites.

**Who Has Access to It?**

Any employee or live-in who is experiencing emotional or mental distress that would not require inpatient care is likely appropriate for EAP counseling. Typically seen are people who have significant stress, relationship problems, anger issues, parenting and couples concerns, the loss of a loved one, life transitions, or depressive symptoms. Others may be seen for substance abuse issues, anxiety, lack of motivation, and other difficulties in the workplace. A growing segment of clients includes people who are managing chronic health conditions and seek assistance for weight loss and other changing lifestyle options.

**How much does it cost?**

The use of Concern is completely free to the employee and/or those in the household for the unlimited number of sessions. We do not want there to be any barriers such as the numbers of times allowed, to keep you from using this amazing service.

**Referral/Resource Service "Just Ask":**

This is an additional service that is provided to clients. There are many times when an individual needs help accessing a resource or attaining information. Our aim is to serve as a conduit to help you with that need. If you are looking for child care providers in your area or long term care facilities for a loved we will do the research for you so you have some options to choose from. We do not make any guarantees about the providers of the service, you must still do your own due diligence and vet whatever entity you select. If you are not sure we can help we say "Just Ask" by emailing Concern@bmhcc.org or complete a form on the website. We will respond within 24 to 72 hours. This is our baseline service. Other resource and referral services are offered for an additional cost.

**Additional services offered:**

- Problem assessment, unlimited problem-solving sessions (affiliate providers need authorizations)
- Critical Incident Stress Debriefings/Management, as needed
- 24/7 licensed counselor on-call via phone for crisis or urgent situations.
- Management consultations available
- Employee education programs, including drug-free workplace, harassment trainings, diversity training, and leadership development.
- Conflict resolution sessions
- Workplace violence prevention training and interventions, participate in health fairs and orientations
- Newsletter. The CONCERN Connection, links to current health care information via social media

CONCERN EMPLOYEE ASSISTANCE PROGRAM

**How do I access the service?**

Start by going to our website www.myconcerneap.com, click on "Client" and fill out the "New Client Intake" form online. Then, simply call Concern at ***901-458-4000*** or ***1-800-445-5011*** then, let the receptionist know where you work plus, let us know you have completed your online paperwork and would like to schedule an appointment. Once you give them some of your basic demographics, we will coordinate with you to schedule you and/or your household members for a phone or a video telehealth session. Once COVID restrictions are lifted you can come to one of our 6 locations or we will connect you with one of our affiliate providers in your area.

**Where are we located?**

| | |
|---|---|
| Concern Midtown (Main Office) | 2670 Union Avenue Extended, Suite 610, Memphis TN 38112 |
| Concern Bartlett, TN | 2996 Kate Bond Rd, Suite 207, Bartlett, TN 38133 |
| Concern Germantown, TN | 2010 Exeter Road, Suite 1, Germantown TN 38138 |
| Concern Jackson, MS | 1225 North State Street, Jackson, MS 39202 |
| Concern Southaven, MS | 7535 Airways Road, Suite 210, Southaven, MS 38671 |
| Concern Tipton, TN | 1995 Highway 51 S, Suite 203B, Covington, TN 38019 |

*Contact us at 901-458-4000*

*Or*

*1-800-445-5011*

CONCERN: EAP is a member of the International Employee Assistance Professionals Associations (EAPA)

2024-25

# PLANNING YOUR RETIREMENT

The State of Tennessee 401(k) Deferred Compensation Program through Tennessee Consolidated Retirement System (TCRS)

# RETIREMENT OPTIONS THROUGH TCRS

**What is the difference between a 401(k), Roth 401(k), 403(b) and 457(b)**


**401(k) and 403(b)** refer to the Tax Code which governs defined contribution retirement plans. Employees participating in a 401(k) or 403(b) supplemental retirement option may defer a portion of their salary pre-tax. The 401(k) plan is offered by RetireReadyTN the most part the rules are the same, but we usually associate a 401(k) with private sector plans and a 403(b) with education or governmental plans. The contribution limits for both are the same.

