



PIERCE GROUP BENEFITS

EMPLOYEE BENEFITS PLAN

PRINCE GEORGE COUNTY PUBLIC SCHOOLS
PLAN YEAR: JULY 1, 2020 - JUNE 30, 2021



ARRANGED BY PIERCE GROUP BENEFITS

WWW.PIERCEGROUPBENEFITS.COM

EMPLOYEE BENEFITS GUIDE

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Welcome to the Prince George County Public Schools comprehensive benefits program. This booklet highlights the benefits offered to all eligible employees for the plan year listed below. Benefits described in this booklet are voluntary, employee-paid benefits unless otherwise noted.

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EFFECTIVE DATES: JULY 1, 2020 - JUNE 30, 2021

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PRE-TAX & POST-TAX BENEFITS

PRINCE GEORGE COUNTY PUBLIC SCHOOLS

ENROLLMENT PERIOD: APRIL 20, 2020 - MAY 15, 2020

EFFECTIVE DATES: JULY 1, 2020 - JUNE 30, 2021

PRE-TAX BENEFITS



Health Insurance
Anthem



Dental Insurance
Delta



Vision Insurance
Anthem Blue View



Health Savings Accounts

HSA Bank

- Employee Maximum \$3,550/year
- Family Maximum \$7,100/year

HSA plans can only be established in conjunction with a qualified High-Deductible Health Plan (HDHP)

Prince George County Public Schools contributes to the Employee HSA twice per year. 12-month employees will receive the first half in July and the second half in January. 10-month employees will receive the first half in September and the second half in January.

Employee Only - \$1,500 / Employee + Spouse - \$1,750 / Employee + Child - \$1,750 / Employee + Children - \$2,000 / Employee + Family - \$2,000

Please Note: Employees must be enrolled in the HDHP to enroll in the HSA with the employer contributions.



Dependent Care Flexible Spending Account

Ameriflex

- Dependent Care Reimbursement FSA Maximum: \$5,000/year

You will need to re-sign for the Flexible Spending Account if you want it to continue next year.

IF YOU DO NOT RE-SIGN, YOUR CONTRIBUTION WILL STOP EFFECTIVE JUNE 30, 2020.



Cancer Benefits
Colonial Life



Accident Benefits
Colonial Life



Medical Bridge Benefits
Colonial Life

POST-TAX BENEFITS



Disability Benefits
Colonial Life



Critical Care Benefits
Colonial Life



Life Insurance
Colonial Life

- Term Life Insurance
- Whole Life Insurance

Please note your insurance products will remain in effect unless you see a representative to change them.

QUALIFICATIONS & IMPORTANT INFO

THINGS YOU NEED TO KNOW

QUALIFICATIONS:

- You must work 30 hours or more per week to be eligible for benefits.

IMPORTANT FACTS:

- The plan year for Anthem Health, Delta Dental, Anthem Blue View Vision, Colonial Insurance products, Health Savings Accounts and the Dependent Care Spending Account lasts from July 1, 2020 through June 30, 2021.
- Deductions for Anthem Health, Delta Dental and Anthem Blue View Vision will begin June 2020. Deductions for Colonial Insurance products, Health Savings Accounts and the Dependent Care Spending Account will begin July 2020.
- If signing up for any coverage on your spouse and/or children, please have their dates of birth and social security numbers available when meeting with the Benefits Representative.
- If you will be receiving a new debit card, whether you are a new participant or to replace your expired card, please be aware that it may take up to 30 days following your plan effective date for your card to arrive. Your card will be delivered by mail in a plain white envelope. During this time you may use manual claim forms for eligible expenses. Please note that your debit card is good through the expiration date printed on the card.
- Elections made during this enrollment period **CANNOT BE CHANGED AFTER THE ENROLLMENT PERIOD** unless there is a family status change as defined by the Internal Revenue Code. Examples of a family status change are: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of a spouse's employment, or the transition of spouse's employment from full-time to part-time, or vice-versa.
- Once a family status change has occurred, an employee has 30 days to notify the Pierce Group Benefits Service Center at 1-800-387-5955 to request a change in elections.
- Dependent Care Flexible Spending Account expenses must be incurred during the Plan Year in order to be eligible for reimbursement.
- An employee has 90 days after the plan year ends to submit claims for spending account expenses that were incurred during the plan year. Please note that if employment terminates during the plan year, that employee's plan year ends the day employment ends. The employee has 90 days after the termination date to submit claims.
- With Dependent Care Flexible Spending Accounts, the maximum reimbursement you can request is equal to the current account balance in your Dependent Care account. *You cannot be reimbursed more than has actually been deducted from your pay.*
- The Health Screening Rider on the Colonial Medical Bridge plan has a 30-day waiting period for new enrollees. Coverage, therefore, will not begin until July 31, 2020.
- Additionally, some policies may include a pre-existing condition clause. Please read your policy carefully for full details.
- Please be aware there are certain coverages that may be subject to federal and state tax when premium is paid by pretax deduction or employee contribution.
- An employee taking a leave of absence, other than under the Family & Medical Leave Act, may not be eligible to re-enter the Flexible Benefits Program until the next plan year. Please contact your Benefit Administrator for more information.

EMPLOYEE BENEFITS GUIDE

PRINCE GEORGE COUNTY PUBLIC SCHOOLS



IN PERSON

During your open enrollment period, a Pierce Group Benefits representative will be available by appointment to answer any questions you may have and to assist you in the enrollment process.



ONLINE

You may enroll or make changes online to your flexible benefits plan. To enroll online, please visit <https://harmonyenroll.coloniallife.com>

ENROLLMENT PERIOD: APRIL 20, 2020 - MAY 15, 2020

YOU CAN MAKE THE FOLLOWING BENEFIT ELECTIONS ONLINE DURING THE ENROLLMENT PERIOD:

- Enroll, change or cancel your Health Insurance.
- Enroll, change or cancel your Vision Insurance.
- Enroll, change or cancel your Dental Insurance.
- Enroll in Health Savings Account (HSA).
- Enroll in Flexible Spending Account (Dependent Care).
- Enroll, change or cancel your Colonial products (see the following pages for changes that can be completed online).

ACCESS YOUR BENEFITS ONLINE WHENEVER, WHEREVER.

Benefits Details | Educational Videos | Download Forms | Online Chat with Service Center

To view your personalized benefits website, go to:

www.piercgroupbenefits.com/princegeorgecountypublicschools
or piercgroupbenefits.com and click “Find Your Benefits”.

IMPORTANT NOTE & DISCLAIMER

This is neither an insurance contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premiums quoted is subject to change. All policy descriptions are for information purposes only. Your actual policies may be different than those in this booklet.



HARMONY ONLINE ENROLLMENT:

COMPLETE THE STEPS BELOW TO BEGIN THE ONLINE ENROLLMENT PROCESS

HELPFUL TIPS:

- If you are a new employee and unable to log into the online system, please speak with the Benefits Representative assigned to your location, or contact Human Resources.
- If you are an existing employee and unable to log into the online system, please contact the Harmony Help Desk at 866-875-4772 between 8:30am and 6:00pm, or speak with the Benefits Representative assigned to your location.

1.

Go to <https://harmonyenroll.coloniallife.com>

• **Enter your User Name:** PRI7J5P *and then* Last Name *and then* Last 4 of Social Security Number

(PRI7J5PSMITH6789)

• **Enter your Password:** Four digit Year of Birth *and then* Last 4 of Social Security Number (19766789)

2.

The screen prompts you to create a NEW password [_____].

3.

Choose a security question and enter answer [_____].

4.

Click on 'I Agree' and then "Enter My Enrollment".

5.

The screen shows 'Me & My Family'. Verify that the information is correct and enter the additional required information (title, marital status, work phone, e-mail address). Click 'Save & Continue' twice.

6.

The screen allows you to add family members. It is only necessary to enter family member information if adding or including family members in your coverage. Click 'Continue'.

7.

The screen shows updated personal information. Verify that the information is correct and make changes if necessary. Click 'Continue'.

8.

The screen shows 'My Benefits'. Review your current benefits and make changes/selections for the upcoming plan year.

• **HEALTH BENEFITS:** You may enroll online in Health benefits.

• **DENTAL BENEFITS:** You may enroll online in Dental benefits.

• **VISION BENEFITS:** You may enroll online in Vision benefits.

• **HEALTH SAVINGS ACCOUNT**

Enter annual amount. EMPLOYEE MAX \$3,550/year FAMILY MAX \$7,100/year

HSA plans can only be established in conjunction with a qualified High Deductible Health Plan (HDHP)

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Employee Only - \$1,500 / Employee + Spouse - \$1,750 / Employee + Child - \$1,750 /

Employee + Children - \$2,000 / Employee + Family - \$2,000

Please Note: Employees must be enrolled in the HDHP to enroll in the HSA with the employer contributions.

• **DEPENDENT CARE FSA**

Enter annual amount. MAX \$5,000/year

<<< enrollment instructions continued on next page >>>



HARMONY ONLINE ENROLLMENT CONT.:

- **CANCER ASSIST**
You may enroll online in Cancer Assist coverage.
- **DISABILITY - EDUCATOR 1.0**
You may enroll online in Educator 1.0 coverage.
- **ACCIDENT 1.0**
You may enroll online in Accident 1.0; however persons over age 64 applying for coverage and employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.
- **MEDICAL BRIDGE**
You may enroll online in Medical Bridge coverage.
- **CRITICAL CARE**
You may enroll online in Critical Care coverage.
- **TERM LIFE 5000**
You may enroll online in Term Life 5000; however, employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.
- **WHOLE LIFE 5000**
You may enroll online in Whole Life 5000; however, employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.

