2024-2025 EMPLOYEE BENEFITS

COUNTY OF BOSQUE
STATE OF TEXAS

CONTENTS

WELCOME LETTER

TO: Bosque County Employees
FROM: Daniel Anderson, ANCO Insurance

We are excited to partner with Bosque County as your benefits broker. This Benefits Guide provides the information you'll need when making decisions about your benefit selections for the 2024 plan year (10/01/24 through 09/30/25) from the following providers:

- Scott & White with NonStop Health: Medical
- Guardian: Dental, Vision, Voluntary Life/AD&D, Short-Term, Voluntary Critical Illness, Accident, Cancer, & Hospital Indemnity Insurance
- MASA: Emergency Transportation
- Texas Republic Life: Whole Life

Please note that certain benefits may require the completion of additional forms, and benefits could be reduced if enrolling for the first time after the initial new hire enrollment period; especially for life and worksite plans.

Should difficulties arise requiring resolution with any carrier, Kelly Coppock can be reached at ANCO via:

Direct: 979-774-6214 // Email: coppockk@anco.com

ANCO is happy to assist with any issues or questions concerning the benefit programs. For some claims research, the following items are often requested:

- Member authorization to disclose health information
- Date-of-service, provider information, amount of charges, and explanation of the problem
- Explanation of Benefits (EOB) from carrier and statement from provider's office

Our continuing effort is to provide any assistance and support as needed. Please feel free to contact our team.

Daniel Anderson
Senior Vice President
Direct: 979-774-6216 // Email: anderson@anco.com

GLOSSARY

BENEFICIARY - The person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor (person covered under the policy) or on the maturity of the policy.

CLAIM - A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

COINSURANCE - The percentage of costs of a covered health care service insurance pays after you've paid your deductible.

COPAYMENT (COPAY) - A fixed dollar amount you pay for a covered health care service.

DEDUCTIBLE - An amount you could owe during a coverage period for covered health care services before your plan begins to pay. An overall deductible applied to all or almost all covered items and services. Copayments do not count towards the deductible.

DEPENDENT - A child or other individual (under the age of 26) for whom a parent, relative, or other person may claim a personal exemption tax deduction.

DISABILITY RESOURCE SERVICES - Provides convenient resources to help address emotional, legal, and financial issues.

ELECTIVE DEFERRAL - A percentage of an employee's salary that's withheld and transferred into a 401(k). Elective-deferrals can be made on a pre-tax or after-tax (Roth) basis.

EVIDENCE OF INSURABILITY (EOI) - An application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

FLEXIBLE SPENDING ACCOUNT (FSA) - A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan.

GUARANTEE ISSUE - A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guarantee issue doesn't limit how much you can be charged if you enroll.

HEALTH SAVINGS ACCOUNT (HSA) - A tax-free financial account where you gain interest and save money while spending on qualified health expenses. Funds in you account roll over from year to year.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

IN-NETWORK - Refers to a health care provider that has a contract with your insurance plan to provide health care services to its plan members at a pre-negotiated rate. Because of this relationship, you pay a lower cost-sharing when you receive services from an in-network doctor.

OPEN ENROLLMENT - The annual period before a new plan year commences that eligible individuals may enroll in or change coverage elections in a job-based insurance plan.

OUT-OF-NETWORK - Refers to a health care provider who does not have a contract with your insurance plan. If you use an out-of-network provider, health care services could cost more since the provider doesn't have a pre-negotiated rate with your health plan. Or, depending on your health plan, the health care services may not be covered at all.

OUT OF POCKET MAXIMUM/LIMIT - The most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM - The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

QUALIFYING EVENT - A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment period, allowing you to enroll in health insurance outside of the yearly Open Enrollment period.

WAITING PERIOD - The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

ELIGIBILITY

If you are a full-time Bosque County employee working a minimum of 30 hours a week, benefits are available starting on the 1st of the month following date of hire. Unless hired on the 1st of the month (ex:11/1/2023), then benefits will begin that date. Part-time employees working 20 hours a week or more are eligible for the voluntary, employee paid benefits.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all of your information is up to date, it's time to make your benefit elections. The decisions you make when enrolling for benefits can have a significant impact on your life and finances, so it is important to weigh your options carefully.

WHEN TO ENROLL

Open enrollment begins on 8/20/2024 to 8/21/2024. The benefits you choose during open enrollment will become effective on October 1, 2024. For the initial enrollment you will use Employee Navigator to make benefit elections.

ENROLLMENT CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next Open Enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or coverage under another employer sponsored plan
- Loss of coverage on yourself or dependents during the year

Request for qualifying events must be submitted to the carrier within 30 days of the event.

SEMI-MONTHLY RATES

MEDICAL PREMIUM	
Employee Only:	$0.00
Employee + Spouse:	$398.43
Employee + Child(ren):	$188.68
Family:	$646.81

DENTAL PREMIUM	
Employee Only:	$13.66
Employee + Spouse:	$25.04
Employee + Child(ren):	$31.30
Family:	$43.81

VISION PREMIUM	VSP CHOICE	DAVIS VISION
Employee Only:	$3.10	$3.01
Employee + Spouse:	$5.90	$5.73
Employee + Child(ren):	$6.22	$6.04
Family:	$9.14	$8.87

ACCIDENT PREMIUM	
Employee Only:	$9.79
Employee + Spouse:	$13.46
Employee + Child(ren):	$13.93
Family:	$17.60

CANCER PREMIUM	
Employee Only:	$11.86
Employee + Spouse:	$23.79
Employee + Child(ren)	$13.26
Family:	$25.19

HOSPITAL INDEMNITY	
Employee Only:	$8.89
Employee + Spouse:	$18.13
Employee + Child(ren):	$14.42
Family:	$23.56

MEDICAL

Baylor Scott & White Health Plan

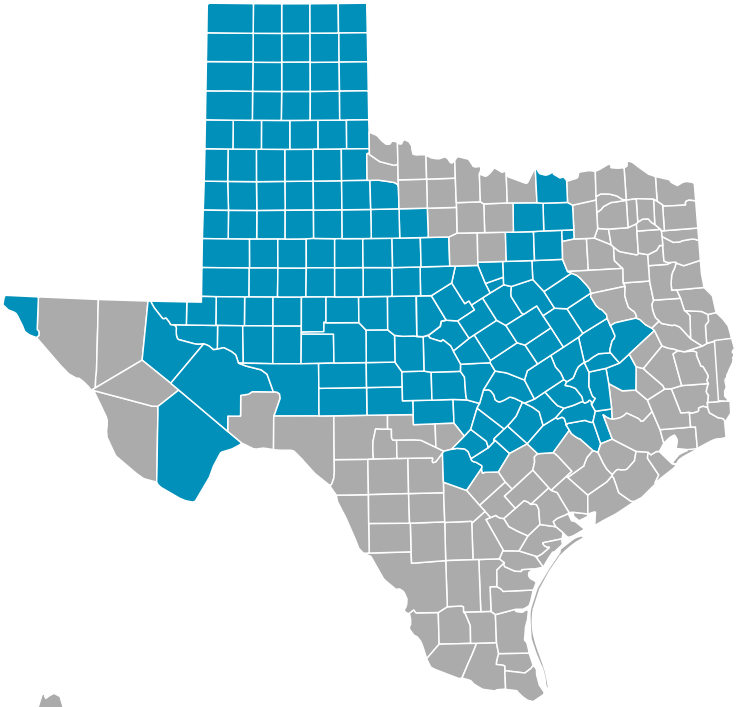
	UHB3H1S1 w. LRXUI023	NonStop Health (NSH) Coverage
Network:	BSW Access PPO	
Coinsurance Level (In/Out):	100 / 50%	
Lifetime Maximum:	Unlimited	
Calendar Year Deductible: • Individual (IN/OUT) • Family (IN/OUT)	 $7,000 / $14,000 $14,000 / $28,000	 Coered by NSH $7,000 Covered by NSH $14,000
Out-of-Pocket Maximum: • Individual (IN/OUT) • Family (IN/OUT)	 $7,000 / $21,000 $14,000 / $42,000	 Coered by NSH $7,000 Covered by NSH $14,000
Office Visit Copay: • Primary Care / Specialist • Urgent Care	100% after deductible	Covered by NSH $7,000 / $14,000
Preventative Care:	100% of allowable amount	Covered by NSH $7,000 / $14,000
Emergency Room Services:	100% after deductible	Covered by NSH $7,000 / $14,000
Inpatient Hospitalization:	100% after deductible	Covered by NSH $7,000 / $14,000
Outpatient Surgery: • Facility Fee • Physician/Surgeon Fees	100% after deductible	Covered by NSH $7,000 / $14,000
Maternity:	Not Covered	Covered by NSH $7,000 / $14,000
PRESCRIPTION DRUGS		
Calendar Year Deductible:	None	
Retail (30 Day Supply): • Generic • Preferred Brand • Non-Preferred Brand • Specialty	100% after deductible	Covered by NSH $7,000 / $14,000
Mail Order (90 Day Supply): • Preferred/ Non-Preferred Generic • Preferred/ Non-Preferred Brand • Preferred/ Non-Preferred Specialty	100% after deductible	Covered by NSH $7,000 / $14,000

EMPLOYEE PAYROLL PREMIUM	
Employee Only:	$0.00
Employee + Spouse:	$398.43
Employee + Child(ren):	$188.68
Family:	$646.81

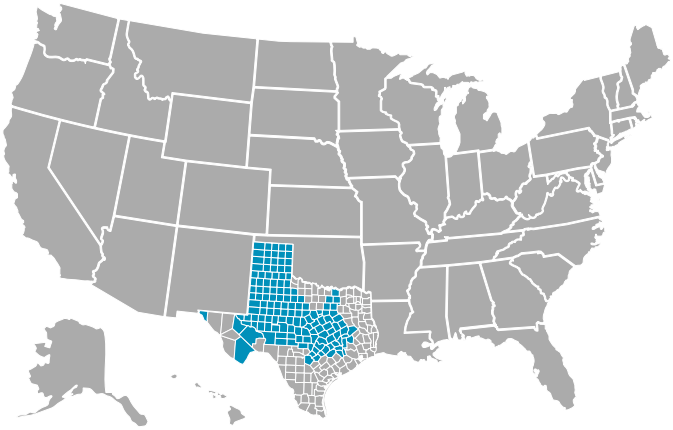
Find a Provider: BSW Access PPO

1. Go to BSWHealthPlan.com/FindProvider
2. Click on the “Employer Group Networks” tab
3. Choose “BSW Access PPO” from the chart
4. Start your search
5. For UnitedHealthcare providers, click the link on the left, just above the map in the search tool

When accessing care within the Baylor Scott & White Health Plan service area—the 141 Texas counties shown in blue—you must visit a Baylor Scott & White Health Plan network provider to receive in-network benefits.



BSWHP Service Area



Outside the blue counties, in Texas and across the United States, you can see providers in the UnitedHealthcare Options PPO network and receive in-network benefits.

Because your plan is a PPO, you may visit providers that are not part of either network; however, you will pay a higher cost share for those services.

Care at your fingertips 24/7

Our members have access to board-certified doctors, pediatricians, licensed therapists and more using your smartphone, tablet or computer.