**Roth 403(b) or 401(k)** also refers to the associated Tax Code which governs defined contribution retirement plans. A Roth is an after-tax supplemental retirement plan.

**457(b)** refers to the Tax Code which governs defined contribution retirement plans. Employees participating in a 457(b) supplemental retirement option may defer a portion of their salary pre-tax.

**What are the contribution limits?** In 2024 the maximum contribution amount is $23,000. It may be indexed for inflation in $500 increments after 2023. If you turn age 50 or older in 2024, you may contribute an additional $7,500.

**Can employees make Roth 401(k) or 403(b) contributions?** In 2024, the maximum limit for elective deferrals, for both traditional pre-tax and Roth 401(k) and/or 403(b) contributions combined, is $23,000. Roth contributions are made with after-tax dollars, instead of the pre-tax dollars you contribute to a traditional 401(k) or 403(b). In other words, with the Roth option, you've already paid taxes on the money you contribute.

**Can employees contribute to multiple plans?** Yes, however, if an employee contributes to another plan, such as a 403(b) plan, the combined total of all contributions cannot exceed the maximum limit of $23,000 in 2024, or $30,500 if age 50 or older. Governmental 457(b) plans have separate deferral limits, so employees who contribute to a 457(b) plan may be able to contribute an additional $23,000 to that plan in 2024 (plus any applicable catch-up contributions). For more information about contribution limits for multiple plans, visit **www.irs.gov**.

**Who may participate?** GMSD full time employees are eligible to participate.

*Please contact TCRS directly if you are interested in participating.*

**TCRS** - 1-800-922-7772 or www.retirereadyTN.com , Monday through Friday, 8am to 7pm (CST)

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-411-3650 or go to www.lucenthealth.com/naa. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-411-3650 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network Providers / Out-Of-Network Providers<br>**$1,500 / $3,000** Individual<br>**$2,250 / $4,500** Individual + One<br>**$3,000 / $6,000** Family<br>*HRA participants have a reduced deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. There is a $100 individual/$300 family annual deductible when purchasing prescription drugs using Out-of-Network pharmacy. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Network Providers / Out-Of-Network Providers<br>**$4,500 / $11,500** Individual<br>**$8,000 / $22,500** Individual + One<br>**$11,500 / $32,500** Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, penalties. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of Network Providers, see www.mycigna.com or call 1-800-411-3650. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 50% coinsurance | None |
| | Specialist visit | 20% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-Network preventive services are only covered for test and reading of PSA, pap smears and mammograms at 50% coinsurance after deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.welldynerx.com. | Generic drugs | Retail: $10 copay/prescription Mail Order: $30 copay/prescription | 50% coinsurance | Deductible does not apply. (Prescription drugs purchased at a non-participation pharmacy are subject to the prescription deductible) Covers up to a 30-day supply (retail prescription); up to 90-day supply (mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA. Specialty drugs are limited to a 30-day supply. |
| | Preferred brand drugs | Retail: $50 copay/prescription Mail Order: $150 copay/prescription | 50% coinsurance | |
| | Non-preferred brand drugs | Retail: $100 copay/prescription Mail Order: $300 copay/prescription | 50% coinsurance | |
| | Specialty drugs | Follows Retail Tiers Above | 50% coinsurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |

* For more information about limitations and exceptions, see the plan or policy document at www.lucenthealth.com/naa.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | | Network deductible applies to Out-of-network services. |
| | Emergency medical transportation | 20% coinsurance | | Network deductible applies to Out-of-network services. |
| | Urgent care | 20% coinsurance | | Network deductible applies to Out-of-network services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and cesarean section deliveries requiring more than a 96 hour stay to avoid penalty. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Limited to 60 combined visits per calendar year for speech, physical, chiropractic, occupational, pulmonary rehabilitation, cognitive therapy, and occupational therapy. Limited to 36 combined visits per calendar year for cardiac pulmonary rehabilitation. |
| | Habilitation services | | | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Limited to 60 days per calendar year. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | None |
| | Hospice services | 20% coinsurance | 50% coinsurance | Preauthorization is required. |