9.

Click 'Finish'.

10.

Click 'I Agree' to electronically sign the authorization for your benefit elections.

11.

Click 'Print a copy of your Elections' to print a copy of your elections, or download and save the document.
Please do not forget this important step!

12.

Click 'Log out & close your browser window' and click 'Log Out'.

Health Benefits – HDHP w/ HSA	Member Pays	
	In-Network	Out-of-Network
Benefit Year Deductible (Individual/Family)	\$3,000/\$6,000	\$6,000/\$12,000
Coinsurance	0%	30%
Benefit Year Out-of-Pocket Maximum (Individual/Family) <i>In and Out-of-Network Out-of-Pocket Maximums combined</i>	\$4,000/\$8,000	\$10,000/\$20,000
Maximum Lifetime Benefit Per Member	Unlimited	
Routine Wellness/Preventive Services	Plan pays 100% Deductible does not apply	30% coinsurance, after the deductible has been met
Physician Office Services – Primary Care Physician (PCP)	0% after deductible has been met	30% coinsurance after the deductible has been met
Physician Office Services – Specialist	0% after deductible has been met	30% co-insurance after the deductible has been met
LiveHealth Online - Telehealth Benefit	0% after deductible has been met	30% after deductible has been met
Annual Routine Eye Exam	\$15 copay per visit.	Reimbursed up to \$30
Labs, Diagnostic X-Rays and other Outpatient Services	0% after deductible has been met	30% after deductible has been met
Advanced Imaging – CT, PET, MRI, MRA and Nuclear Medicine – Precertification Required	0% after deductible has been met	30% after deductible has been met
Urgent Care Services	0% after deductible has been met	30% after deductible has been met
Emergency Room Hospital and Physician Services - <i>must meet Emergency criteria, subject to prudent layperson review</i>	0% after deductible has been met	0% after deductible has been met
Ambulance Services	0% after deductible has been met	0% after deductible has been met
Inpatient Services - Facility and Services	0% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Outpatient Surgery	0% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Skilled Nursing Facility (150 day per stay limit)	0% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Hospice Care Inpatient -/Health Care Facility	0% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Home Health Care (100-visit plan year limit per member)	0% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met

Health Benefits – HDHP w/ HSA	Member Pays	
	In-Network	Out-of-Network
Short Term Rehabilitation Physical Therapy* Occupational Therapy* *60 visits combined Speech Therapy (30 visit limit) Chiropractic (30 visit limit)	0% after deductible has been met	30% coinsurance after deductible has been met
Mental Health Services Outpatient Inpatient Partial Hospitalization/Intensive Outpatient Treatment	0% after deductible has been met	30% coinsurance after the deductible has been met
Substance Use Disorder Services Outpatient Inpatient Partial Hospitalization/Intensive Outpatient Treatment	0% after deductible has been met	30% coinsurance after the deductible has been met
Prescription Drug Coverage	After deductible has been met: (30 Day Supply) Tier 1 - \$10 Tier 2 - \$40 Tier 3 - \$60 Tier 4 – 20% up to \$250/script (Home Delivery– 90 Day Supply) Tier 1 - \$25 Tier 2 - \$100 Tier 3 - \$150 Tier 4 – 20% up to \$250/script	30% coinsurance after deductible has been met (Retail) Not Covered (Home Delivery)

This overview does not replace your Certificate of Coverage. Many words are defined in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this overview by itself could give you an inaccurate impression of the terms of your coverage. This overview must be read with the rest of your Certificate of Coverage. Prior authorization is required for specific services.

Health Benefits – Anthem POS	Member Pays	
	In-Network	Out-of-Network
Benefit Year Deductible (Individual/Family)	\$500/\$1,000	\$1,000/\$2,000
Coinsurance	30%	30%
Benefit Year Out-of-Pocket Maximum (Individual/Family) <i>In and Out-of-Network Out-of-Pocket Maximums combined</i>	\$4,000/\$8,000	\$11,250/\$22,500
Maximum Lifetime Benefit Per Member	Unlimited	
Routine Wellness/Preventive Services	\$0	30% coinsurance, after the deductible has been met
Physician Office Services – Primary Care Physician (PCP)	\$30 Copay	30% coinsurance after the deductible has been met
Physician Office Services – Specialist	\$60 Copay	30% co-insurance after the deductible has been met
LiveHealth Online - Telehealth Benefit	\$20 copay per visit	30% co-insurance after the deductible has been met
Annual Routine Eye Exam	\$15 copay per visit.	Reimbursed up to \$30
Diagnostic Labs	\$0	30% after deductible has been met
X-Rays and other Outpatient Services	30% after deductible has been met	30% after deductible has been met
Advanced Imaging – CT, PET, MRI, MRA and Nuclear Medicine – Precertification Required	30% after deductible has been met	30% after deductible has been met
Urgent Care Services	\$50 copay per visit	30% after deductible has been met
Emergency Room Hospital and Physician Services - <i>must meet Emergency criteria, subject to prudent layperson review</i>	30% after deductible has been met	30% after deductible has been met
Ambulance Services	30% after deductible has been met	30% after deductible has been met
Inpatient Services - Facility and Services	30% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Outpatient Surgery	30% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Skilled Nursing Facility (150 day per stay limit)	30% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Hospice Care Inpatient -/Health Care Facility	30% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met

Health Benefits – Anthem POS	Member Pays	
	In-Network	Out-of-Network
Home Health Care (100-visit plan year limit per member)	30% coinsurance after the deductible has been met	30% coinsurance after the deductible has been met
Short Term Rehabilitation Physical Therapy* Occupational Therapy* *60 visits combined Speech Therapy (60 visit limit. Limit does not apply to autism services)	30% after deductible has been met	30% coinsurance after deductible has been met
Chiropractic Services (30-visits per plan year max)	\$30 Copay	30% coinsurance after deductible has been met
Mental Health Services Outpatient office visits Inpatient Partial Hospitalization/Intensive Outpatient Treatment	\$30 per visit 30% after deductible has been met	30% coinsurance after the deductible has been met
Substance Use Disorder Services Outpatient office visits Inpatient Partial Hospitalization/Intensive Outpatient Treatment	\$30 per visit 30% after deductible has been met	30% coinsurance after the deductible has been met
Prescription Drug Coverage	(30 Day Supply) Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$60 Tier 4 – \$125 (Home Delivery– 90 Day Supply) Tier 1 - \$35 Tier 2 - \$75 Tier 3 - \$150 Tier 4 – \$125	30% coinsurance (retail) and Not Covered (home delivery)

This overview does not replace your Certificate of Coverage. Many words are defined in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this overview by itself could give you an inaccurate impression of the terms of your coverage. This overview must be read with the rest of your Certificate of Coverage. Prior authorization is required for specific services.

Benefits for Prince George County Schools Low Option Group Number: 6107

Annual Deductible (<i>Applies to Basic and Major Services</i>)	\$75 per person; \$225 per family, per contract year
Annual Maximum	\$1,250 per enrollee, per contract year
MaxOver™ Carryover	Your plan allows a portion of an enrollee's annual maximum to be carried over to the next year.
<i>Healthy Smile, Healthy You</i> ® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the <i>Healthy Smile, Healthy You</i> Program is simple. Visit DeltaDentalVA.com to print an enrollment form.

Covered Benefits					
Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.					
Coverage	Coinsurances			Benefit Limitations	Benefit Waiting Period
	In-Network		Out-of-Network		
	PPO	Premier			
Diagnostic and Preventive Services	100%	100%	100%		None
<ul style="list-style-type: none">Oral exams and cleaningsPeriodontal cleaningsFluoride applicationsBitewing X-raysFull mouth/panelpipse X-raysSealantsSpace maintainers				Twice in a 12 consecutive month period. Twice in a 12 consecutive month period. Twice in a 12 consecutive month period for enrollees under the age of 19. One set in a 12 consecutive month period. Once in a 5-year period. One application per tooth every 5 years for enrollees under the age of 16 on non-carious, non-restored 1 st and 2 nd permanent molars. Once per quadrant per arch for enrollees under the age of 14.	
Basic Services	50%	50%	50%		None
<ul style="list-style-type: none">Amalgam (silver) and composite (white) fillingsStainless steel crownsSimple extractionsDenture repair and recementation of crowns, bridges and dentures				Once per surface in a 24-month period; Composite (white) fillings are limited to upper and lower 6 front teeth. Primary (baby) teeth for enrollees under the age of 14. Once in a 12-month period after 6 months from initial placement.	

Other Basic Services	50%	50%	50%		12 months
<ul style="list-style-type: none"> • Complex oral surgery • Endodontic services/root canal therapy • Periodontic services 				Surgical extractions and other surgical procedures. Retreatment only after 24 months from initial root canal therapy treatment. Once per quadrant in a 24-36 month period based on services rendered.	
Major Services	50%	50%	50%		12 months
<ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed • Implants 				Once per tooth in a 7 year period for enrollees age 12 and older. Once in a 7 year period for enrollees age 16 and older. Once per site for enrollees age 16 and older.	

. Employees hired after the initial enrollment may have the waiting period waived by providing proof of credible coverage.

COVERAGE IS AVAILABLE FOR

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

CHOOSING A DENTIST

You may select the dentist of your choice. However, to get the full advantage of your Delta Dental coverage, you should choose a dentist who participates in the Delta Dental network(s) covered by your plan.