MyBSWHealth

eVisits are online interviews that take about 5-10 minutes; you'll receive a response within one hour. Behavioral Health eVisits are available 8:00AM-4:30PM and offer referrals for care options.

Same-Day Video Visits are scheduled, live conversations with a provider.

Prescriptions: After your visit, any prescriptions needed will be sent directly to pharmacy of your choice.

MDLIVE

Access board-certified doctors and mental health professionals for common conditions from allergies to addictions. To learn more and register, visit MDLIVE.com, call 800.718.5082 or download the MDLIVE app.

Be sure to tell them you're a Baylor Scott & White Health Plan member and have your member ID card available.

Where to go for care

Choosing the right option for your condition can save you time and money.

Less $

VIRTUAL CARE - $0 COPAY

Using your mobile device or computer

For conditions like acne, allergies, bladder infection, cold, flu, pink eye, Quit tobacco, sinus infection, stomach problems or yeast infections.

PRIMARY CARE DOCTOR

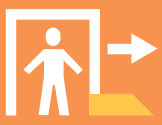
Your best choice for care when it's not an emergency

For conditions like asthma, diabetes management, earache, high blood pressure, headaches, preventive health, sprains, etc.

WALK-IN CLINICS

Same-day appointments when your doctor is not available; includes select primary care clinics and some pharmacy locations

For conditions like asthma, bladder infection, ear or sinus pain, flu, sore throat or sprains.



URGENT CARE

Needs immediate attention but is not life-threatening, or an appointment is not available with your doctor

For conditions like back pain, bladder infection, earache, minor burns, minor eye injuries, minor cuts that may need stitches, sore throat or sprains.

EMERGENCY ROOM

Any condition you believeto be life-threatening

For conditions like chest pain, deep cuts or wounds, difficulty breathing, poisoning, overdoses and suicidal behavior, abdominal pain, coughing or vomiting blood, severe burns, severe head injuries, sudden loss of balance, vision change, facial droop, arm or leg weakness.

More $

MyBSWHealth member portal

With the MyBSWHealth member portal, you can manage your health-care needs in one place, 24/7. Inside the portal, you can:

- Find doctors and locations in your network and schedule appointments with ease
- View or print your ID card and benefit plan documents
- Securely communicate with your care team
- View lab results and past visit summaries
- Review and pay bills
- Complete a telehealth visit and get a diagnosis and prescription on your smart phone without leaving home
- View deductible, out-of-pocket max, and claims information
- Transfer or refill prescriptions at BSW pharmacies
- Upload health and fitness data
- Manage your family's healthcare needs from a single place

MyBSWHealth is just one way Baylor Scott & White is helping to make healthcare the way it should be. Create an account or log in at **MyBSWHealth.com**.

HEALTHCARE **TO GO**

Virtually all of the information in the member portal is available on your phone through the highly rated MyBSWHealth app. For example, you can view a digital copy of your ID card, see plan details, and track your deductible and out-of-pocket maximum for yourself and your dependents. Use the same user name and password you set up for the member portal to log in to the app. To learn more, visit our website: **BSWHealthPlan.com**.

Be sure to link your account in the app:

1. Tap the gear icon
   (top right corner of app welcome screen)
2. Tap "Manage Linked Accounts"
3. Tap "Link Account"
4. Enter member information

GET IT ON Google Play

Download on the App Store

Manage your whole family's healthcare

MyBSWHealth makes it easy to keep track of appointments, prescriptions, bills and more for every member of the family—from young children to elderly parents. It's called proxy access. With proxy access, you can manage care needs for the whole family, all in one place and all conveniently on your favorite mobile device.

Learn more about proxy access and how to set it up.

What is Nonstop Health?

Nonstop Health is a type of healthcare program that allows organizations to fund a portion of their employees' healthcare premiums and out-of-pocket expenses (e.g. deductibles, copays, and coinsurance) while also saving on premium expenses annually. The Nonstop Health program combines an ACA-compliant health plan with a section 105 medical expense reimbursement plan (MERP) – and provides you, the member, with a Visa card to help pay for in-network, covered medical expenses, up to the allowed amount of $7,000 for employee plans and $14,000 for employee + dependent plans.

With Nonstop Health, you will receive two cards in the mail after you enroll: your identification card from Baylor Scott & White and your Nonstop Visa card from Nonstop Administration and Insurance Services, Inc. (Nonstop).

What should I do with each card?

Baylor Scott & White ID CARD

Your ID card comes from Baylor Scott & White, and includes information relevant to the HDHP.

You must present your ID card from Baylor Scott & White during every doctor visit and for prescription purchases. This is important to ensure that Baylor Scott & White is apprised of the charge and properly credits your services towards your in-network deductible/out-of-pocket maximum.

NONSTOP VISA CARD

The Nonstop Visa card comes from Nonstop and can be used to pay for in-network, Baylor Scott & White approved medical services and prescriptions, up to the allowed amount for your plan. You cannot use the Nonstop Visa card to purchase over the counter drugs.

You will receive two Nonstop Visa cards and they will both only be in your name. If you need additional cards, please call us at 1-877-626-6057. We recommend that you DO NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

nonstop HEALTH

How to use Nonstop Health

1 Present your **CARRIER CARD** to the front desk so they can apply service costs to your deductible and/or out-of-pocket maximum.

2 Pay for covered services and prescriptions with your **NONSTOP HEALTH VISA CARD**

3 If/when you receive a bill with a remaining balance, pay for those expenses with your **NONSTOP HEALTH VISA CARD**

(note: an Explanation of Benefits (EOB) is not a bill)

If there's a problem with using your card, contact us immediately at 877.626.6057 or clientsupport@nonstophealth.com .

Go home happy and healthy!

If you are receiving services outside of Nonstop's regular customer service hours (6am-5pm PT) and are having difficulty using your Nonstop Visa card, you may need to pay for services/prescriptions and be reimbursed through our claims process.

5 Things to Remember

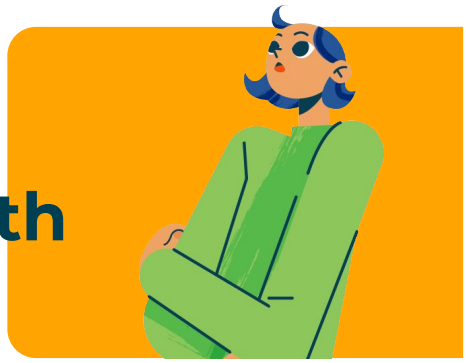
1. The Nonstop Health program can only be used for qualifying/covered **MEDICAL** expenses.
2. Nonstop Health only covers expenses that are incurred **ON or AFTER** your start date with the program.
3. The Nonstop Health program **DOES NOT COVER VISION or DENTAL** expenses unless they are covered under your medical plan.
4. Use the **NONSTOP EXCHANGE** to file/view claims, view Nonstop Visa card spending, or get help. (members.nonstophealth.com).
5. If you leave your employer or are no longer benefits eligible, submit all claims within **90 DAYS** of your last day of coverage. Your card will be cancelled.

Questions? We're here to help!

877.626.6057 Monday-Friday, 6am-5pm PST
clientsupport@nonstophealth.com

nonstop HEALTH

How to access Nonstop Health without a Nonstop Visa Card



While Nonstop makes every effort to get you your Nonstop Visa card as quickly as possible, there are times when you may not have it in hand on the first day of coverage. Additionally, if you lose your Nonstop Visa card or it is stolen, it may take a few weeks for your new one to arrive.

But not to worry! As long as you are enrolled in Nonstop Wellness, you can still access all of the benefits of the program - even if you don't have your Nonstop Visa card available.

Prescriptions

If you need to pick up a prescription and do not have your Nonstop Visa card, you can pay for that prescription out-of-pocket and be reimbursed by Nonstop. For information on submitting a claim, please visit www.nonstophealth.com/claims. If your prescription is urgent and the cost is more than you are comfortable paying out-of-pocket, please reach out to us by calling 877.626.6057.

QUICK TIP

For both medical services and prescriptions, make sure you provide your medical plan carrier identification card to the pharmacy or provider to ensure all costs are applied to your in-network deductible and out-of-pocket maximum! Make sure your dependents do this as well. This is an essential step in the process as you will be responsible for all charges that are not applied toward your in-network deductible and out-of-pocket maximum.

Medical Services

If you receive medical services before receiving your Nonstop Visa card in the mail, please request that your provider bill you for those services. Typically bills can take 30-60 days to move through the medical insurance carrier and provider systems. As such, you should have your Nonstop Visa card by the time you receive the bill. If you receive the bill before you receive your Nonstop Visa card, you can use the claims form found at www.nonstophealth.com/claims and request we pay the provider directly.

If you need to pay a copay or coinsurance at the point of service, you will need to pay for those costs out-of-pocket and submit a claim to be reimbursed by Nonstop Health. For information on submitting a claim, please visit www.nonstophealth.com/claims.

What if I have more questions?

Contact us! Nonstop's member support team is here to help. We can be reached at 877.626.6057 or clientsupport@nonstophealth.com. We are open Monday-Friday, 6am-5pm PST.

What is/isn't covered under Nonstop Health

The Nonstop Health program only works with in-network providers/facilities and covered services and prescriptions. But what exactly does this mean?

Key terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.

In-network: Providers that are in-network are those that have a contract with your insurance company, and have set up a pre-negotiated rate for different services. As such, the provider can only charge your insurance – and you – a set price for the services you receive. This results in lower costs, as in-network providers almost always charge less than an out-of-network provider.

Covered services: A covered service is one that Baylor Scott & White has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service please check with Baylor Scott & White first. They may have a cost or visit limit for specified services, or other limitations.

Covered prescriptions: Baylor Scott & White will set a "formulary" or drug list at the beginning of each plan year, which lists what prescriptions will be covered under your medical plan. Just because a doctor prescribes you a medication doesn't mean it's automatically covered by your insurance! So before paying for a new prescription, be sure to call Baylor Scott & White or ask your pharmacist if it's covered.

Baylor Scott & White approved: This means that your insurance has agreed to cover a service or prescription as part of your underlying medical plan. This includes covered services and prescriptions. However, it also can indicate that Baylor Scott & White has given you explicit/written permission to see an out-of-network provider for services and agreed that those costs will be considered in-network and covered under your plan.

Examples of what Nonstop Health covers – and what It doesn't

COVERED EXPENSES

Nonstop Health can be used to pay for all services and prescriptions that are covered under your medical plan. In essence this means that if your health insurance has agreed to pay for a medical service or prescription as part of your medical coverage, then you can use your Nonstop Visa card to pay for it. If Baylor Scott & White does not cover a service or prescription, then you will be responsible for 100% of those costs. If you're not sure if a service or prescription is covered, check your Summary of Benefits and Coverage (SBC) or contact Baylor Scott & White before receiving care.

NON-COVERED EXPENSES

Because medical plans cover services and prescriptions differently, there's not an exhaustive list of where you can/can't use your Nonstop Visa card. **But below are a few examples of services/providers/facilities that are never covered by Nonstop Health.** This is only a sample – if you are not sure if a service or prescription is covered, please check with Baylor Scott & White!