* For more information about limitations and exceptions, see the plan or policy document at www.lucenthealth.com/naa.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Hearing aids
- Long-Term Care
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care for Non-Diabetics
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Infertility treatment (except In-Vitro, GIFT, ZIFT, etc.
- Non-emergency care when traveling outside the U.S. provided travel was not for the sole purpose of medical treatment. Call 1-800-411-3650 for details.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-411-3650. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Germantown Municipal School District Employee Benefit Plan c/o Lucent Health Solutions, LLC at PO Box 1984, Nashville, TN 37202 or at 1-800-411-3650. You may also contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-236-0844.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-236-0844.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-236-0844.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-236-0844.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $10 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,770** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $500 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,110** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $10 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,810** |

Participants in HRA will pay a reduced deductible. The examples above show individual coverage. The Annual Health Fund provided to employees and dependents is $500 individual; $750 individual plus one; $1,000 Family.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network Providers / Out-Of-Network Providers<br>**$500 / $1,000** Individual<br>**$750 / $1,500** Individual + One<br>**$1,000 / $2,000** Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, prescription drugs, Diagnostic tests, specialty drugs, specialist visits and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. There is a $100 individual/$300 family annual deductible when purchasing prescription drugs using Out-of-Network pharmacy. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Network Providers / Out-Of-Network Providers<br>**$3,500 / $8,500** Individual<br>**$6,000 / $16,000** Individual + One<br>**$8,500 / $23,500** Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, penalties. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of Network Providers, see www.mycigna.com or call 1-800-411-3650. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/visit<br>deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $40 copay/visit<br>deductible does not apply | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-Network preventive services are only covered for test and reading of PSA, pap smears and mammograms at 50% coinsurance after deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; deductible does not apply | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.welldynerx.com. | Generic drugs | Retail: $10 copay/prescription<br>Mail Order: $30 copay/prescription | 50% coinsurance | Deductible does not apply. (Prescription drugs purchased at a non-participation pharmacy are subject to the prescription deductible)<br><br>Covers up to a 30-day supply (retail prescription); up to 90-day supply (mail order prescription).<br><br>Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.<br><br>Specialty drugs are limited to a 30-day supply. |
| | Preferred brand drugs | Retail: $50 copay/prescription<br>Mail Order: $150 copay/prescription | 50% coinsurance | |
| | Non-preferred brand drugs | Retail: $100 copay/prescription<br>Mail Order: $300 copay/prescription | 50% coinsurance | |
| | Specialty drugs | Follows Retail Tiers Above | 50% coinsurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |

* For more information about limitations and exceptions, see the plan or policy document at www.lucenthealth.com/naa.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit + deductible | | Copay waived if admitted. Network deductible applies to Out-of-network services. |
| | Emergency medical transportation | 20% coinsurance | | Network deductible applies to Out-of-network services. |
| | Urgent care | $75 copay/visit + deductible | | Network deductible applies to Out-of-network services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/initial office visit; deductible does not apply | 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | $30 copay/initial office visit; deductible does not apply | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and cesarean section deliveries requiring more than a 96 hour stay to avoid penalty. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Rehabilitation services | $40 copay/visit deductible does not apply | 50% coinsurance | Limited to 60 combined visits per calendar year for speech, physical, chiropractic, occupational, pulmonary rehabilitation, cognitive therapy, and occupational therapy. Limited to 36 combined visits per calendar year for cardiac pulmonary rehabilitation. |
| | Habilitation services | | | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Limited to 60 days per calendar year. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | None |
| | Hospice services | 20% coinsurance | 50% coinsurance | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Hearing aids
- Infertility treatment
- Long-Term Care
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care for Non-Diabetics
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Non-emergency care when traveling outside the U.S. provided travel was not for the sole purpose of medical treatment. Call 1-800-411-3650 for details.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-411-3650. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Germantown Municipal School District Employee Benefit Plan c/o Lucent Health Solutions, LLC at PO Box 1984, Nashville, TN 37202 or at 1-800-411-3650. You may also contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-236-0844.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-236-0844.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-236-0844.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-236-0844.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copay** | **$40** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,670** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copay** | **$40** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $800 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,380** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copay** | **$40** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-411-3650 or go to www.lucenthealth.com/naa. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-411-3650 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | N/A | N/A |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network Providers<br>**$2,500** Individual<br>**$4,000** Individual + One<br>**$5,500** Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, penalties. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of Network Providers, see www.mycigna.com or call 1-800-411-3650. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit | None |
| | Specialist visit | $40 copay/visit | None |
| | Preventive care/screening/ immunization | No Charge | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.welldynerx.com. | Generic drugs | Retail: $10 copay/prescription Mail Order: $30 copay/prescription | Covers up to a 30-day supply (retail prescription); up to 90-day supply (mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA. Specialty drugs are limited to a 30-day supply. |
| | Preferred brand drugs | Retail: $50 copay/prescription Mail Order: $150 copay/prescription | |
| | Non-preferred brand drugs | Retail: $100 copay/prescription Mail Order: $300 copay/prescription | |
| | Specialty drugs | Follows Retail Tiers Above | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $250 copay/visit | None |
| | Physician/surgeon fees | No Charge | None |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | Copay waived if admitted. |
| | Emergency medical transportation | No Charge | None |
| | Urgent care | $75 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay/admission | Preauthorization is required. |
| | Physician/surgeon fees | No Charge | |