Delta Dental PPO™ and Delta Dental Premier® dentists have agreed to accept Delta Dental's plan allowance, plus any required coinsurance and deductible (if applicable) as payment in full. In addition, Delta Dental PPO™ and Delta Dental Premier® dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist.

Non-Participating dentists have not agreed to accept Delta Dental's plan allowance as full payment. After Delta Dental pays its portion of the bill, you are responsible for any required coinsurance and deductible (if applicable), as well as the difference between the non-participating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

Please visit DeltaDentalVA.com to find a participating dentist in your area.

The following chart illustrates how choosing a network dentist helps you save on out-of-pocket costs.

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

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

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

**Benefits for Prince George County Schools
High Option
Group Number: 6107**

Annual Deductible (<i>Applies to Basic and Major Services</i>)	\$50 per person; \$150 per family, per contract year
Annual Maximum	\$1,250 per enrollee, per contract year
Orthodontic Lifetime Maximum	\$1,000 per person
MaxOver™ Carryover	Your plan allows a portion of an enrollee's annual maximum to be carried over to the next year.
Healthy Smile, Healthy You® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the Healthy Smile, Healthy You Program is simple. Visit DeltaDentalVA.com to print an enrollment form.

Covered Benefits					
Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.					
Coverage	Coinsurances			Benefit Limitations	Benefit Waiting Period
	In-Network		Out-of-Network		
	PPO	Premier			
Diagnostic and Preventive Services	100%	100%	100%		None
<ul style="list-style-type: none">Oral exams and cleaningsPeriodontal cleaningsFluoride applicationsBitewing X-raysFull mouth/panelpipse X-raysSealantsSpace maintainers				Twice in a 12 consecutive month period. Twice in a 12 consecutive month period. Twice in a 12 consecutive month period for enrollees under the age of 19. One set in a 12 consecutive month period. Once in a 5-year period. One application per tooth every 5 years for enrollees under the age of 16 on non-carious, non-restored 1 st and 2 nd permanent molars. Once per quadrant per arch for enrollees under the age of 14.	
Basic Services	80%	80%	80%		None
<ul style="list-style-type: none">Amalgam (silver) and composite (white) fillingsStainless steel crownsSimple extractionsDenture repair and recementation of crowns, bridges and dentures				Once per surface in a 24-month period. Primary (baby) teeth for enrollees under the age of 14. Once in a 12-month period after 6 months from initial placement.	

Other Basic Services	50%	50%	50%		12 months
<ul style="list-style-type: none"> • Complex oral surgery • Endodontic services/root canal therapy • Periodontic services 				Surgical extractions and other surgical procedures. Retreatment only after 24 months from initial root canal therapy treatment. Once per quadrant in a 24-36 month period based on services rendered.	
Major Services	50%	50%	50%		12 months
<ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed • Implants 				Once per tooth in a 7 year period for enrollees age 12 and older. Once in a 7 year period for enrollees age 16 and older. Once per site for enrollees age 16 and older.	
Orthodontic Services	50%	50%	50%		None
<ul style="list-style-type: none"> • Treatment for the proper alignment of teeth 				For dependent children to the end of the month they reach age 19.	

Employees hired after the initial enrollment may have the waiting period waived by providing proof of credible coverage.

COVERAGE IS AVAILABLE FOR

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

CHOOSING A DENTIST

You may select the dentist of your choice. However, to get the full advantage of your Delta Dental coverage, you should choose a dentist who participates in the Delta Dental network(s) covered by your plan.

Delta Dental PPO™ and Delta Dental Premier® dentists have agreed to accept Delta Dental's plan allowance, plus any required coinsurance and deductible (if applicable) as payment in full. In addition, Delta Dental PPO™ and Delta Dental Premier® dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist.

Non-Participating dentists have not agreed to accept Delta Dental's plan allowance as full payment. After Delta Dental pays its portion of the bill, you are responsible for any required coinsurance and deductible (if applicable), as well as the difference between the non-participating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

Please visit DeltaDentalVA.com to find a participating dentist in your area.

The following chart illustrates how choosing a network dentist helps you save on out-of-pocket costs.

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

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

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

Welcome to your Blue View Vision plan!

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

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$15 copay	Up to \$30 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	\$140 allowance, then 20% off any remaining balance	Up to \$45 allowance	Once every 12 months
Eyeglass Lenses <i>(instead of contact lenses)</i>			
One pair of standard plastic prescription lenses: <ul style="list-style-type: none">• Single vision lenses• Bifocal lenses• Trifocal lenses	\$25 copay \$25 copay \$25 copay	Up to \$25 allowance Up to \$40 allowance Up to \$55 allowance	Once every 12 months
Eyeglass Lens Enhancements			
When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
<ul style="list-style-type: none">• Transitions Lenses (for a child under age 19)• Standard polycarbonate (for a child under age 19)• Factory scratch coating	\$0 copay \$0 copay \$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses <i>(instead of eyeglass lenses)</i>			
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
<ul style="list-style-type: none">• Elective conventional (non-disposable) OR <ul style="list-style-type: none">• Elective disposable OR <ul style="list-style-type: none">• Non-elective (medically necessary)	\$140 allowance, then 15% off any remaining balance \$140 allowance <i>(no additional discount)</i> Covered in full	Up to \$105 allowance Up to \$105 allowance Up to \$210 allowance	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Plano sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than \$39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> • Transitions lenses (Adults) \$75 • Standard Polycarbonate (Adults) \$40 • Tint (Solid and Gradient) \$15 • UV Coating \$15 • Progressive Lenses¹ <ul style="list-style-type: none"> • Standard \$65 • Premium Tier 1 \$85 • Premium Tier 2 \$95 • Premium Tier 3 \$110 • Anti-Reflective Coating² <ul style="list-style-type: none"> • Standard \$45 • Premium Tier 1 \$57 • Premium Tier 2 \$68 • Other Add-ons 20% off retail price 	
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	<ul style="list-style-type: none"> • Complete Pair 40% off retail price • Eyeglass materials purchased separately 20% off retail price 	
Eyewear Accessories	<ul style="list-style-type: none"> • Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 20% off retail price 	
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	<ul style="list-style-type: none"> • Standard contact lens fitting³ • Premium contact lens fitting⁴ 	Up to \$55 10% off retail price
Conventional Contact Lenses	<ul style="list-style-type: none"> • Discount applies to materials only 	15% off retail price

¹ Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the available coating brands by tier.

³ Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

⁴ Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

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

GLASSES.com

contactsdirect



OPTICAL



JCPenney | optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK


If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form.

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

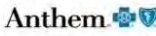
Prince George County Public Schools

July 1, 2020 - June 30, 2021

Contribution Schedule

	Anthem High Deductible Health Plan (HDHP) w/ HSA					
	Employee Only	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family	Dual EE/Family PGCPS
Total Monthly Premium	\$553.73	\$740.90	\$960.73	\$1,057.64	\$1,267.51	\$1,267.51
County Monthly Contribution	\$526.73	\$676.90	\$729.73	\$750.64	\$837.51	\$1,050.30
Employee Monthly Contribution	\$27.00	\$64.00	\$231.00	\$307.00	\$430.00	\$217.21

Health Savings Account	Annual Employer Contribution for HDHP plan participants (amount will be divided and deposited semi annually)				
	Employee	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family
	\$1,500.00	\$1,750.00	\$2,000.00	\$1,750.00	\$2,000.00

	Anthem POS 30/500/30					
	Employee	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family	Dual EE/Family PGCPS
Total Monthly Premium	\$621.47	\$831.52	\$1,078.24	\$1,187.01	\$1,422.55	\$1,422.55
County Monthly Contribution	\$526.73	\$676.90	\$729.73	\$750.64	\$837.51	\$1,050.30
Employee Monthly Contribution	\$94.74	\$154.62	\$348.51	\$436.37	\$585.04	\$372.25

	Delta Dental - Low Plan Option				
	Employee	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family
Total Monthly Premium	\$31.47	\$67.68	\$67.68	\$64.11	\$74.66

	Delta Dental - High Plan Option				
	Employee	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family
Total Monthly Premium	\$38.62	\$86.72	\$86.72	\$77.24	\$109.18

	Blue View Vision				
	Employee	Employee + Child	Employee + Child(ren)	Employee + Spouse	Employee + Family
Total Monthly Premium	\$5.91	\$10.34	\$11.81	\$10.34	\$17.18



Health Savings Accounts

Start saving more on healthcare.



A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options¹.

How an HSA works:

- You can contribute to your HSA via payroll deduction, online banking transfer, or by sending a personal check to HSA Bank. Your employer or third parties, such as a spouse or parent, may contribute to your account as well.
- You can pay for qualified medical expenses with your Health Benefits Debit Card directly to your medical provider or pay out-of-pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.
- Unused funds will roll over year to year. After age 65, funds can be withdrawn for any purpose without penalty (subject to ordinary income taxes).
- Check balances and account information via HSA Bank's Member Website or mobile device 24/7.

Are you eligible for an HSA?

If you have a qualified High Deductible Health Plan (HDHP) - either through your employer, through your spouse, or one you've purchased on your own - chances are you can open an HSA. Additionally:

- You cannot be covered by any other non-HSA-compatible health plan, including Medicare Parts A and B.
- You cannot be covered by TriCare.
- You cannot be claimed as a dependent on another person's tax return (unless it's your spouse).
- You must be covered by the qualified HDHP on the first day of the month.

When you open an account, HSA Bank will request certain information to verify your identity and to process your application.

What are the annual IRS contribution limits?