- Amazon.com or any FSA/HSA stores
- Weight Loss Programs
- FullScripts
- FreeSpira
- Massage Envy
- Carex
- Smile Direct Club
- PeopleCare
- Warby Parker
- Hero Health

As a general rule the Nonstop Visa card cannot be used for the following:

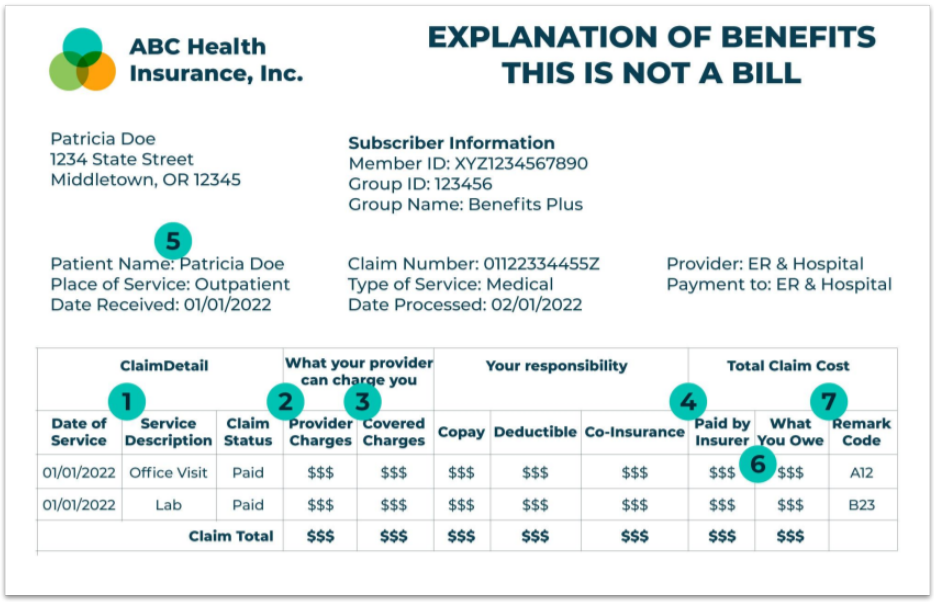
- Over the counter medication, vitamins or supplements
- Dental services, unless covered under your medical plan
- Vision services, unless covered under your medical plan
- Services and medications not approved by your health insurance
- Durable Medical Equipment (DME) not approved by your health insurance
- Alternative care that is not approved by your health insurance
- Mental health services not approved by your health insurance
- Feminine hygiene products

How to find and read your EOB

An Explanation of Benefits (EOB) is a statement generated by your health insurance company summarizing how it processed a claim from a doctor, hospital, or other medical provider**. This is the most critical piece of paperwork that Nonstop will need to substantiate a charge on your Visa card or process a claim for reimbursement or provider payment!** ***We cannot do either without an EOB.***

Your medical insurance is required to provide you with an EOB for each medical service that you receive under your insurance plan. Most health insurance companies mail EOBs to your home, although you can opt out of receiving paper EOBs and instead sign up for an online account with BCBS of Texas to access your documents digitally. Each health insurance company has slightly different approaches to EOB delivery so if you aren't sure where to find your EOBs, contact BCBS of Texas directly.

The below example shows what an EOB may look like (*actual format varies*) and what information will be provided:



ABC Health Insurance, Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Patricia Doe
1234 State Street
Middletown, OR 12345

Subscriber Information
Member ID: XYZ1234567890
Group ID: 123456
Group Name: Benefits Plus

5
Patient Name: Patricia Doe
Place of Service: Outpatient
Date Received: 01/01/2022

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2022

Provider: ER & Hospital
Payment to: ER & Hospital

ClaimDetail			What your provider can charge you		Your responsibility			Total Claim Cost		
1 Date of Service	Service Description	Claim Status	2 Provider Charges	3 Covered Charges	Copay	Deductible	4 Co-Insurance	Paid by Insurer	7 What You Owe	Remark Code
01/01/2022	Office Visit	Paid	$$$	$$$	$$$	$$$	$$$	$$$	6 $$$	A12
01/01/2022	Lab	Paid	$$$	$$$	$$$	$$$	$$$	$$$	$$$	B23
		Claim Total	$$$	$$$	$$$	$$$	$$$	$$$	$$$	

1. **Service Description** is a description of the health care services you received, like a medical visit, lab tests, screenings, surgery or lab tests.
2. **Provider Charges** is the amount your provider bills for your visit.
3. **Allowed Charges** is the amount that your provider will be reimbursed, negotiated between the carrier and the provider (this may not be the same as the Provider Charges).
4. **Paid by Insurer** is the amount your insurance plan will pay to your provider.
5. **Payee** is the person who will receive any reimbursement for over-paying the claim.
6. **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid. You may have already paid part of this amount, and payments made directly to your provider may not be subtracted from this amount. Wait to receive a bill from your provider before paying for the services.
7. **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

HELPFUL TIP

It's a good idea to have an online account with your insurance carrier so you can access EOBs, look up providers, review plan benefits/coverage and more. If you need help setting up your account, logging in or finding your information, contact your carrier.

What information Nonstop needs from your EOB:
Nonstop needs the information/dollar amounts listed as "your responsibility" on your EOB; this includes: in-network deductible, copays, and coinsurance. Before sending us an EOB, please make sure this information is accurate and matches your provider bill. In addition, we will be looking at the remarks or comments section to confirm that the service was covered under your plan and received at an in-network provider.

Nonstop is not affiliated with your insurance carrier. This, in addition to HIPAA privacy laws, means that we cannot request EOBs or any other documents on your behalf. We can, however, participate in three-way calls with your carrier if you need help requesting an EOB for a particular service.

Using the Nonstop Exchange member portal

Once you are enrolled with Nonstop Health, you will be able to access your plan information via the Nonstop Exchange member portal (members.nonstophealth.com). When you log into the system all your information will be available, allowing you to:

+ View available card balances
+ View demographic information
+ View documents about your plan (e.g. summary plan description, benefits summary)
+ Navigate to our member help site through the HELP button, where you can find fast answers to questions
+ File and view claims submissions

As a reminder, please refer to the Member Documents tab in the Nonstop Exchange (NSE) member portal to access and view all complete plan summaries for your medical benefits. All legal and compliance-related notices will also be located under the Member Docs tab in NSE.

Logging into the NSE for the first time

1. Using the Chrome internet browser, go to members.nonstophealth.com. Click on "Don't Remember Your Password?" on the login page and enter your email address (If you're unsure about what email to use, contact Nonstop). You will be emailed a link to set a personal and private password.
2. Then come back to members.nonstophealth.com and re-enter your email and new password.
3. When you log in for the first time you must go through our two-factor authentication process. You will be asked to enter your mobile phone number, and then a six-digit code will be texted to you. Enter that code to log into NSE. A second "backup" code will be provided when you log in and we recommend writing down or taking a picture of this backup code. If you're using a trusted computer/browser, you can click "Remember This Browser" to bypass two-factor authentication for 30 days. If you don't have a mobile phone number, please contact us!

DENTAL

Guardian

Your dental coverage

PPO plan, you'll have access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when they belong to a tier in the Tier 1 reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
	Tier 1	Tier 2
Your Network is DentalGuard Preferred Network	In-Network	Out-of-Network
Your Semi-monthly premium	**$13.66**	
You and Spouse	$25.04	
You and Child(ren)	$31.30	
You, Spouse and Child(ren)	$43.81	
Calendar year deductible	*Tier 1*	*Tier 2*
Individual	$50	$50
Family limit	3 per family (applies to all levels)	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*Tier 1*	*Tier 2*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	Not Covered (applies to all levels)	
Annual Maximum Benefit	$1500 (applies to all levels)	
Maximum Rollover	Yes (applies to all levels)	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	Not Applicable (applies to all levels)	
Dependent Age Limits	26 (applies to all levels)	

DENTAL PREMIUM	
Employee Only:	$13.66
Employee + Spouse:	$25.04
Employee + Child(ren):	$31.30
Family:	$43.81

DENTAL

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		Tier 1	Tier 2
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	2 in 12 Months (applies to all levels)	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 14 (applies to all levels)	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	2 in 12 months (applies to all levels)	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Single Crowns	50%	50%

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	Maximum rollover account limit
$1,500 Maximum claims reimbursement	**$700** Claims amount that determines rollover eligibility	**$350** Additional dollars added to a plan's annual maximum for future years	**$1,250** The limit that cannot be exceeded within the maximum rollover account

VISION

Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Option 2: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Costco®, Wal-Mart®, JCPenney®, Target®, Sam's Club®, Pearle®, Visionworks®. You can also use your network benefits online at Visionworks®.com, glasses®.com, WarbyParker®.com, or 1800contacts®.com.

Your Vision Plan	**Option 1: Full Feature**		**Option 2: Full Feature - Designer**	
Your Network is	VSP Choice Network		Davis Vision	
Your Semi-monthly premium	**$ 3.10**		**$ 3.01**	
You and Spouse	$ 5.90		$ 5.73	
You and Child(ren)	$ 6.22		$ 6.04	
You, Spouse and Child(ren)	$ 9.14		$ 8.87	
Copay				
Exams Copay	$ 10		$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 15		$ 15	
Sample of Covered Services	*You pay (after copay if applicable):*		*You pay (after copay if applicable):*	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Eye Exams	$0	Amount over $39	$0	Amount over $50
Single Vision Lenses	$0	Amount over $23	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $37	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $49	$0	Amount over $86
Lenticular Lenses	$0	Amount over $64	$0	Amount over $126
Frames	80% of amount over $130[1]	Amount over $46	80% of amount over $130*[2]	Amount over $48
Costco, Walmart and Sam's Club Frame Allowance	Amount over $70		N/A	
Contact Lenses *(Elective)*	Amount over $130	Amount over $100	N/A	N/A
Contact Lenses *(Elective and conventional)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts	No discounts	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts	Avg. 40-60% off retail price	No discounts

VISION PREMIUM	VSP CHOICE	DAVIS VISION
Employee Only:	$3.10	$3.01
Employee + Spouse:	$5.90	$5.73
Employee + Child(ren):	$6.22	$6.04
Family:	$9.14	$8.87

VISION

Guardian

Your vision coverage

Your Vision Plan	Option 1: Full Feature	Option 2: Full Feature - Designer
Glasses *(Additional pair of frames and lenses)*	20% off retail price** No discounts	50% at Visionworks and 30% at other in network providers No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price No discounts	Savings of 40-50% off national average price thru Davis laser vision network No discounts
Service Frequencies		
Exams	Every calendar year	Every calendar year
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	Every calendar year
Frames	Every two calendar years‡‡‡	Every two calendar years
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	Applies to first purchase & courtesy discount from most providers on subsequent purchases.
Dependent Age Limits	26	26
To Find a Provider:	Register at VSP.com to find a participating provider.	Visit www.Guardianlife.com and click on "Find a Provider"

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- ‡‡‡.*The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*
- In Network Routine Retinal Screening Covered after no more than a $39 copay.