* For more information about limitations and exceptions, see the plan or policy document at www.lucenthealth.com/naa.

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit | None |
| | Inpatient services | $500 copay/admission | Preauthorization is required. |
| **If you are pregnant** | Office visits | $25 copay/visit (PCP); $40 copay/visit (Specialist) | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and cesarean section deliveries requiring more than a 96 hour stay to avoid penalty. |
| | Childbirth/delivery professional services | No Charge | |
| | Childbirth/delivery facility services | $500 copay/admission | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Preauthorization is required. |
| | Rehabilitation services | $40 copay/visit | Limited to 60 combined visits per calendar year for speech, physical, chiropractic, occupational, pulmonary rehabilitation, cognitive therapy, and occupational therapy. Limited to 36 combined visits per calendar year for cardiac pulmonary rehabilitation. |
| | Habilitation services | | |
| | Skilled nursing care | No Charge | Limited to 60 days per calendar year. Preauthorization is required. |
| | Durable medical equipment | No Charge | None |
| | Hospice services | No Charge | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |
| | Children's glasses | Not covered | None |
| | Children's dental check-up | Not covered | Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Hearing aids
- Infertility treatment
- Long-Term Care
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care for Non-Diabetics
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Non-emergency care when traveling outside the U.S. provided travel was not for the sole purpose of medical treatment. Call 1-800-411-3650 for details.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-411-3650. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Germantown Municipal School District Employee Benefit Plan c/o Lucent Health Solutions, LLC at PO Box 1984, Nashville, TN 37202 or at 1-800-411-3650. You may also contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-236-0844.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-236-0844.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-236-0844.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-236-0844.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copay** | **$40** |
| **Hospital (facility) copay** | **$500** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$560** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copay** | **$40** |
| **Hospital (facility) copay** | **$500** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$720** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copay** | **$40** |
| **Hospital (facility) copay** | **$500** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

## 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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

## Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

## When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

## What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

## How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's 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.

# 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 | 4. Employer Identification Number (EIN) |
|---|---|
| Germantown Municipal School District | 46-4230642 |
| 5. Employer address | 6. Employer phone number |
| 3350 S. FOREST HILL IRENE ROAD | (901) 752-7890 |

| 7. City | 8. State | 9. ZIP code |
|---|---|---|
| Germantown | TN | 38138 |

| 10. Who can we contact about employee health coverage at this job? | |
|---|---|
| Gina Eddleman | |
| 11. Phone number (if different from above) | 12. Email address gina.eddleman@gmsdk12.org |

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full-Time employees who are regularly scheduled to work a minimum of 30 hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Outlined in the 2024-25 Germantown Municipal Schools' Open Enrollment Brochure
  - ☐ We do not offer coverage.

☒ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 112.45
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? NO CHANGES
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)