Contributions made by all parties to an HSA cannot exceed the annual HSA limit set by the Internal Revenue Service (IRS). Anyone can contribute to your HSA, but only the accountholder and employer can receive tax deductions on those contributions. Combined annual contributions for the accountholder, employer, and third parties (i.e., parent, spouse, or anyone else) must not exceed these limits.²

2019 Annual HSA Contribution Limits

Individual = \$3,500
Family = \$7,000

2020 Annual HSA Contribution Limits

Individual = \$3,550
Family = \$7,100

According to IRS guidelines, each year you have until the tax filing deadline to contribute to your HSA (typically April 15 of the following year). Online contributions must be submitted by 2:00 p.m., Central Time, the business day before the tax filing deadline. Wire contributions must be received by noon, Central Time, on the tax filing deadline, and contribution forms with checks must be received by the tax filing deadline.

Catch-up Contributions

Accountholders who meet these qualifications are eligible to make an HSA catch-up contribution of \$1,000: Health Savings accountholder; age 55 or older (regardless of when in the year an accountholder turns 55); not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated). Spouses who are 55 or older and covered under the accountholder's medical insurance can also make a catch-up contribution into a separate HSA in their own name.

How can you benefit from tax savings?

An HSA provides triple tax savings.³ Here's how:

- Contributions to your HSA can be made with pre-tax dollars and any after-tax contributions that you make to your HSA are tax deductible.
- HSA funds earn interest and investment earnings are tax free.
- When used for IRS-qualified medical expenses, distributions are free from tax.

IRS-Qualified Medical Expenses

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. Funds used to pay for IRS-qualified medical expenses are always tax-free.

HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to HSA Bank, you must save your bills and receipts for tax purposes.

Examples of IRS-Qualified Medical Expenses⁴:

Acupuncture	Gynecologist	Psychologist
Alcoholism treatment	Hearing aids and batteries	Smoking cessation programs
Ambulance services	Hospital bills	Special education tutoring
Annual physical examination	Insurance premiums⁵	Surgery
Artificial limb or prosthesis	Laboratory fees	Telephone or TV equipment to assist the hearing or vision impaired
Birth control pills (by prescription)	Lactation expenses	Therapy or counseling
Chiropractor	Lodging (away from home for outpatient care)	Medical transportation expenses
Childbirth/delivery	Nursing home	Transplants
Convalescent home (for medical treatment only)	Nursing services	Vaccines
Crutches	Obstetrician	Vasectomy
Doctor's fees	Osteopath	Vision care (including eyeglasses, contact lenses, lasik surgery)
Dental treatments (including x-rays, braces, dentures, fillings, oral surgery)	Oxygen	Weight loss programs (for a specific disease diagnosed by a physician – such as obesity, hypertension, or heart disease)
Dermatologist	Pregnancy test kit	Wheelchairs
Diagnostic services	Podiatrist	X-rays
Disabled dependent care	Prescription drugs and medicines (over-the-counter drugs are not IRS-qualified medical expenses unless prescribed by a doctor)	
Drug addiction therapy	Prenatal care & postnatal treatments	
Fertility enhancement (including in-vitro fertilization)	Psychiatrist	
Guide dog (or other service animal)		

¹ Investment accounts are not FDIC insured, may lose value and are not a deposit or other obligation of, or guarantee by the bank. Investment losses which are replaced are subject to the annual contribution limits of the HSA.

² HSA funds contributed in excess of these limits are subject to penalty and tax unless the excess and earnings are withdrawn prior to the due date, including any extensions for filing Federal Tax returns. Accountholders should consult with a qualified tax advisor in connection with excess contribution removal. The Internal Revenue Service requires HSA Bank to report withdrawals that are considered refunds of excess contributions. In order for the withdrawal to be accurately reported, accountholders may not withdraw the excess directly. Instead, an excess contribution refund must be requested from HSA Bank and an Excess Contribution Removal Form completed.

³ Federal tax savings are available regardless of your state. State tax laws may vary. HSA Bank does not provide tax or legal advice. Please consult with a qualified tax or legal professional for tax related questions.

⁴ This list is not comprehensive. It is provided to you with the understanding that HSA Bank is not engaged in rendering tax advice. The information provided is not intended to be used to avoid Federal tax penalties. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses". Publications can be ordered directly from the IRS by calling 1-800-TAXFORM. If tax advice is required, you should seek the services of a professional.

⁵ Insurance premiums only qualify as an IRS-qualified medical expense: while continuing coverage under COBRA; for qualified long-term care coverage; coverage while receiving unemployment compensation; for any healthcare coverage for those over age 65 including Medicare (except Medicare supplemental coverage).



Please call the number on the back of your HSA Bank debit card or visit us at www.hsabank.com





HSA Bank Mobile

Health savings in the palm of your hand!



At HSA Bank, our goal is to help you Own Your HealthSM. HSA Bank Mobile is all about giving you the tools to take control and better manage your health accounts. Safe and secure, HSA Bank Mobile offers real-time access for all your account needs, 24 hours a day, 7 days a week. It's simple, intuitive, and convenient.

Features & Benefits



Simple and secure login



Check account balances



View account activity



Review and verify
IRS-qualified medical expenses



Make a payment
from your account



Scan for IRS-qualified
medical expenses



Schedule HSA contributions



Enter and track expenses



Easy access to the Client
Assistance Center

To get started, follow these three simple steps.

1

Create Your Username and Password

Register on the Member Website.

2

Download HSA Bank Mobile

At [Google Play](#) or the [App Store](#).

3

Login to HSA Bank Mobile

Start managing your account on the go.



HSA Bank Mobile is compatible with iOS devices (iPhone, iPod Touch, iPad) and Android-powered devices.



While the HSA Mobile app is free to download, message and data rates may apply. Check with your mobile services provider for any charges that may apply for data usage on your mobile device. Please refer to the Online Services Agreement for further details regarding HSA Bank mobile banking services.



Please call the number on the back of your HSA Bank debit card or visit us at www.hsabank.com

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Mobile App 120718_FL-10436

hsabank
own your health.

Getting real about your healthcare savings starts here

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT



HOW YOUR DCA WORKS

Your DCA is a spending account that can be used to pay for services like daycare, nursery school, and elder care. By simply participating in a DCA, you get to experience benefits like:

- 1 A higher take-home pay thanks to your pre-tax payroll deductions
- 2 Savings on daycare and other dependent care services you're already paying for
- 3 Easy-to-use MyAmeriflex Debit Mastercard to make purchases

WHAT CAN I SPEND MY DCA FUNDS ON?

The IRS determines what expenses are eligible under a DCA. Here are some examples of common eligible expenses



Daycare



Summer day camp



Before and after
school programs



Private sitter



Custodial care for
dependent adults



Nursery school



Nanny service



Pre-school

GETTING STARTED CHECKLIST

Use this checklist to take full advantage of all the great resources made available to you through your DCA.



Set up your MyAmeriflex account

MyAmeriflex is where you'll have real-time access to all of your account information, including your current balance, transaction history, payment status, and more. To register your account, visit myameriflex.com, select "Login to your account," and click "Participants." Then click the "New User" link to get started. You will be asked to enter an Employee ID, which will be your Social Security number with no dashes or spaces, as well as a Registration ID, which will either be your Ameriflex Debit Mastercard number or Employer ID. If you don't know your Employer ID, please reach out to your HR representative or contact the Ameriflex Participants Services team at 888.868.FLEX (3539).



Download mobile app

The MyAmeriflex App lets you access and manage your account anywhere you go, 24/7. It puts all of the great features of the MyAmeriflex Portal right at your fingertips. You can download the app on the Apple App Store and Google Play.



Register for complimentary ID theft protection

Ameriflex is pleased to offer our cardholders complimentary access to Mastercard's comprehensive Identity Theft Protection program*, powered by CSID®. You can rest assured knowing that if your MyAmeriflex Debit Mastercard (or any other debit/credit cards you choose to register!) gets misplaced or stolen, you can utilize Mastercard's industry-leading ID theft protection and restoration services for everything you may need. To register, visit myameriflex.com/IDtheftprotection.



Use your card

You will receive a MyAmeriflex Debit Mastercard that can be used to make eligible purchases. Your card will be mailed within 7-10 business days after your enrollment is processed by Ameriflex.



Enroll for direct deposit

By enrolling for direct deposit, getting reimbursed is easier and faster anytime you need to pay for an eligible expense out of pocket. Login to MyAmeriflex to set up direct deposit.



Start spending

You're ready to make purchases as funds become available! Your account will be funded each pay period. Be sure to hang on to your receipts anytime you make a purchase. Login to MyAmeriflex for a full list of eligible expenses.

HOW TO GET REIMBURSED FOR OUT-OF-POCKET EXPENSES

As you begin to use your account, it's important to understand how to submit a request for reimbursement or payment to a provider.

Two most common reasons for requesting a reimbursement or payment:

- 1** You paid an eligible expense out of pocket
- 2** To request a payment be made directly to a provider

Your MyAmeriflex Debit Mastercard is the quickest and easiest way to access your account funds. But if you can't use your card, getting reimbursed is quick and painless.

Step 1: Login in to your MyAmeriflex account online or through the MyAmeriflex App

Step 2: Click the Submit Claim button

Step 3: Fill out all of the required fields and attach documentation

Step 4: If requesting to pay a provider, enter the provider's information, including address, and select "Pay Provider." Once processed, the reimbursement will be sent directly to the provider. You can also save the provider for any future reimbursements.

Step 5: Click submit

You can view the status of a pending reimbursement anytime through MyAmeriflex or the MyAmeriflex App. If any further action is needed before the reimbursement is processed, you will receive a message through your account.