Davis

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Additional discounts are not available at all private practice locations. Costco, Walmart, Sam's Club, glasses.com, and 1800contacts.com do not allow additional discounts.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- [2]Extra $50 at Visionworks stores and at Visionworks.com.
- In Network Routine Retinal Screening Covered after no more than a $39 copay.
- Members can use their in network benefits at visionworks.com, warbyparker.com, glasses.com, and 1800contacts.com. Additional discounts are not available at glasses.com or 1800contacts.com. Discounts may vary at Warby Parker.

LIFE

Guardian

Your life coverage

	VOLUNTARY TERM LIFE
Employee Benefit	$10,000 increments to a maximum of $500,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse Benefit	$5,000 increments to a maximum of $250,000. See Cost Illustration page for details.‡
Child Benefit	Your dependent children age birth† to 26 years. $1,000 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to: Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000. Spouse Less than age 65 $50,000, 65-69 $10,000. Dependent children $10,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions

LIFE

Guardian

Your life coverage

	VOLUNTARY TERM LIFE
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 50% at age 70

Subject to coverage limits

† Voluntary Life: Infant coverage is limited based on age.

‡ **Spouse coverage terminates at age 70.**

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Annual Election Option allows employees to increase the amount of their life coverage without a medical exam when they re-enroll in their company's Voluntary Life plan. This option allows employees to step up to an amount of up to $50,000, up to the Guarantee Issue amount.

LIFE

Guardian®

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Semi-monthly premiums displayed. Cost of AD&D is included.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000	$.64	$.67	$.85	$1.20	$1.83	$2.93	$4.66	$7.40	$15.10
$20,000	$1.28	$1.34	$1.70	$2.39	$3.65	$5.85	$9.31	$14.79	$30.20
$30,000	$1.92	$2.01	$2.55	$3.59	$5.48	$8.78	$13.97	$22.19	$45.30
$40,000	$2.56	$2.68	$3.40	$4.78	$7.30	$11.70	$18.62	$29.58	$60.40
$50,000	$3.20	$3.35	$4.25	$5.98	$9.13	$14.63	$23.28	$36.98	$75.50
$60,000	$3.84	$4.02	$5.10	$7.17	$10.95	$17.55	$27.93	$44.37	$90.60
$70,000	$4.48	$4.69	$5.95	$8.37	$12.78	$20.48	$32.59	$51.77	$105.70
$80,000	$5.12	$5.36	$6.80	$9.56	$14.60	$23.40	$37.24	$59.16	$120.80
$90,000	$5.76	$6.03	$7.65	$10.76	$16.43	$26.33	$41.90	$66.56	$135.90
$100,000	$6.40	$6.70	$8.50	$11.95	$18.25	$29.25	$46.55	$73.95	$151.00
$110,000	$7.04	$7.37	$9.35	$13.15	$20.08	$32.18	$51.21	$81.35	$166.10
$120,000	$7.68	$8.04	$10.20	$14.34	$21.90	$35.10	$55.86	$88.74	$181.20
$130,000	$8.32	$8.71	$11.05	$15.54	$23.73	$38.03	$60.52	$96.14	$196.30
$140,000	$8.96	$9.38	$11.90	$16.73	$25.55	$40.95	$65.17	$103.53	$211.40
$150,000	$9.60	$10.05	$12.75	$17.93	$27.38	$43.88	$69.83	$110.93	$226.50
$160,000	$10.24	$10.72	$13.60	$19.12	$29.20	$46.80	$74.48	$118.32	$241.60
$170,000	$10.88	$11.39	$14.45	$20.32	$31.03	$49.73	$79.14	$125.72	$256.70
$180,000	$11.52	$12.06	$15.30	$21.51	$32.85	$52.65	$83.79	$133.11	$271.80
$190,000	$12.16	$12.73	$16.15	$22.71	$34.68	$55.58	$88.45	$140.51	$286.90
$200,000	$12.80	$13.40	$17.00	$23.90	$36.50	$58.50	$93.10	$147.90	$302.00
$210,000	$13.44	$14.07	$17.85	$25.10	$38.33	$61.43	$97.76	$155.30	$317.10
$220,000	$14.08	$14.74	$18.70	$26.29	$40.15	$64.35	$102.41	$162.69	$332.20
$230,000	$14.72	$15.41	$19.55	$27.49	$41.98	$67.28	$107.07	$170.09	$347.30
$240,000	$15.36	$16.08	$20.40	$28.68	$43.80	$70.20	$111.72	$177.48	$362.40
$250,000	$16.00	$16.75	$21.25	$29.88	$45.63	$73.13	$116.38	$184.88	$377.50
$260,000	$16.64	$17.42	$22.10	$31.07	$47.45	$76.05	$121.03	$192.27	$392.60
$270,000	$17.28	$18.09	$22.95	$32.27	$49.28	$78.98	$125.69	$199.67	$407.70
$280,000	$17.92	$18.76	$23.80	$33.46	$51.10	$81.90	$130.34	$207.06	$422.80
$290,000	$18.56	$19.43	$24.65	$34.66	$52.93	$84.83	$135.00	$214.46	$437.90

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Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$300,000	$19.20	$20.10	$25.50	$35.85	$54.75	$87.75	$139.65	$221.85	$453.00
$310,000	$19.84	$20.77	$26.35	$37.05	$56.58	$90.68	$144.31	$229.25	$468.10
$320,000	$20.48	$21.44	$27.20	$38.24	$58.40	$93.60	$148.96	$236.64	$483.20
$330,000	$21.12	$22.11	$28.05	$39.44	$60.23	$96.53	$153.62	$244.04	$498.30
$340,000	$21.76	$22.78	$28.90	$40.63	$62.05	$99.45	$158.27	$251.43	$513.40
$350,000	$22.40	$23.45	$29.75	$41.83	$63.88	$102.38	$162.93	$258.83	$528.50
$360,000	$23.04	$24.12	$30.60	$43.02	$65.70	$105.30	$167.58	$266.22	$543.60
$370,000	$23.68	$24.79	$31.45	$44.22	$67.53	$108.23	$172.24	$273.62	$558.70
$380,000	$24.32	$25.46	$32.30	$45.41	$69.35	$111.15	$176.89	$281.01	$573.80
$390,000	$24.96	$26.13	$33.15	$46.61	$71.18	$114.08	$181.55	$288.41	$588.90
$400,000	$25.60	$26.80	$34.00	$47.80	$73.00	$117.00	$186.20	$295.80	$604.00
$410,000	$26.24	$27.47	$34.85	$49.00	$74.83	$119.93	$190.86	$303.20	$619.10
$420,000	$26.88	$28.14	$35.70	$50.19	$76.65	$122.85	$195.51	$310.59	$634.20
$430,000	$27.52	$28.81	$36.55	$51.39	$78.48	$125.78	$200.17	$317.99	$649.30
$440,000	$28.16	$29.48	$37.40	$52.58	$80.30	$128.70	$204.82	$325.38	$664.40
$450,000	$28.80	$30.15	$38.25	$53.78	$82.13	$131.63	$209.48	$332.78	$679.50
$460,000	$29.44	$30.82	$39.10	$54.97	$83.95	$134.55	$214.13	$340.17	$694.60
$470,000	$30.08	$31.49	$39.95	$56.17	$85.78	$137.48	$218.79	$347.57	$709.70
$480,000	$30.72	$32.16	$40.80	$57.36	$87.60	$140.40	$223.44	$354.96	$724.80
$490,000	$31.36	$32.83	$41.65	$58.56	$89.43	$143.33	$228.10	$362.36	$739.90
$500,000	$32.00	$33.50	$42.50	$59.75	$91.25	$146.25	$232.75	$369.75	$755.00
Policy Election Amount									
Spouse									
$5,000	$.32	$.34	$.43	$.60	$.91	$1.46	$2.33	$3.70	$7.55
$10,000	$.64	$.67	$.85	$1.20	$1.83	$2.93	$4.66	$7.40	$15.10
$15,000	$.96	$1.01	$1.28	$1.79	$2.74	$4.39	$6.98	$11.09	$22.65
$20,000	$1.28	$1.34	$1.70	$2.39	$3.65	$5.85	$9.31	$14.79	$30.20
$25,000	$1.60	$1.68	$2.13	$2.99	$4.56	$7.31	$11.64	$18.49	$37.75
$30,000	$1.92	$2.01	$2.55	$3.59	$5.48	$8.78	$13.97	$22.19	$45.30
$35,000	$2.24	$2.35	$2.98	$4.18	$6.39	$10.24	$16.29	$25.88	$52.85
$40,000	$2.56	$2.68	$3.40	$4.78	$7.30	$11.70	$18.62	$29.58	$60.40
$45,000	$2.88	$3.02	$3.83	$5.38	$8.21	$13.16	$20.95	$33.28	$67.95
$50,000	$3.20	$3.35	$4.25	$5.98	$9.13	$14.63	$23.28	$36.98	$75.50

Guardian®

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$55,000	$3.52	$3.69	$4.68	$6.57	$10.04	$16.09	$25.60	$40.67	$83.05
$60,000	$3.84	$4.02	$5.10	$7.17	$10.95	$17.55	$27.93	$44.37	$90.60
$65,000	$4.16	$4.36	$5.53	$7.77	$11.86	$19.01	$30.26	$48.07	$98.15
$70,000	$4.48	$4.69	$5.95	$8.37	$12.78	$20.48	$32.59	$51.77	$105.70
$75,000	$4.80	$5.03	$6.38	$8.96	$13.69	$21.94	$34.91	$55.46	$113.25
$80,000	$5.12	$5.36	$6.80	$9.56	$14.60	$23.40	$37.24	$59.16	$120.80
$85,000	$5.44	$5.70	$7.23	$10.16	$15.51	$24.86	$39.57	$62.86	$128.35
$90,000	$5.76	$6.03	$7.65	$10.76	$16.43	$26.33	$41.90	$66.56	$135.90
$95,000	$6.08	$6.37	$8.08	$11.35	$17.34	$27.79	$44.22	$70.25	$143.45
$100,000	$6.40	$6.70	$8.50	$11.95	$18.25	$29.25	$46.55	$73.95	$151.00
$105,000	$6.72	$7.04	$8.93	$12.55	$19.16	$30.71	$48.88	$77.65	$158.55
$110,000	$7.04	$7.37	$9.35	$13.15	$20.08	$32.18	$51.21	$81.35	$166.10
$115,000	$7.36	$7.71	$9.78	$13.74	$20.99	$33.64	$53.53	$85.04	$173.65
$120,000	$7.68	$8.04	$10.20	$14.34	$21.90	$35.10	$55.86	$88.74	$181.20
$125,000	$8.00	$8.38	$10.63	$14.94	$22.81	$36.56	$58.19	$92.44	$188.75
$130,000	$8.32	$8.71	$11.05	$15.54	$23.73	$38.03	$60.52	$96.14	$196.30
$135,000	$8.64	$9.05	$11.48	$16.13	$24.64	$39.49	$62.84	$99.83	$203.85
$140,000	$8.96	$9.38	$11.90	$16.73	$25.55	$40.95	$65.17	$103.53	$211.40
$145,000	$9.28	$9.72	$12.33	$17.33	$26.46	$42.41	$67.50	$107.23	$218.95
$150,000	$9.60	$10.05	$12.75	$17.93	$27.38	$43.88	$69.83	$110.93	$226.50
$155,000	$9.92	$10.39	$13.18	$18.52	$28.29	$45.34	$72.15	$114.62	$234.05
$160,000	$10.24	$10.72	$13.60	$19.12	$29.20	$46.80	$74.48	$118.32	$241.60
$165,000	$10.56	$11.06	$14.03	$19.72	$30.11	$48.26	$76.81	$122.02	$249.15
$170,000	$10.88	$11.39	$14.45	$20.32	$31.03	$49.73	$79.14	$125.72	$256.70
$175,000	$11.20	$11.73	$14.88	$20.91	$31.94	$51.19	$81.46	$129.41	$264.25
$180,000	$11.52	$12.06	$15.30	$21.51	$32.85	$52.65	$83.79	$133.11	$271.80
$185,000	$11.84	$12.40	$15.73	$22.11	$33.76	$54.11	$86.12	$136.81	$279.35
$190,000	$12.16	$12.73	$16.15	$22.71	$34.68	$55.58	$88.45	$140.51	$286.90
$195,000	$12.48	$13.07	$16.58	$23.30	$35.59	$57.04	$90.77	$144.20	$294.45
$200,000	$12.80	$13.40	$17.00	$23.90	$36.50	$58.50	$93.10	$147.90	$302.00
$205,000	$13.12	$13.74	$17.43	$24.50	$37.41	$59.96	$95.43	$151.60	$309.55
$210,000	$13.44	$14.07	$17.85	$25.10	$38.33	$61.43	$97.76	$155.30	$317.10