ONE-TIME CLAIM FOR DEPENDENT CARE SERVICES

Ameriflex makes it easy to get reimbursed automatically from your account as your funds build up during the year. If you're paying for childcare or elderly care each month, you can avoid submitting a manual claim every month to get reimbursed for expenses you paid out of pocket. All you have to do is submit one Claim Form for the entire year that shows the date range for which childcare/eldercare services will be provided, along with a signature from the service provider on the designated line of the form. As long as the form is signed by the provider, no receipt is needed. Once the recurring claim has been processed, Ameriflex will automatically reimburse you every month with a check or direct deposit as funds in your Dependent Care Account become available.

FREQUENTLY ASKED QUESTIONS

How do I check my account balance?

You can check your real-time balance online by logging into MyAmeriflex or through the MyAmeriflex Mobile App. Ameriflex also provides 24/7 access to automated account information via telephone. Call 888.868.FLEX (3539) and follow the prompts to listen to balance and transaction information for your account.

How do I access my account?

If you're a new user, setting up your account is easy! To register your account, visit myameriflex.com, select "Login to your account," and click "Participants." Then click the "New User" link to get started. You will be asked to enter an Employee ID, which will be your Social Security number with no dashes or spaces, as well as a Registration ID, which will either be your Ameriflex Mastercard debit card number or Employer ID. If you don't know your Employer ID, please reach out to your HR representative or contact the Ameriflex Participants Services team at 888.868.FLEX (3539).

What expenses are eligible?

The IRS, and sometimes your employer, determine what goods and services are eligible. This will vary based on what type of account you have. Login to MyAmeriflex for a full list of eligible expenses.

How do I order a new card?

You can request a free replacement card online through your Ameriflex account or through the MyAmeriflex Mobile App.

What happens if I don't use my DCA account balance by the end the year?

Employers may offer a 2.5-month grace period to help employees use their unused money at the end of the plan year. If your employer offers a 2.5-month grace period, you can continue using your unused money 2.5 months into the new plan year. Please refer to your plan documents or contact Ameriflex to verify the specific rules and features associated with your company's plan.

How do these programs save me money on taxes?

Since the accounts are tax-advantaged, you get to leverage pre-tax payroll deductions – increasing your take-home pay and saving you money on everyday expenses. In many cases, you can experience savings of up to 40% on expenses eligible under your employer-sponsored plan.

If I leave my employer, can I still use my funds?

No, your funds are forfeited if you leave your employer.

What does pre-tax dollars mean and why is this important?

Essentially, "pre-taxing," which can be used for life insurance, disability insurance, HSA contributions, dependent care contributions, health savings account contributions and commuter account contributions, means taking income that would otherwise be taxable and diverting it to something else before (so: "pre") is becomes taxable.

By making pre-tax contributions to an HSA, you are lowering the amount your income is taxed, which results in taking home a bigger paycheck.

Can I change my annual election amount?

DCA elections can be changed if the cost of the services received changes (i.e. daycare increases fees), or if the dependent no longer goes to daycare.

How can I get more information about my account?

For an overview of account features, visit myameriflex.com/participants.

You can manage your account, check your balance, file and claim anytime online through MyAmeriflex or through the Ameriflex App.

How can I change my reimbursement setting to add direct deposit?

To set up direct deposit, simply login to MyAmeriflex, select reimbursement settings under the my account tab, then enter your banking information.

**If you have any questions you can contact the Ameriflex Participant Services team
Monday - Friday, 8:30 a.m. - 8:00 p.m. (ET).**

Phone: 888.868.FLEX (3539)

Email: service@myameriflex.com

Chat: myameriflex.com



Cancer Insurance

How would cancer impact your way of life?

Hopefully, you and your family will never face cancer. If you do, a financial safety net can help you and your loved ones focus on what matters most — recovery.

If you were diagnosed with cancer, you could have expenses that medical insurance doesn't cover. In addition to your regular, ongoing bills, you could have indirect treatment and recovery costs, such as child care and home health care services.

Help when you need it most

Cancer coverage from Colonial Life & Accident Insurance Company can help protect the lifestyle you've worked so hard to build. It provides benefits you can use to help cover:

- Loss of income
- Out-of-network treatment
- Lodging and meals
- Deductibles and co-pays

One family's journey

Paul and Kim were preparing for their second child when they learned Paul had cancer. They quickly realized their medical insurance wouldn't cover everything. Thankfully, Kim's job enabled her to have a cancer insurance policy on Paul to help them with expenses.



DOCTOR'S SCREENING

Wellness benefit

Paul's wellness benefit helped pay for the screening that discovered his cancer.



SECOND OPINION

Travel expenses

When the couple traveled several hundred miles from their home to a top cancer hospital, they used the policy's lodging and transportation benefits to help with expenses.



SURGERY

Out-of-pocket costs

The policy's benefits helped with deductibles and co-pays related to Paul's surgery and hospital stay.

For illustrative purposes only

With cancer insurance:

- Coverage options are available for you and your eligible dependents.
- Benefits are paid directly to you, unless you specify otherwise.
- You're paid regardless of any insurance you may have with other companies.
- You can take coverage with you, even if you change jobs or retire.



ONLY 5%
of ALL
CANCERS
are hereditary.

American Cancer Society, *Cancer Facts & Figures*, 2013

Cancer insurance provides benefits to help with cancer expenses — from diagnosis to recovery.



TREATMENT



RECOVERY

Experimental care

Paul used his plan’s benefits to help pay for experimental treatments not covered by his medical insurance.

Follow-up evaluations

Paul has been cancer-free for more than four years. His cancer policy provides a benefit for periodic scans to help ensure the cancer stays in check.



Our cancer insurance offers more than 30 benefits that can help you with costs that may not be covered by your medical insurance.

Treatment benefits
(inpatient or outpatient)

- Radiation/chemotherapy
- Anti-nausea medication
- Medical imaging studies
- Supportive or protective care drugs and colony stimulating factors
- Second medical opinion
- Blood/plasma/platelets/immunoglobulins
- Bone marrow or peripheral stem cell donation
- Bone marrow or peripheral stem cell transplant
- Egg(s) extraction or harvesting/sperm collection and storage
- Experimental treatment
- Hair/external breast/voice box prosthesis
- Home health care services
- Hospice (initial or daily care)

Surgery benefits

- Surgical procedures
- Anesthesia
- Reconstructive surgery
- Outpatient surgical center
- Prosthetic device/artificial limb

Travel benefits

- Transportation
- Companion transportation
- Lodging

Inpatient benefits

- Hospital confinement
- Private full-time nursing services
- Skilled nursing care facility
- Ambulance
- Air ambulance

Additional benefits

- Family care
- Cancer vaccine
- Bone marrow donor screening
- Skin cancer initial diagnosis
- Waiver of premium

LIFETIME RISK OF
DEVELOPING CANCER



American Cancer Society, *Cancer Facts & Figures*, 2013



ColonialLife.com

Optional riders

For an additional cost, you may have the option of purchasing additional riders for even more financial protection against cancer. Talk with your benefits counselor to find out which of these riders are available for you to purchase.

- **Diagnosis of cancer rider** — Pays a one-time, lump-sum benefit for the initial diagnosis of cancer. You may choose a benefit amount in \$1,000 increments between \$1,000 and \$10,000. If your dependent child is diagnosed with cancer, we will pay two and a half times (\$2,500 - \$25,000) the chosen benefit amount.
- **Diagnosis of cancer progressive payment rider** — Provides a lump-sum payment of \$50 for each month the rider has been in force and before cancer is first diagnosed.
- **Specified disease hospital confinement rider** — Pays \$300 per day if you or a covered family member is confined to a hospital for treatment for one of the 34 specified diseases covered under the rider.

If cancer impacts your life, you should be able to focus on getting better — not on how you'll pay your bills. Talk with your Colonial Life benefits counselor about how cancer insurance can help provide financial security for you and your family.

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for the diagnosis of internal cancer or skin cancer that is a pre-existing condition, nor will we pay benefits for the treatment of internal cancer or skin cancer that is a pre-existing condition unless the covered person has satisfied the six-month pre-existing condition limitation period shown on the Policy Schedule. Pre-existing condition means a condition for which a covered person was diagnosed prior to the effective date of this policy, and for which medical advice or treatment was recommended by or received from a doctor within six months immediately preceding the effective date of this policy.

EXCLUSIONS

We will not pay benefits for cancer or skin cancer:

- If the diagnosis or treatment of cancer is received outside of the territorial limits of the United States and its possessions; or
- For other conditions or diseases, except losses due directly from cancer.

The policy and its riders may have additional exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form CanAssist-VA and rider forms R-CanAssistIndx-VA, R-CanAssistProg-VA and R-CanAssistSpDis-VA.

Cancer Insurance

Level 4 Benefits

Cancer insurance helps provide financial protection through a variety of benefits. These benefits are not only for you but also for your covered family members.



For more information,
talk with your
benefits counselor.