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Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$215,000	$13.76	$14.41	$18.28	$25.69	$39.24	$62.89	$100.08	$158.99	$324.65
$220,000	$14.08	$14.74	$18.70	$26.29	$40.15	$64.35	$102.41	$162.69	$332.20
$225,000	$14.40	$15.08	$19.13	$26.89	$41.06	$65.81	$104.74	$166.39	$339.75
$230,000	$14.72	$15.41	$19.55	$27.49	$41.98	$67.28	$107.07	$170.09	$347.30
$235,000	$15.04	$15.75	$19.98	$28.08	$42.89	$68.74	$109.39	$173.78	$354.85
$240,000	$15.36	$16.08	$20.40	$28.68	$43.80	$70.20	$111.72	$177.48	$362.40
$245,000	$15.68	$16.42	$20.83	$29.28	$44.71	$71.66	$114.05	$181.18	$369.95
$250,000	$16.00	$16.75	$21.25	$29.88	$45.63	$73.13	$116.38	$184.88	$377.50
Policy Election Amount									
Child(ren)									
$1,000	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09
$2,000	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17
$3,000	$0.26	$0.26	$0.26	$0.26	$0.26	$0.26	$0.26	$0.26	$0.26
$4,000	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34
$5,000	$0.43	$0.43	$0.43	$0.43	$0.43	$0.43	$0.43	$0.43	$0.43
$6,000	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51
$7,000	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60
$8,000	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68
$9,000	$0.77	$0.77	$0.77	$0.77	$0.77	$0.77	$0.77	$0.77	$0.77
$10,000	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
Infant coverage is limited for the first two weeks of infant's life.
Spouse coverage premium is based on Employee age.
†Benefit reductions apply.
The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

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DISABILITY

Guardian

Your disability coverage

	Short-Term Disability	Long-Term Disability
Coverage amount	60% of salary to maximum $1500/week	60% of salary to maximum $6000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	12 weeks	Lesser of 2 years or to age 70
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1500 in coverage	We Guarantee Issue $6000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation	12 months look back; 12 months after exclusion
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes	Yes
Survivor benefit: Additional benefit payable to your family if you die while disabled.	No	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary excludes bonuses and commissions.
- **Special limitations:** Provides a 24-month benefit limit for mental health and substance abuse.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

DISABILITY

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Short-Term Disability Plan Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*6*
Your premium rate	$0.404	$0.539	$0.899	$0.764	$0.472	$0.427	$0.539	$0.629	$0.8

Election Cost Per Age Bracket

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*6*
$20,000 Annual Salary $231 Weekly Benefit	$4.67	$6.23	$10.38	$8.82	$5.45	$4.93	$6.23	$7.27	$10
$30,000 Annual Salary $346 Weekly Benefit	$6.99	$9.33	$15.55	$13.22	$8.17	$7.39	$9.33	$10.88	$15
$40,000 Annual Salary $462 Weekly Benefit	$9.33	$12.45	$20.77	$17.65	$10.90	$9.86	$12.45	$14.53	$20
$50,000 Annual Salary $577 Weekly Benefit	$11.66	$15.55	$25.94	$22.04	$13.62	$12.32	$15.55	$18.15	$25
$60,000 Annual Salary $692 Weekly Benefit	$13.98	$18.65	$31.11	$26.43	$16.33	$14.77	$18.65	$21.76	$31
$70,000 Annual Salary $808 Weekly Benefit	$16.32	$21.78	$36.32	$30.87	$19.07	$17.25	$21.78	$25.41	$36
$80,000 Annual Salary $923 Weekly Benefit	$18.65	$24.88	$41.49	$35.26	$21.78	$19.71	$24.88	$29.03	$41
$90,000 Annual Salary $1,038 Weekly Benefit	$20.97	$27.97	$46.66	$39.65	$24.50	$22.16	$27.97	$32.65	$46
$100,000 Annual Salary $1,154 Weekly Benefit	$23.31	$31.10	$51.87	$44.08	$27.23	$24.64	$31.10	$36.29	$51
$110,000 Annual Salary $1,269 Weekly Benefit	$25.63	$34.20	$57.04	$48.48	$29.95	$27.09	$34.20	$39.91	$57
$120,000 Annual Salary $1,385 Weekly Benefit	$27.98	$37.33	$62.26	$52.91	$32.69	$29.57	$37.33	$43.56	$62
$130,000 Annual Salary $1,500 Weekly Benefit	$30.30	$40.43	$67.43	$57.30	$35.40	$32.03	$40.43	$47.18	$67

Long-Term Disability Plan Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*6*
Your premium rate	$0.070	$0.080	$0.120	$0.180	$0.230	$0.330	$0.480	$0.650	$1.(

DISABILITY

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	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
					Election Cost Per Age Bracket				
	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$20,000 Annual Salary $1,000 Monthly Benefit	$0.58	$0.67	$1.00	$1.50	$1.92	$2.75	$4.00	$5.42	$8.34
$30,000 Annual Salary $1,500 Monthly Benefit	$0.88	$1.00	$1.50	$2.25	$2.88	$4.13	$6.00	$8.13	$12.50
$40,000 Annual Salary $2,000 Monthly Benefit	$1.17	$1.33	$2.00	$3.00	$3.83	$5.50	$8.00	$10.83	$16.67
$50,000 Annual Salary $2,500 Monthly Benefit	$1.46	$1.67	$2.50	$3.75	$4.79	$6.88	$10.00	$13.54	$20.84
$60,000 Annual Salary $3,000 Monthly Benefit	$1.75	$2.00	$3.00	$4.50	$5.75	$8.25	$12.00	$16.25	$25.00
$70,000 Annual Salary $3,500 Monthly Benefit	$2.04	$2.33	$3.50	$5.25	$6.71	$9.62	$14.00	$18.96	$29.17
$80,000 Annual Salary $4,000 Monthly Benefit	$2.33	$2.67	$4.00	$6.00	$7.67	$11.00	$16.00	$21.67	$33.34
$90,000 Annual Salary $4,500 Monthly Benefit	$2.63	$3.00	$4.50	$6.75	$8.63	$12.38	$18.00	$24.38	$37.50
$100,000 Annual Salary $5,000 Monthly Benefit	$2.92	$3.33	$5.00	$7.50	$9.58	$13.75	$20.00	$27.08	$41.67
$110,000 Annual Salary $5,500 Monthly Benefit	$3.21	$3.67	$5.50	$8.25	$10.54	$15.13	$22.00	$29.79	$45.84
$120,000 Annual Salary $6,000 Monthly Benefit	$3.50	$4.00	$6.00	$9.00	$11.50	$16.50	$24.00	$32.50	$50.00

DISABILITY

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Long-Term Disability Plan Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate	$0.070	$0.080	$0.120	$0.180	$0.230	$0.330	$0.480	$0.650	$1.000
$20,000 Annual Salary $1,000 Monthly Benefit	$0.58	$0.67	$1.00	$1.50	$1.92	$2.75	$4.00	$5.42	$8.34
$30,000 Annual Salary $1,500 Monthly Benefit	$0.88	$1.00	$1.50	$2.25	$2.88	$4.13	$6.00	$8.13	$12.50
$40,000 Annual Salary $2,000 Monthly Benefit	$1.17	$1.33	$2.00	$3.00	$3.83	$5.50	$8.00	$10.83	$16.67
$50,000 Annual Salary $2,500 Monthly Benefit	$1.46	$1.67	$2.50	$3.75	$4.79	$6.88	$10.00	$13.54	$20.84
$60,000 Annual Salary $3,000 Monthly Benefit	$1.75	$2.00	$3.00	$4.50	$5.75	$8.25	$12.00	$16.25	$25.00
$70,000 Annual Salary $3,500 Monthly Benefit	$2.04	$2.33	$3.50	$5.25	$6.71	$9.62	$14.00	$18.96	$29.17
$80,000 Annual Salary $4,000 Monthly Benefit	$2.33	$2.67	$4.00	$6.00	$7.67	$11.00	$16.00	$21.67	$33.34
$90,000 Annual Salary $4,500 Monthly Benefit	$2.63	$3.00	$4.50	$6.75	$8.63	$12.38	$18.00	$24.38	$37.50
$100,000 Annual Salary $5,000 Monthly Benefit	$2.92	$3.33	$5.00	$7.50	$9.58	$13.75	$20.00	$27.08	$41.67
$110,000 Annual Salary $5,500 Monthly Benefit	$3.21	$3.67	$5.50	$8.25	$10.54	$15.13	$22.00	$29.79	$45.84
$120,000 Annual Salary $6,000 Monthly Benefit	$3.50	$4.00	$6.00	$9.00	$11.50	$16.50	$24.00	$32.50	$50.00

CRITICAL ILLNESS

Guardian

Your critical illness coverage

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $50,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain or Spinal Tumor	100%	0%
Skin Cancer	$250	$0
BRCA 1 & BRCA 2	30%	Not Covered
Bone Marrow Failure (including Stem Cells)	100%	50%
Lung and Vascular Disorder		
Aneurysm	10%	0%
Pulmonary Embolism	30%	0%
Stroke – Moderate	50%	25%
Stroke – Severe	100%	50%
Transient Ischemic Attack (TIA)	10%	0%
Heart Conditions		
Coronary Artery Disease	10%	0%
Coronary Artery Disease – bypass needed	50%	0%
Heart Attack	100%	50%
Heart Failure	100%	50%
Pacemaker	10%	0%
Additional Conditions		
Kidney Failure	100%	50%
Major Organ Failure	100%	50%
	1st OCCURRENCE ONLY	
Addison's Disease	30%	
Coma	100%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Permanent Paralysis	100% for 1 or more limbs	
Severe Burns	100%	
Chronic Disorders		
Crohn's Disease	30%	
Epilepsy	10%	
Lupus	30%	
Ulcerative Colitis	30%	
Neurological Disorders		

CRITICAL ILLNESS

Guardian

Your critical illness coverage

	CRITICAL ILLNESS
Alzheimer's Disease – Early	50%
Alzheimer's Disease – Advanced	100%
ALS (Lou Gehrig's Disease)	100%
Dementia – other causes	100%
Huntington's Disease	30%
Multiple Sclerosis – Early	50%
Multiple Sclerosis – Advanced	100%
Myasthenia Gravis	30%
Parkinson's Disease – Early	50%
Parkinson's Disease – Advanced	100%
Childhood Illnesses and Disorders	
Autism Spectrum Disorder	100%
Cerebral Palsy	100%
Cleft Lip/Cleft Palate	100%
Club Foot	100%
Congenital Heart Defect	100%
Cystic Fibrosis	100%
Diabetes – Type 1	100%
Down Syndrome	100%
Hemophilia	100%
Multisystem Inflammatory Disease (MLS)	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Spouse Benefit	May choose a lump sum benefit of $2,500 to $25,000 in $2,500 increments up to 50% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue/ Conditional Issue: The 'Guarantee/Conditional' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue up to: $20,000 For a spouse: $10,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included

CRITICAL ILLNESS

Guardian

Your critical illness coverage

	CRITICAL ILLNESS
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/6 months treatment free/12 months after
Waiver of Premium: If you become disabled due to a covered critical illness that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled.	Included
Cancer Vaccine Benefit	$50 Employee, $50 Spouse, $50 Child per lifetime for receiving a cancer vaccine.
Health Screening Benefit	$50 Employee, $50 Spouse, $50 Child per year limit.

Condition Definitions

- BRCA1 or BRCA2 Mutation: occurs the date you're scheduled to undergo a mastectomy, or ovary or fallopian tube removal prior to a breast or ovarian cancer diagnosis as a preventive measure.
- Stroke - Moderate: requires clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage.
- Stroke - Severe: a permanent neurological deficit which persists at least 30 days after the event.
- Coronary Artery Disease: requires a diagnosis and severity level that requires one or more of the following procedures: atherectomy (rotation or laser), balloon angioplasty, laser angioplasty, stent implantation, thrombectomy (angiojet).
- Coronary Artery Disease - requiring a bypass: requires a diagnosis to be of such a severity that it requires one or more coronary artery bypass grafts.
- Heart Failure: requires a heart valve replacement or acceptance into the heart transplant waiting list.
- Kidney Failure: occurs on the earlier date of when renal or peritoneal dialysis begins, or the date you're accepted onto the kidney transplant waiting list of a recognized kidney transplant program in the United States.
- Major Organ Failure: occurs on the date you're accepted onto the liver, pancreas or lung transplant waiting list of a recognized transplant program in the United States.
- Crohn's Disease: benefit is available for the initial diagnosis of the disease, not the periodic flare-ups that may occur after the initial diagnosis.
- Epilepsy: requires initial diagnosis after at least two seizures, which are 24 hours apart and have no known trigger.
- Lupus: requires at least four symptoms be present at time of diagnosis. The benefit is available for initial diagnosis of the disease, not for periodic flare-ups that may occur after the initial diagnosis.
- Ulcerative Colitis: benefit is available for the initial diagnosis based on the results of a colonoscopy, not for periodic flare-ups that may occur after the initial diagnosis.
- Early-Stage Alzheimer's Disease: occurs on the date a physician diagnoses the progression which causes a loss of cognitive ability and functioning.
- Advanced Alzheimer's Disease: occurs on the date a physician diagnoses the cognitive decline to have progressed to the point that there's permanent inability to perform 2 or more Activities of Daily Living.
- Early-Stage Multiple Sclerosis (MS): must be diagnosed by a physician and confirmed by neurological exams, imaging studies, and analysis of cerebrospinal fluid.
- Advanced Stage Multiple Sclerosis (MS): requires neurological deficits for at least six months and confirmed by neurological exams, imaging studies, and analysis of cerebrospinal fluid.
- Early-Stage Parkinson's Disease: occurs on the date diagnosed by a physician with at least 1 symptom(s) affecting movement and the central nervous system.
- Advanced Parkinson's Disease: occurs on the date diagnosed by a physician and requires at least 3 or more symptom(s) affecting movement and the central nervous system.

CRITICAL ILLNESS

Guardian®

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Semi-monthly Premiums Displayed *Election Cost Per Age Bracket*					
	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+†*
Employee						
$5,000	$1.23	$2.03	$3.85	$7.45	$12.58	$21.35
$10,000	$2.45	$4.05	$7.70	$14.90	$25.15	$42.70
$15,000	$3.68	$6.08	$11.55	$22.35	$37.73	$64.05
$20,000	$4.90	$8.10	$15.40	$29.80	$50.30	$85.40
$25,000	$6.13	$10.13	$19.25	$37.25	$62.88	$106.75
$30,000	$7.35	$12.15	$23.10	$44.70	$75.45	$128.10
$35,000	$8.58	$14.18	$26.95	$52.15	$88.03	$149.45
$40,000	$9.80	$16.20	$30.80	$59.60	$100.60	$170.80
$45,000	$11.03	$18.23	$34.65	$67.05	$113.18	$192.15
$50,000	$12.25	$20.25	$38.50	$74.50	$125.75	$213.50
Benefit Amount Up To 50% of Employee Amount to a Maximum of $25,000						
Spouse						
$2,500	$0.62	$1.02	$1.93	$3.73	$6.29	$10.68
$5,000	$1.23	$2.03	$3.85	$7.45	$12.58	$21.35
$7,500	$1.84	$3.04	$5.78	$11.18	$18.87	$32.03
$10,000	$2.45	$4.05	$7.70	$14.90	$25.15	$42.70
$12,500	$3.07	$5.07	$9.63	$18.63	$31.44	$53.38
$15,000	$3.68	$6.08	$11.55	$22.35	$37.73	$64.05
$17,500	$4.29	$7.09	$13.48	$26.08	$44.02	$74.73
$20,000	$4.90	$8.10	$15.40	$29.80	$50.30	$85.40
$22,500	$5.52	$9.12	$17.33	$33.53	$56.59	$96.08
$25,000	$6.13	$10.13	$19.25	$37.25	$62.88	$106.75

†Benefit reductions may apply. See plan details.

ACCIDENT

Guardian

Your accident coverage

	ACCIDENT
COVERAGE - DETAILS	
Your Semi-monthly premium	$9.79
You and Spouse	$13.46
You and Child(ren)	$13.93
You, Spouse and Child(ren)	$17.60
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $25,000 Spouse $12,500 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
RAINY DAY FUND	Benefit Amount: $400 Rollover Maximum: $200 Fund Maximum: $800
FEATURES	
Air Ambulance	$1,000
Ambulance	$200
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: $0/$2,000 18 sq inches To 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burns - Skin Graft	50% of burn benefit

ACCIDENT PREMIUM	
Employee Only:	$9.79
Employee + Spouse:	$13.46
Employee + Child(ren):	$13.93
Family:	$17.60

ACCIDENT

Guardian

Your accident coverage

FEATURES (Cont.)	
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits
Chiropractic Visits	$50/visit, up to 6 visits
Coma	$10,000
Concussion Baseline Study	$25
Concussions	$200
Diagnostic Exam (Major)	$200
Dislocations	Schedule up to $5,000
Doctor Follow-Up Visits	$50, up to 6 treatments
Emergency Dental Work	$300/Crown, $75/Extraction
Emergency Room Treatment	$200
Epidural Anesthesia Pain Management	$100, 2 times per accident
Eye Injury	$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	$20/day, up to 30 days
Fractures	Schedule up to $6,000
Gun Shot Wound	$750
Hospital Admission	$1,000
Hospital Confinement	$250/day - up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$500/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	$100
Joint Replacement (Hip/Knee/Shoulder)	$2,500/$1,250/$1,250
Knee Cartilage	$500
Laceration	Schedule up to $400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	$125/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to $500
Outpatient Therapies	$35/day, up to 10 days
Post-Traumatic Stress Disorder	$400
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$100/day, up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to $1,250 Hernia: $250
Surgery (Exploratory or Arthroscopic)	$400
Tendon/Ligament/Rotator Cuff	1: $500 2 or more: $1,000

ACCIDENT

Guardian

Your accident coverage

FEATURES (Cont.)	
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$0.50 per mile, limited to $500/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	$4,000
X - Ray	$40

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.
- **Rainy Day Fund** – Can pay benefits when a claimant has exhausted a frequency limitation that applies to a particular benefit. Rainy Day Fund will apply to the following benefits Air Ambulance, Ambulance, Blood/Plasma/Platelets, Chiropractic visits, Diagnostic Exam (Major), Doctor Follow-Up visits, Emergency Dental Work, Epidural Anesthesia Pain Management, Eye Injury, Family Care, Fractures, Gun Shot Wound, Hospital Confinement, Hospital ICU Confinement, Joint Replacement, Knee Cartilage, Lodging, Outpatient Therapies, Rehabilitation Unit Confinement, Ruptured Disc with Surgical Repair, Surgery (Cranial, Open Abdominal, Thoracic, Hernia), Surgery (Exploratory and Arthroscopic), Transportation and X-Ray, if they are included on your plan.

CANCER

Guardian

Your cancer coverage

	CANCER
COVERAGE - DETAILS	
Your Semi-monthly premium	$11.86
You and Spouse	$23.79
You and Child(ren)	$13.26
You, Spouse and Child(ren)	$25.19
INITIAL DIAGNOSIS BENEFIT - Paid when you are diagnosed with internal invasive cancer for the first time while insured under this Plan.	
Benefit Amount(s)	Employee $2,500 Spouse $2,500 Child $2,500
Benefit Waiting Period - A specified period of time after your effective date during which the Initial Diagnosis benefits will not be payable.	30 Days
CANCER SCREENING	
Benefit Amount	$50; $50 for Follow-Up screening
RADIATION THERAPY OR CHEMOTHERAPY	
Benefit	Schedule amounts up to a $10,000 benefit year maximum.
Pre-Existing Conditions Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/ 6 months treatment free/ 12 months after.
Portability: Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70.	Included
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Air Ambulance	$1,500/trip, limit 2 trips per hospital confinement
Ambulance	$200/trip, limit 2 trips per hospital confinement
Anesthesia	25% of surgery benefit
Anti-Nausea	$50/day up to $150 per month
Attending Physician	$25/day while hospital confined. Limit 75 visits.
Blood/Plasma/Platelets	$100/day up to $5,000 per year
Bone Marrow/Stem Cell	Bone Marrow: $7,500 Stem Cell: $1,500 50% benefit for 2nd transplant. $1,000 benefit if a donor
Experimental Treatment	$100/day up to $1,000/month
Extended Care Facility/Skilled Nursing care	$100/day up to 90 days per year
Government or Charity Hospital	$300 per day in lieu of all other benefits
Home Health Care	$50/visit up to 30 visits per year
Hormone Therapy	$25/treatment up to 12 treatments per year
Hospice	$50/day up to 100 days/lifetime