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Air ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$2,000 per trip
Ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$250 per trip
Anesthesia Administered during a surgical procedure for cancer treatment	
■ General anesthesia	25% of surgical procedures benefit
■ Local anesthesia	\$50 per procedure
Anti-nausea medication Doctor-prescribed medication for radiation or chemotherapy <i>[\$240 monthly max.]</i>	\$60 per day administered or per prescription filled
Blood/plasma/platelets/immunoglobulins A transfusion required during cancer treatment <i>[\$10,000 calendar year max.]</i>	\$250 per day
Bone marrow donor screening Testing in connection with being a potential donor <i>[once per lifetime]</i>	\$50
Bone marrow or peripheral stem cell donation Receiving another person's bone marrow or stem cells for a transplant <i>[once per lifetime]</i>	\$1,000
Bone marrow or peripheral stem cell transplant Transplant you receive in connection with cancer treatment <i>[max. of two bone marrow transplant benefits per lifetime]</i>	\$10,000 per transplant
Cancer vaccine An FDA-approved vaccine for the prevention of cancer <i>[once per lifetime]</i>	\$50
Companion transportation Companion travels by plane, train or bus to accompany a covered cancer patient more than 50 miles one way for treatment <i>[up to \$1,500 per round trip]</i>	\$0.50 per mile
Egg(s) extraction or harvesting/sperm collection and storage Extracted/harvested or collected before chemotherapy or radiation <i>[once per lifetime]</i>	
■ Egg(s) extraction or harvesting/sperm collection	\$1,500
■ Egg(s) or sperm storage (cryopreservation)	\$500
Experimental treatment Hospital, medical or surgical care for cancer <i>[\$15,000 lifetime max.]</i>	\$300 per day
Family care Inpatient or outpatient treatment for a covered dependent child <i>[\$3,000 calendar year max.]</i>	\$60 per day
Hair/external breast/voice box prosthesis Prosthesis needed as a direct result of cancer	\$500 per calendar year
Home health care services Examples include physical therapy, occupational therapy, speech therapy and audiology; prosthesis and orthopedic appliances; rental or purchase of durable medical equipment <i>[up to 100 days per covered person per lifetime]</i>	\$175 per day
Hospice (initial or daily care) An initial, one-time benefit and a daily benefit for treatment <i>[\$15,000 lifetime max. for both]</i>	
■ Initial hospice care <i>[once per lifetime]</i>	\$1,000
■ Daily hospice care	\$50 per day



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BENEFIT DESCRIPTION

BENEFIT AMOUNT

Hospital confinement

Hospital stay (including intensive care) required for cancer treatment

- 30 days or less \$350 per day
- 31 days or more \$700 per day

Lodging

Hotel/motel expenses when being treated for cancer more than 50 miles from home
[70-day calendar year max.]

\$80 per day

Medical imaging studies

Specific studies for cancer treatment [\$450 calendar year max.]

\$225 per study

Outpatient surgical center

Surgery at an outpatient center for cancer treatment [\$1,200 calendar year max.]

\$400 per day

Private full-time nursing services

Services while hospital confined other than those regularly furnished by the hospital

\$150 per day

Prosthetic device/artificial limb

A surgical implant needed because of cancer surgery [payable one per site, \$6,000 lifetime max.]

\$3,000 per device or limb

Radiation/chemotherapy

[per day with a max. of one per calendar week]

- Injected chemotherapy by medical personnel \$1,000
- Radiation delivered by medical personnel \$1,000

[per day with a max. of one per calendar month]

- Self-injected \$400
- Pump \$400
- Topical \$400
- Oral hormonal [1-24 months] \$400
- Oral hormonal [25+ months] \$350
- Oral non-hormonal \$400

Reconstructive surgery

A surgery to reconstruct anatomic defects that result from cancer treatment
[min. \$350 per procedure, up to \$3,000, including 25% for general anesthesia]

\$60 per surgical unit

Second medical opinion

A second physician's opinion on cancer surgery or treatment [once per lifetime]

\$300

Skilled nursing care facility

Confinement to a covered facility after hospital release [up to 100 days per covered person per lifetime]

\$175 per day

Skin cancer diagnosis

A skin cancer diagnosis while the policy is in force [once per lifetime]

\$600

Supportive or protective care drugs and colony stimulating factors

Doctor-prescribed drugs to enhance or modify radiation/chemotherapy treatments
[\$1,600 calendar year max.]

\$200 per day

Surgical procedures

Inpatient or outpatient surgery for cancer treatment [min. \$350 per procedure, up to \$6,000]

\$70 per surgical unit

Transportation

Travel expenses when being treated for cancer more than 50 miles from home
[up to \$1,500 per round trip]

\$0.50 per mile

Waiver of premium

No premiums due if the named insured is disabled longer than 90 consecutive days

Is available

The policy has limitations and exclusions that may affect benefits payable. Most benefits require that a charge be incurred. Coverage may vary by state and may not be available in all states. For cost and complete details, see your benefits counselor.

This chart highlights the benefits of policy forms CanAssist-NJ and CanAssist-VA. This chart is not complete without form 101505-NJ or 101481-VA.

Cancer Insurance

Wellness Benefits

To encourage early detection, our cancer insurance offers benefits for wellness and health screening tests.



For more information,
talk with your
benefits counselor.

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Part one: Cancer wellness/health screening

Provided when one of the tests listed below is performed while the policy is in force. Payable once per calendar year, per covered person.

Cancer wellness tests

- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Skin biopsy
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

Health screening tests

- Blood test for triglycerides
- Carotid Doppler
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Serum cholesterol test for HDL and LDL levels
- Stress test on a bicycle or treadmill

Part two: Cancer wellness — additional invasive diagnostic test or surgical procedure

Provided when a doctor performs a diagnostic test or surgical procedure as the result of an abnormal result from one of the covered cancer wellness tests in part one. We will pay the benefit regardless of the test results. Payable once per calendar year, per covered person.

The policy has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form CanAssist (and state abbreviations where applicable).

Group Specified Disease Insurance



How will you pay for what your health insurance won't?

It's true—a serious medical event such as heart attack or stroke could leave you in a period of financial difficulty. Even if you have major medical coverage, there are typically uncovered expenses to consider, such as deductibles and copayments, travel expenses to and from treatment centers and the loss of wages or salary. If faced with this situation, would you be able to maintain your current way of life?

Group Critical Care Insurance may help guard you against financial hardship.

This specified disease coverage from Colonial Life & Accident Insurance Company offers the protection you need to concentrate on what is most important—your treatment, care and recovery.

You're free to use the benefits however you choose. And coverage may be available for you, your spouse and your eligible dependents.

Plan Features:

- A lump sum payment allows you the flexibility to better plan your treatment and care.
- You may adjust the face amount to best meet your personal needs.
- May pay multiple times for a covered critical illness.

What benefits are included?

Face Amount: \$ _____

Critical Illness Benefit: This is a lump sum benefit to assist with the medical and/or non-medical costs associated with the diagnosis of a covered critical illness.

Covered Critical Illness Conditions

For this critical illness...	We will pay this percentage of the face amount:
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Coma	100%
Permanent Paralysis Due to a Covered Accident	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
Coronary Artery Bypass Graft Surgery/Disease ¹	25%

¹ Benefit for Coronary Artery Disease applicable in lieu of benefit for Coronary Artery Bypass Graft Surgery when Health Savings Account (HSA) compliant plan is selected.

Can I use the critical illness coverage more than once?

Yes! This plan includes coverage for subsequent diagnosis of a different critical illness.²

If you receive a benefit for a critical illness, and later you are diagnosed with a *different* critical illness, we will pay the original percentage of the face amount for that particular critical illness.

Yes! This plan includes coverage for subsequent diagnosis of the same critical illness.²

If you receive a benefit for a critical illness and later you are diagnosed with the *same* critical illness (except those listed below), we will pay 25% of the original face amount. *Critical illness conditions that do not qualify are: Coronary Artery Bypass Graft Surgery/ Coronary Artery Disease¹ and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D.*

¹ Benefit for Coronary Artery Disease applicable in lieu of benefit for Coronary Artery Bypass Graft Surgery when Health Savings Account (HSA) compliant plan is selected.

² Dates of Diagnoses of a covered critical illness must be separated by at least 180 days.

EXCLUSIONS AND LIMITATIONS - We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of a Critical Illness that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C (including state abbreviations where used, for example: GCC1.0-C-TX). Not available in all states. Please see your Colonial Life benefits counselor for details.

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Health Screening Benefit

This benefit helps you pay for part of the expense of tests you may normally have each year. The benefit allows a maximum of 1 screening test per covered person per calendar year.

Tests that qualify:

Stress test on a bicycle or treadmill	CEA (blood test for colon cancer)
Fasting blood glucose test	Chest x-ray
Blood test for triglycerides	Colonoscopy
Serum cholesterol test to determine level of HDL and LDL	Flexible sigmoidoscopy
Bone marrow testing	Hemoccult stool analysis
Carotid Doppler	Mammography
Electrocardiogram (EKG, ECG)	Pap smear
Echocardiogram (ECHO)	PSA (blood test for prostate cancer)
Skin cancer biopsy	Serum protein electrophoresis (blood test for myeloma)
Breast ultrasound	Thermography
CA 15-3 (blood test for breast cancer)	ThinPrep pap test
CA 125 (blood test for ovarian cancer)	Virtual colonoscopy

The person must incur a charge and the certificate must be in force for benefits to be payable. For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate form GCC-1.0-C (including state abbreviations where used, for example, GCC1.0-C-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual certificate provisions will control. The certificate contains exclusions and limitations which may affect benefits payable.

Educator Disability Income Insurance



How long could you afford to go without a paycheck?

Help protect your paycheck with Colonial Life's short-term disability insurance.

You use your paycheck mainly to pay for your home, your car, groceries, medical bills and utilities. What if you couldn't go to work due to an accident or sickness?

Monthly Expenses:	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____
		Total	\$ _____

My Coverage Worksheet (For use with your Colonial Life Benefits Counselor)

Who's being covered?

- ☐ You only
- ☐ You and your spouse
- ☐ You and your dependent children
- ☐ You, your spouse and your dependent children

How much coverage do I need?