CANCER PREMIUM	
Employee Only:	$11.86
Employee + Spouse:	$23.79
Employee + Child(ren):	$13.26
Family:	$25.19

CANCER

Guardian

Your cancer coverage

FEATURES (Cont.)	
Hospital Confinement	$300/day for first 30 days; $600/day for 31st day thereafter per confinement
ICU Confinement	$400/day for first 30 days; $600/day for 31st day thereafter per confinement
Immunotherapy	$500 per month, $2500 lifetime max
Inpatient Special Nursing	$100/day up to 30 days per year
Medical Imaging	$100/image up to 2 per year
Outpatient and family member lodging - Lodging must be more than 50 miles from your home.	$75/day, up to 90 days per year
Outpatient or Ambulatory Surgical Center	$250/day, 3 days per procedure
Physical or Speech Therapy	$25/visit up to 4 visits per month, $400 lifetime max
Prosthetic	Surgically Implanted: $2,000/device, $4,000 lifetime max Non-Surgically: $200/device, $400 lifetime max
Reconstructive Surgery	Breast TRAM Flap $2,000 Breast reconstruction $500 Breast Symmetry $250 Facial reconstruction $500
Second Surgical Opinion	$200/surgery procedure
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600
Surgical Benefit	Schedule amount up to $4,125
Transportation/Companion Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive treatment for internal cancer.	$0.50/mile up to $1,000 per round trip/equal benefit for companion
Waiver of Premium - If you become disabled due to cancer that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled.	Included

UNDERSTANDING YOUR BENEFITS :

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

HOSPITAL INDEMNITY

Guardian

Your hospital indemnity coverage

	Hospital Indemnity
	Option 1
Coverage Details	
Your Semi-monthly premium	$8.98
You and Spouse	$18.13
You and Child(ren)	$14.42
You, Spouse and Child(ren)	$23.56
Benefits	
Hospital/ICU Admission	$1,000 per admission, limited to 1 admission(s) per insured and 3 admission(s) per covered family per benefit year.
Hospital/ICU Confinement	$200/$200 per day, limited to 15 day(s) per insured per benefit year.
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/6 months treatment free/12 months after
Portability - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.	Included
Child(ren) Age Limits	Children age birth to 26 years
Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.	

UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.

Premium will be waived if you are hospitalized for more than 30 days.

Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefit.

After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.

HOSPITAL INDEMNITY	
Employee Only:	$8.89
Employee + Spouse:	$18.13
Employee + Child(ren):	$14.42
Family:	$23.56

Guardian

Electronic Evidence of Insurability (EOI)

Our online EOI forms are an easier, quicker alternative to traditional paper forms, helping you get covered when you need to provide additional information.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for*:

- Basic life
- Voluntary life
- Short term disability
- Long term disability

How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit'.

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is available using most internet browsers.

Guardian

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.

Visit
worklife.uprisehealth.com

Access Code
worklife

For more information or support, you can reach out by phoning **1 800 386 7055**. The team is available 24 hours a day, 7 days a week[1].

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WorkLifeMatters Program services are provided by Uprise Health, and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[1]Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

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Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

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- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support
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- Moving and relocation
- Shelter and government assistance

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- Connect to counseling, work-life support or other services
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- Improve your skills with On-Demand trainings

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- Quickly and easily complete a will on your computer with EstateGuidance®
- Specify guardians, trustees and property division
- Provide funeral and burial instructions

Wellness Support
- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

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App: GuidanceNow℠
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GuidanceResources®

Guide to Using GuidanceResources® Online

First-time users, follow these simple instructions and start exploring the resources offered to you on GuidanceResources® Online.

- Go to **guidanceresources.com** to reach the website.
- Once on the guidanceresources.com home page, click the **Register** tab.
- Enter your **Organization Web ID (web ID: Guardian)** and click the Register button.
- You will then be asked to enter a **User Name** and **Password**. Both can be anything you would like them to be but should be something you will remember. The **User Name** (often your name) must be at least six characters long and should have no spaces (for example: joesmith). The **Security Questions** are meant to prompt you if you forget your password. You must select the button verifying that you are at least 13 years of age, as required by federal law. Be sure to read the **Terms of Use** and click inside the check box to indicate your agreement to those terms. Make sure that you complete all fields that have red asterisks, as these are required fields. When you've finished, click the **Submit** button at the bottom of the page. You should now be on the website.

For Future Logins

You will only need to remember your **User Name** and **Password**. When you get to step 2 above, instead of clicking on the **Register** tab, use the **Login** section and enter your **User Name** and **Password** and click the **Login** button. This will take you directly to GuidanceResources® Online.

If you have any problems registering or logging into GuidanceResources® Online, email Member Services at **memberservices@compsych.com**.

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Call: (855) 239.0743
TRS: Dial 711

Online: guidanceresources.com
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TEXAS REPUBLIC LIFE INSURANCE COMPANY

EMPLOYEE

FINANCIAL PROTECTION FOR TODAY AND TOMORROW, STARTS AT WORK.

You decide how much coverage is appropriate for you, and who you would like to cover. Employee, spouse, children and grandchildren are eligible. For less than a cup of coffee, a premium of $3.16 a week, a 35-year-old employee can purchase $30,000 of life insurance coverage (without ADB or WOP riders), through Texas Republic Life's, TrueFlex Universal life product. *(See form: TRLIC-TF-NT52LO)*

EMPLOYEES CAN EASILY QUALIFY

TrueFlex is easy to qualify for. You only answer 3 questions (at right) covering the last six months: **NO MEDICAL EXAM!**

TRUEFLEX IS EASY TO ENROLL IN

TrueFlex is easy to enroll in, right at your place of employment. No one coming to your home.

TRUEFLEX IS EASY TO FUND

TrueFlex is easy to fund by payroll deduction.

TRUEFLEX IS EASY TO PORT

TrueFlex policies are easy to port, you keep the same premium, your payment simply changes from a payroll deduction to a bank draft. No requalifying, no conversions and no decreasing face amounts.

TRUEFLEX IS EASY TO KEEP AND MAINTAIN

TrueFlex is easy to keep, *(See form: TRLIC-WFUL1)* you have permanent life insurance coverage to age 121 as long as you pay the required premiums. Texas Republic Life has a service desk to address any questions you may have, or policy services that you may need.

QUALIFICATION QUESTIONS

During the last six months, has the proposed insured:

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

Eligibility:
Employee: Ages 17-65
Spouse: Ages 17-60
Child(ren): Ages 14 days - 26 years

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TrueFlex

Class: Non-Tobacco

TEXAS REPUBLIC LIFE INSURANCE COMPANY

Issue Age (ALB)	Semi-Monthly Premium with ADB (24 Pay Periods per Year)								Age to Which Coverage is Guaranteed at Table Premium
	25,000	30,000	40,000	50,000	75,000	100,000	125,000	150,000	
17-20	5.15	5.96	7.56	9.17	13.19	17.21	21.23	25.25	66
21	5.27	6.09	7.75	9.40	13.54	17.67	21.81	25.94	66
22	5.27	6.09	7.75	9.40	13.54	17.67	21.81	25.94	65
23	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
24	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
25	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
26	5.50	6.38	8.13	9.88	14.25	18.63	23.00	27.38	63
27	5.62	6.52	8.31	10.11	14.60	19.09	23.58	28.06	63
28	5.62	6.52	8.31	10.11	14.60	19.09	23.58	28.06	62
29	5.73	6.65	8.50	10.34	14.94	19.55	24.15	28.75	62
30	5.85	6.79	8.68	10.57	15.29	20.00	24.72	29.44	60
31	5.85	6.79	8.68	10.57	15.29	20.00	24.72	29.44	60
32	6.08	7.07	9.05	11.03	15.97	20.92	25.87	30.81	61
33	6.32	7.35	9.43	11.50	16.69	21.88	27.07	32.25	62
34	6.55	7.63	9.80	11.96	17.38	22.80	28.21	33.62	62
35	6.90	8.06	10.36	12.67	18.44	24.21	29.98	35.75	64
36	7.13	8.33	10.73	13.13	19.13	25.13	31.13	37.13	64
37	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	64
38	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	65
39	8.17	9.58	12.40	15.21	22.25	29.30	36.34	43.37	66
40	8.64	10.14	13.15	16.15	23.66	31.17	38.68	46.19	67
41	9.22	10.84	14.08	17.32	25.41	33.50	41.60	49.69	68
42	10.04	11.82	15.38	18.94	27.85	36.75	45.66	54.56	70
43	10.85	12.79	16.68	20.57	30.29	40.00	49.72	59.44	72
44	11.66	13.77	17.98	22.19	32.72	43.25	53.79	64.31	73
45	12.59	14.88	19.46	24.05	35.51	46.96	58.42	69.88	74
46	13.53	16.01	20.96	25.92	38.32	50.71	63.11	75.50	75
47	14.34	16.98	22.26	27.55	40.76	53.96	67.17	80.38	76
48	15.27	18.09	23.75	29.40	43.54	57.67	71.81	85.94	77
49	16.32	19.35	25.43	31.50	46.69	61.88	77.07	92.25	78
50	17.59	20.88	27.46	34.05	50.51	66.96	83.42	99.88	79
51	19.10	22.69	29.88	37.07	55.04	73.00	90.97	108.94	80
52	20.96	24.93	32.86	40.80	60.63	80.46	100.30	120.13	82
53	22.82	27.15	35.83	44.50	66.19	87.88	109.57	131.25	83
54	24.68	29.39	38.81	48.23	71.79	95.34	118.89	142.44	85
55	26.31	31.34	41.41	51.48	76.66	101.84	127.02	152.19	86
56	27.47	32.74	43.28	53.82	80.16	106.50	132.85	159.19	85
57	28.29	33.72	44.58	55.44	82.60	109.75	136.91	164.06	84
58	29.21	34.83	46.06	57.30	85.38	113.46	141.55	169.63	84
59	30.38	36.23	47.93	59.63	88.88	118.13	147.38	176.63	84
60	31.12	37.12	49.11	61.11	91.10	121.09	151.08	181.06	84
61	33.80	40.33	53.40	66.46	99.13	131.80	164.46	197.12	85
62	37.05	44.23	58.60	72.96	108.88	144.80	180.71	216.62	87
63	39.25	46.88	62.13	77.38	115.50	153.63	191.75	229.88	89
64	41.50	49.58	65.73	81.88	122.25	162.63	203.00	243.38	93
65	43.88	52.43	69.53	86.63	129.38	172.13	214.88	257.63	94

Spouse Covered Ages: (17-60) - Spouse Policy: Based on Spouse Age: Max of $50,000

Child Policy: $25,000 for $4.50 per pay period, per child.

TrueFlex

Class: Tobacco

TEXAS REPUBLIC LIFE INSURANCE COMPANY

Issue Age (ALB)	Semi-Monthly Premium with ADB (24 Pay Periods per Year)								Age to Which Coverage is Guaranteed at Table Premium
	25,000	30,000	40,000	50,000	75,000	100,000	125,000	150,000	
17-20	7.13	8.33	10.73	13.13	19.13	25.13	31.13	37.13	66
21	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	66
22	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	65
23	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
24	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
25	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
26	7.83	9.17	11.85	14.53	21.22	27.92	34.62	41.31	63
27	7.94	9.30	12.03	14.75	21.57	28.38	35.19	42.00	63
28	8.06	9.44	12.21	14.98	21.91	28.84	35.77	42.69	62
29	8.17	9.58	12.40	15.21	22.25	29.30	36.34	43.37	62
30	9.11	10.70	13.90	17.09	25.07	33.05	41.03	49.00	60
31	9.11	10.70	13.90	17.09	25.07	33.05	41.03	49.00	60
32	9.34	10.98	14.26	17.55	25.76	33.96	42.17	50.38	61
33	9.45	11.12	14.45	17.78	26.10	34.42	42.74	51.06	62
34	9.57	11.25	14.63	18.00	26.44	34.88	43.32	51.75	62
35	10.15	11.96	15.56	19.17	28.19	37.21	46.23	55.25	64
36	10.50	12.38	16.13	19.88	29.25	38.63	48.00	57.38	64
37	11.08	13.07	17.05	21.03	30.97	40.92	50.87	60.81	64
38	11.43	13.49	17.61	21.73	32.04	42.34	52.64	62.94	65
39	12.13	14.33	18.73	23.13	34.13	45.13	56.13	67.13	66
40	13.17	15.58	20.40	25.21	37.25	49.30	61.34	73.37	67
41	13.98	16.55	21.70	26.84	39.69	52.55	65.40	78.25	68
42	15.04	17.82	23.38	28.94	42.85	56.75	70.66	84.56	70
43	16.66	19.77	25.98	32.19	47.72	63.25	78.79	94.31	72
44	17.59	20.88	27.46	34.05	50.51	66.96	83.42	99.88	73
45	18.87	22.42	29.51	36.61	54.35	72.09	89.83	107.56	74
46	20.04	23.82	31.38	38.94	57.85	76.75	95.66	114.56	75
47	21.19	25.20	33.23	41.25	61.32	81.38	101.44	121.50	76
48	22.36	26.60	35.10	43.59	64.82	86.05	107.28	128.50	77
49	24.21	28.83	38.06	47.30	70.38	93.46	116.55	139.63	78
50	25.49	30.37	40.11	49.86	74.22	98.59	122.95	147.31	79
51	27.47	32.74	43.28	53.82	80.16	106.50	132.85	159.19	80
52	29.91	35.67	47.18	58.69	87.47	116.25	145.04	173.81	82
53	31.89	38.04	50.35	62.65	93.41	124.17	154.93	185.69	83
54	34.33	40.97	54.25	67.53	100.72	133.92	167.12	200.31	85
55	36.08	43.07	57.05	71.03	105.97	140.92	175.87	210.81	86
56	37.59	44.88	59.46	74.05	110.51	146.96	183.42	219.88	85
57	38.74	46.27	61.31	76.36	113.97	151.59	189.20	226.81	84
58	40.84	48.78	64.66	80.55	120.26	159.96	199.67	239.38	84
59	42.59	50.88	67.46	84.05	125.51	166.96	208.42	249.88	84
60	43.68	52.19	69.21	86.23	128.79	171.34	213.89	256.44	84
61	46.70	55.82	74.05	92.28	137.85	183.42	228.99	274.56	85
62	50.54	60.42	80.18	99.94	149.35	198.75	248.16	297.56	87
63	54.48	65.15	86.50	107.84	161.19	214.55	267.90	321.25	89
64	58.79	70.32	93.38	116.44	174.10	231.75	289.41	347.06	93
65	61.69	73.80	98.03	122.25	182.82	243.38	303.94	364.50	94

Spouse Covered Ages: (17-60) - Spouse Policy: Based on Spouse Age: Max of $50,000

Child Policy: $25,000 for $4.50 per pay period, per child.

MASA Medical Transport Solutions®

DID YOU KNOW?

25 MILLION PEOPLE
are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in in-network out-of-pocket costs.**

Ground ambulance out-of-network transportation costs may be even higher than in-network.

EMERGENT PLUS MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefi ts network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]
MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Contact Your Representative, to learn more:

@ ☎

457B PLAN

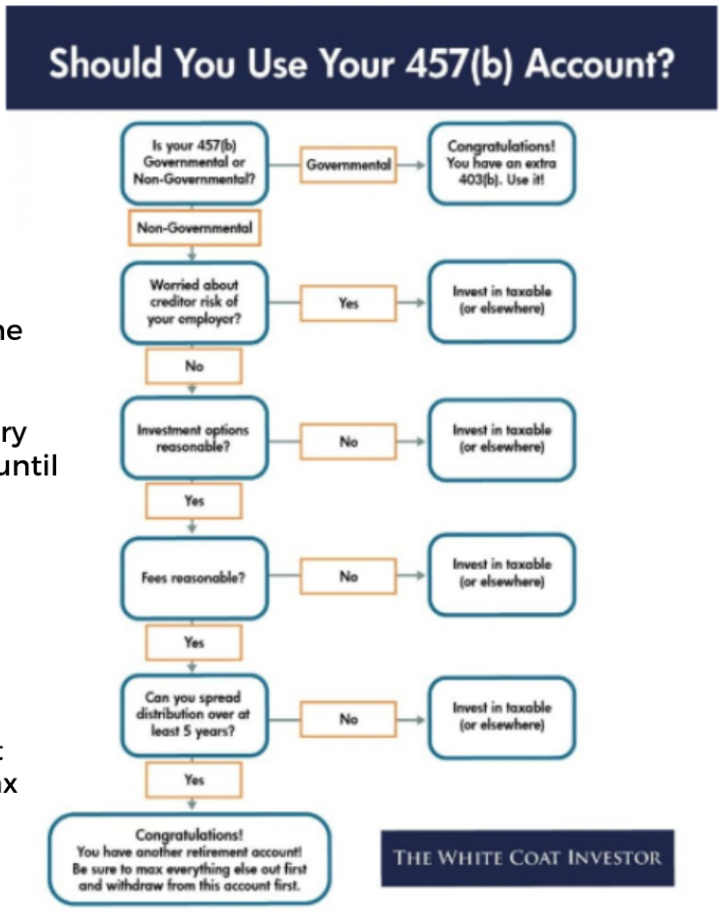
WHAT IS A 457(B) PLAN?

-Section 457 (b) of the Internal Revenue code.

-It can help you save and invest extra retirement money.

-You can voluntarily set aside some of your income before you pay current taxes.

-Contributions to the plan through voluntary salary deferral and any earnings can grow tax deferred until withdrawn, usually during retirement



BENEFITS OF A 457(B) PLAN?

#1 Additional savings- the main benefit of using a 457(b) plan is you basically get another retirement plan similar to your 403(b). you can double your tax deduction and double your savings.

#2 No Early Withdrawal Penalty
457(b) plans are not subject to the Age 59 1/2 rule, meaning you can access the money without penalty as soon as you leave the employer. They're a great option to spend during early retirement. You just withdraw from the 457(b) first and leave your other retirement accounts until your 60s and later.

#3 Asset Protection
Like most retirement plans, 457(b) plans are good asset protection vehicles since they are generally protected from YOUR creditors. Governmental 457(b) plans are held in trust. Non-governmental 457(b) plans are subject to the creditors of your employer.

STONEWATER
Wealth Management, Inc
Relationships Matter

CONTACTS

	Darcie Ragsdale Human Resources	254-978-4810 hr@bosquecounty.us
ANCO INSURANCE	Kelly Coppock Account Manager	979-774-6214 coppockk@anco.com
BaylorScott&White Health Plan	Medical Network: BSW Access PPo Group Number: 06663	844-633-5325
Guardian	Dental/Vision/Life/Disability/ Critical Illness/Accident/Hospital Indemnity Dental Network: DentalGuard Preferred Vision Network: VSP Choice & Davis Vision Group Number: 00055060	1-800-627-4200 guardiananytime.com Employee Assistance Program 1-800-386-7055 worklife.uprisehealth.com Access Code: worklife
nonstop	NonStop Health	877-626-6057 www.nonstophealth.com
STONEWATER Wealth Management, Inc *Relationships Matter*	Stonewater Wealth Management, Inc.	Office: 361-482-0699 Fax: 361-482-0701 admin@stonewaterwealth.info

NOTES

NOTES

HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, **you must request enrollment within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, please contact:

Darcie Ragsdale
hr@bosquecounty.us | 254-978-4810

Important Warning
If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Women's Health and Cancer Act of 1998 (WHCRA)

Under Women's Health and Cancer Rights Act of 1998 (WHCRA), group health plans are required to provide benefits for mastectomy-related services. If you have had or are going to have a mastectomy, you may be entitled to certain benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation withthe attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefitsprovided under the plan. Please review your plan materials regarding any deductibles and/or coinsurance or call your Plan Administrator/benefits contact representative with any questions, concerns and/or more information on WHCRA benefits.

Notice for Newborns' and Mothers' Health Protection Act (Newborns' Act)

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

USERRA Notice

HEALTH INSURANCE PROTECTION ☆☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. ☆☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For your full Uniformed Service Employment and Reemployment Rights Act protections, please visit:

https://www.dol.gov/agencies/vets/programs/userra

Summary of Material Modifications Disclosure

This Employee Benefits Communication serves as notice of material changes to your employer sponsored health benefits plan(s). It describes the changes that affect your benefits plans and updates the Summary Plan Description (SPD). Please read this information thoroughly and keep it with your group health plan SPD. You can request a copy of your SPD by contacting your group health plan administrator.

No Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact Federal No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

For Patients and Plans that have protections under the State Law by **the Texas Department of Insurance, please visit https://www.tdi.texas.gov/medical-billing/index.html for more information.**

Medicare Part D – Notice of CREDITABLE Coverage

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

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

2. **Bosque County** has determined that the prescription drug coverage offered by the **Baylor Scott & White** is, on average for all plan participants on Plan UHB4H1S1 w. LRXPIO24 is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current **Bosque County** coverage will or will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription coverage. If they select Medicare Part D prescription drug coverage, the group health plan drug coverage *may or may not* coordinate with Medicare Part D prescription coverage.

If you do decide to join a Medicare drug plan and drop your current **Bosque County** coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage: Visit

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

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

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

CONTACT INFORMATION:

Bosque County
Plan Effective Date: October 1, 2024
Plan Sponsor Contact: Darcie Ragsdale
hr@bosquecounty.us | 254-978-4810

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the **2024 Plan Year** with respect to mental health or substance use disorder benefits, please contact your plan administrator:

Darcie Ragsdale
hr@bosquecounty.us | 254-978-4810

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.

[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 **Darcie Ragsdale**
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: Bosque County		4. Employer Identification Number (EIN): 74-6001721
5. Employer Address: 110 S Main		6. Employer Phone Number 254-435-2382
7. City: Meridian	8. State: TX	9. Zip Code: 76665
10. Who can we contact about employee health coverage at this job?: Darcie Ragsdale		
11. Phone # (If different than above:	12. Email Address: hr@bosquecounty.us	

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:

  [X] Full time equivalent employees working 30 hours or more per week.

  [ ] Some employees. Eligible employees are:

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:

  Spouses and children to age 26

  [ ] We do not offer coverage.

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

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

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

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? $ 0.00
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?_____
☐ 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)

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