On-Job Accident/On-Job Sickness \$ _____ Off-Job Accident/Off-Job Sickness \$ _____

Select **One** Benefit Period Option:

On-Job

Off-Job

● Total Disability

- | | | | |
|--------------------------------|----------------|----------------|----------------|
| <input type="radio"/> Option A | First 3 months | \$ _____/month | \$ _____/month |
| | Next 9 months | \$ _____/month | \$ _____/month |
| <input type="radio"/> Option B | First 6 months | \$ _____/month | \$ _____/month |
| | Next 6 months | \$ _____/month | \$ _____/month |

● Partial Disability

- | | | |
|----------------|----------------|----------------|
| Up to 3 months | \$ _____/month | \$ _____/month |
|----------------|----------------|----------------|

When will my benefits start?

After an Accident: _____ days

After a Sickness: _____ days

How much will it cost?

Your cost will vary based on the level of coverage you select.

Employee Coverage

In addition to disability coverage, this plan also provides employees with benefits for medical fees related to accidents, hospital confinement, accidental death and dismemberment, as well as fractures and dislocations.

Even if you're not disabled, the following benefits are payable for covered accidental injuries:

Medical Fees for Accidents Only

Doctor's Office or Urgent Care Facility Visit (Once per covered accident)	\$75
X-Ray and Other Diagnostic Imaging (Once per covered accident)	\$75
Emergency Room Visit (Once per covered accident)	\$150

Hospital Confinement Benefit for Accident or Sickness

Pays in addition to disability benefit.

- Benefits begin on the first day of confinement in a hospital for a covered accident or sickness.
Up to 3 months \$1,200/month (\$40/day)
The Hospital Confinement benefit increases to \$6,000/month (\$200/day) when the Total Disability benefit ends at age 70

Accidental Death and Dismemberment Benefits

Benefits payable for death or dismemberment.

- Accidental Death..... \$25,000
- Loss of a Finger or Toe
 Single Dismemberment \$750
 Double Dismemberment\$1,500
- Loss of a Hand, Foot or Sight of an Eye
 Single Dismemberment\$7,500
 Double Dismemberment \$15,000
- Accidental Death Common Carrier \$50,000

Complete Fractures

Complete Fractures requiring closed reduction

Hip, Thigh	\$1,500
Vertebrae	1,350
Pelvis	1,200
Skull (depressed)	1,125
Leg	900
Foot, Ankle, Kneecap	750
Forearm, Hand, Wrist	750
Lower Jaw	600
Shoulder Blade, Collarbone	600
Skull (simple)	525
Upper Arm, Upper Jaw	525
Facial Bones	450
Vertebral Processes	300
Coccyx, Rib, Finger, Toe	120

Complete Dislocations

Complete Dislocations requiring closed reduction with anesthesia

Hip	\$1,350
Knee	975
Collarbone - sternoclavicular	750
Shoulder	750
Collarbone - acromioclavicular separation	675
Ankle, Foot	600
Hand	525
Lower Jaw	450
Wrist	375
Elbow	300
One Finger, Toe	120

For a fracture or dislocation requiring an open reduction, your benefit would be 1½ times the amount shown.

Additional Features

- Waiver of Premium
- Worldwide Coverage

Optional Spouse and Dependent Coverage

You may cover one or all of the eligible dependent members of your family for an additional premium.

Medical Fees for Accidents Only

Doctor's Office or Urgent Care Facility Visit (Once per covered accident)	\$75
X-Ray and Other Diagnostic Imaging (Once per covered accident)	\$75
Emergency Room Visit (Once per covered accident)	\$150

Hospital Confinement Benefit for Accident or Sickness

- Up to 3 months \$1,200/month (\$40/day)

Accidental Death and Dismemberment Benefits

- Accidental Death Spouse \$10,000
Child(ren) \$5,000
- Loss of a Finger or Toe
Single Dismemberment.....\$75
Double Dismemberment \$150
- Loss of a Hand, Foot or Sight of an Eye
Single Dismemberment.....\$750
Double Dismemberment \$1,500
- Accidental Death Common Carrier Spouse \$20,000
Child(ren) \$10,000

Here are some frequently asked questions about Colonial Life's disability insurance:

Will my disability income payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies. Benefits are paid directly to you (unless you specify otherwise).

When am I considered totally disabled?

Totally disabled means you are:

- Unable to perform the material and substantial duties of your job;
- Not, in fact, engaged in any employment or occupation for wage or profit for which you are qualified by reason of education, training or experience; and
- Under the regular and appropriate care of a doctor.

What if I want to return to work part-time after I am totally disabled?

You may be able to return to work part-time and still receive benefits. We call this "Partial Disability." This means you may be eligible for coverage if:

- You are unable to perform the material and substantial duties of your job for more than 20 hours per week,
- You are able to work at your job or your place of employment for 20 hours or less per week,
- Your employer will allow you to return to your job or place of employment for 20 hours or less per week; and
- You are under the regular and appropriate care of a doctor.

The total disability benefit must have been paid for at least one full month immediately prior to your being partially disabled.

When do disability benefits end?

The Total Disability Benefit will end on the policy anniversary date on or after your 70th birthday. The Hospital Confinement benefit increases when the Total Disability Benefit ends.

What is a pre-existing condition?

A pre-existing condition is when you have a sickness or physical condition for which you were treated, had medical testing, received medical advice, or had taken medication within 12 months testing, or before the effective date of your policy.

If you become disabled because of a pre-existing condition, Colonial Life will not pay for any disability period if it begins during the first 12 months the policy is in force.

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What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable for life as long as you continue to pay your premiums when they are due.

Can my premium change?

You may choose the amount of coverage to meet your needs (subject to your income). You can elect more or less coverage which will change your premium. Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

What is a covered accident or a covered sickness?

A covered accident is an accident. A covered sickness means an illness, infection, disease or any other abnormal physical condition, not caused by an injury.

A covered accident or covered sickness:

- Occurs after the effective date of the policy;
- Occurs while the policy is in force;
- Is of a type listed on the Policy Schedule; and
- Is not excluded by name or specific description in the policy.

EXCLUSIONS

We will not pay benefits for injuries received in accidents or sicknesses which are caused by or are the result of: alcoholism or drug addiction; flying; giving birth within the first nine months after the effective date of the policy; felonies or illegal occupations; having a pre-existing condition as described and limited by the policy; psychiatric or psychological condition; committing or trying to commit suicide or injuring yourself intentionally; being exposed to war or any act of war or serving in the armed forces of any country or authority.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form ED DIS 1.0-VA. Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

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Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they're unexpected. How you care for them shouldn't be.

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries
- Car accidents
- Falls & spills
- Dislocation
- Accidental injuries that send you to the Emergency Room, Urgent Care or doctor's office

Colonial Life's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Plus you'll feel better knowing you can have greater financial security.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Healthcare Spending Account (HSA) guidelines

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable for life as long as you pay your premiums when they are due or within the grace period.

Can my premium change?

Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment..... \$125
- X-ray Benefit\$30
- Ambulance\$200
- Air Ambulance..... \$2,000

Common Accidental Injuries

Dislocations (Separated Joint)	Non-Surgical	Surgical
Hip	\$2,200	\$4,400
Knee (except patella)	\$1,100	\$2,200
Ankle – Bone or Bones of the Foot (other than Toes)	\$880	\$1,760
Collarbone (Sternoclavicular)	\$550	\$1,100
Lower Jaw, Shoulder, Elbow, Wrist	\$330	\$660
Bone or Bones of the Hand	\$330	\$660
Collarbone (Acromioclavicular and Separation)	\$110	\$220
One Toe or Finger	\$110	\$220

Fractures	Non-Surgical	Surgical
Depressed Skull	\$2,750	\$5,500
Non-Depressed Skull	\$1,100	\$2,200
Hip, Thigh	\$1,650	\$3,300
Body of Vertebrae, Pelvis, Leg	\$825	\$1,650
Bones of Face or Nose (except mandible or maxilla)	\$385	\$770
Upper Jaw, Maxilla	\$385	\$770
Upper Arm between Elbow and Shoulder	\$385	\$770
Lower Jaw, Mandible, Kneecap, Ankle, Foot	\$330	\$660
Shoulder Blade, Collarbone, Vertebral Process	\$330	\$660
Forearm, Wrist, Hand	\$330	\$660
Rib	\$275	\$550
Coccyx	\$220	\$440
Finger, Toe	\$110	\$220

Your Colonial Life policy also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) \$1,000 to \$12,000
- Coma\$10,000
- Concussion \$60
- Emergency Dental Work\$75 Extraction, \$300 Crown, Implant, or Denture
- Lacerations (based on size)..... \$30 to \$500

Requires Surgery

- Eye Injury.....\$300
- Tendon/Ligament/Rotator Cuff.....\$500 - one, \$1,000 - two or more
- Ruptured Disc\$500
- Torn Knee Cartilage\$500

Surgical Care

- Surgery (cranial, open abdominal or thoracic)..... \$1,500
- Surgery (hernia)\$150
- Surgery (arthroscopic or exploratory)\$200
- Blood/Plasma/Platelets\$300

Transportation/Lodging Assistance

If injured, covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Transportation.....\$500 per round trip up to 3 round trips
- Lodging (family member or companion).....\$125 per night up to 30 days for a hotel/motel lodging costs

Accident Hospital Care

- Hospital Admission*\$1,000 per accident
- Hospital ICU Admission*\$2,000 per accident
- * We will pay either the Hospital Admission or Hospital Intensive Care Unit (ICU) Admission, but not both.
- Hospital Confinement\$225 per day up to 365 days per accident
- Hospital ICU Confinement\$450 per day up to 15 days per accident

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit\$50 (up to 3 visits per accident)
- Medical Imaging Study\$150 per accident
(limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy\$25 per treatment up to 10 days
- Appliances\$100 (such as wheelchair, crutches)
- Prosthetic Devices/Artificial Limb\$500 - one, \$1,000 - more than 1
- Rehabilitation Unit.....\$100 per day up to 15 days per covered accident,
and 30 days per calendar year.
Maximum of 30 days per calendar year

Accidental Dismemberment

- Loss of Finger/Toe\$750 – one, \$1,500 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye\$7,500 – one, \$15,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg or
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured\$25,000 Spouse\$25,000 Child(ren).....\$12,500

365-day elimination period. Amounts reduced for covered persons age 65 and over.

Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	\$25,000	\$100,000
• Spouse	\$25,000	\$100,000
• Child(ren)	\$5,000	\$20,000

Health Screening Benefit

- \$50 per covered person per calendar year

Provides a benefit if the covered person has one of the health screening tests performed. This benefit is payable once per calendar year per person and is subject.

Tests include:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid doppler
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Skin cancer biopsy
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

My Coverage Worksheet (For use with your Colonial Life benefits counselor)

Who will be covered? (check one)

- ☐ Employee Only ☐ Spouse Only ☐ One Child Only ☐ Employee & Spouse
- ☐ One-Parent Family, with Employee ☐ One-Parent Family, with Spouse ☐ Two-Parent Family

When are covered accident benefits available? (check one)

- ☐ On and Off -Job Benefits ☐ Off -Job Only Benefits

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of: felonies or illegal occupations; sickness; suicide or self-inflicted injuries; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of: birth; intoxication.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form Accident 1.0-HS -VA. This is not an insurance contract and only the actual policy provisions will control.

Hospital Confinement Indemnity Insurance

Plan 1



For more information,
talk with your
benefits counselor.

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Our Individual Medical BridgeSM insurance can help with medical costs that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement \$ _____

Maximum of one benefit per covered person per calendar year

Observation room \$100 per visit

Maximum of two visits per covered person per calendar year

Rehabilitation unit confinement \$100 per day

Maximum of 15 days per confinement with a 30-day maximum per covered person per calendar year

Waiver of premium

Available after 30 continuous days of a covered hospital confinement of the named insured

Health savings account (HSA) compatible

This plan is compatible with HSA guidelines. This plan may also be offered to employees who do not have HSAs.

Colonial Life & Accident Insurance Company's Individual Medical Bridge offers an HSA compatible plan in most states.

THIS POLICY PROVIDES LIMITED BENEFITS.

EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, war, or giving birth within the first nine months after the effective date of the policy. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition. A pre-existing condition is a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within the 12 months before the effective date of the policy.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000 (including state abbreviations where used, for example: IMB7000-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

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Hospital Confinement Indemnity Insurance

Plan 3



For more information,
talk with your
benefits counselor.

Our Individual Medical BridgeSM insurance can help with medical costs that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement \$ _____
Maximum of one benefit per covered person per calendar year

Observation room \$100 per visit
Maximum of two visits per covered person per calendar year

Rehabilitation unit confinement \$100 per day
Maximum of 15 days per confinement with a 30-day maximum per covered person per calendar year

Waiver of premium
Available after 30 continuous days of a covered hospital confinement of the named insured

Diagnostic procedure

■ Tier 1	\$250
■ Tier 2	\$500

Maximum of \$500 per covered person per calendar year for all covered diagnostic procedures combined

Outpatient surgical procedure

■ Tier 1	\$ _____
■ Tier 2	\$ _____

Maximum of \$ _____ per covered person per calendar year for all covered outpatient surgical procedures combined

The following is a list of common diagnostic procedures that may be covered.

Tier 1 diagnostic procedures

- **Breast**
 - Biopsy (incisional, needle, stereotactic)
- **Diagnostic radiology**
 - Nuclear medicine test
- **Digestive**
 - Barium enema/lower GI series
 - Barium swallow/upper GI series
 - Esophagogastroduodenoscopy (EGD)
- **Ear, nose, throat, mouth**
 - Laryngoscopy
- **Gynecological**
 - Amniocentesis
 - Cervical biopsy
 - Cone biopsy
 - Endometrial biopsy
 - Hysteroscopy
 - Loop electrosurgical excisional procedure (LEEP)

- **Liver** – biopsy
- **Lymphatic** – biopsy
- **Miscellaneous**
 - Bone marrow aspiration/biopsy
- **Renal** – biopsy
- **Respiratory**
 - Biopsy
 - Bronchoscopy
 - Pulmonary function test (PFT)
- **Skin**
 - Biopsy
 - Excision of lesion
- **Thyroid** – biopsy
- **Urologic**
 - Cystoscopy

Tier 2 diagnostic procedures

- **Cardiac**
 - Angiogram
 - Arteriogram
 - Thallium stress test
 - Transesophageal echocardiogram (TEE)
- **Diagnostic radiology**
 - Computerized tomography scan (CT scan)
 - Electroencephalogram (EEG)
 - Magnetic resonance imaging (MRI)
 - Myelogram
 - Positron emission tomography scan (PET scan)



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The surgeries listed below are only a sampling of the surgeries that may be covered. Surgeries must be performed by a doctor in a hospital or ambulatory surgical center. For complete details and definitions, please refer to your policy.

Tier 1 outpatient surgical procedures

■ Breast

- Axillary node dissection
- Breast capsulotomy
- Lumpectomy

■ Cardiac

- Pacemaker insertion

■ Digestive

- Colonoscopy
- Fistulotomy
- Hemorrhoidectomy
- Lysis of adhesions

■ Skin

- Laparoscopic hernia repair
- Skin grafting

■ Ear, nose, throat, mouth

- Adenoidectomy
- Removal of oral lesions
- Myringotomy
- Tonsillectomy
- Tracheostomy
- Tympanotomy

■ Gynecological

- Dilation and curettage (D&C)
- Endometrial ablation
- Lysis of adhesions

■ Liver

- Paracentesis

■ Musculoskeletal system

- Carpal/cubital repair or release
- Foot surgery (bunionectomy, exostectomy, arthroplasty, hammertoe repair)
- Removal of orthopedic hardware
- Removal of tendon lesion

Tier 2 outpatient surgical procedures

■ Breast

- Breast reconstruction
- Breast reduction

■ Cardiac

- Angioplasty
- Cardiac catheterization

■ Digestive

- Exploratory laparoscopy
- Laparoscopic appendectomy
- Laparoscopic cholecystectomy

■ Ear, nose, throat, mouth

- Ethmoidectomy
- Mastoidectomy
- Septoplasty
- Stapedectomy
- Tympanoplasty

■ Eye

- Cataract surgery
- Corneal surgery (penetrating keratoplasty)
- Glaucoma surgery (trabeculectomy)
- Vitrectomy

■ Gynecological

- Hysterectomy
- Myomectomy

■ Musculoskeletal system

- Arthroscopic knee surgery with meniscectomy (knee cartilage repair)
- Arthroscopic shoulder surgery
- Clavicle resection
- Dislocations (open reduction with internal fixation)
- Fracture (open reduction with internal fixation)
- Removal or implantation of cartilage
- Tendon/ligament repair

■ Thyroid

- Excision of a mass

■ Urologic

- Lithotripsy

EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, war, or giving birth within the first nine months after the effective date of the policy. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition. A pre-existing condition is a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within the 12 months before the effective date of the policy.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000 (including state abbreviations where used, for example: IMB7000-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

Hospital Confinement Indemnity Insurance

Health Screening



For more information,
talk with your
benefits counselor.

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Individual Medical BridgeSM insurance’s health screening benefit can help pay for health and wellness tests you have each year.

Health screening \$ _____

Maximum of one health screening test per covered person per calendar year;
subject to a 30-day waiting period

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Carotid Doppler
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

Waiting period means the first 30 days following any covered person’s policy coverage effective date, during which no benefits are payable. For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000 (including state abbreviations where used, for example: IMB7000-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

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Hospital Confinement Indemnity Insurance

Medical Treatment Package



For more information,
talk with your
benefits counselor.

ColonialLife.com

The medical treatment package for Individual Medical BridgeSM coverage can help pay for deductibles, co-payments and other out-of-pocket expenses related to a covered accident or covered sickness.

The medical treatment package cannot be paired with Plan 1.

Air ambulance	\$1,000
Maximum of one benefit per covered person per calendar year	
Ambulance	\$100
Maximum of one benefit per covered person per calendar year	
Appliance	\$100
Maximum of one benefit per covered person per calendar year	
Doctor's office visit	\$25 per visit
Maximum of three visits per calendar year for named insured coverage or maximum of five visits per calendar year for all covered persons combined	
Emergency room visit	\$100 per visit
Maximum of two visits per covered person per calendar year	
X-ray	\$25 per benefit
Maximum of two benefits per covered person per calendar year	

THIS POLICY PROVIDES LIMITED BENEFITS.

EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, or war.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000-VA. This is not an insurance contract and only the actual policy provisions will control.

Hospital Confinement Indemnity Insurance

Optional Riders



Individual Medical BridgeSM offers two optional benefit riders – the daily hospital confinement rider and the enhanced intensive care unit confinement rider. For an additional cost, these riders can help provide extra financial protection to help with out-of-pocket medical expenses.

Daily hospital confinement rider **\$100 per day**
Per covered person per day of hospital confinement
Maximum of 365 days per covered person per confinement

Enhanced intensive care unit confinement rider **\$500 per day**
Per covered person per day of intensive care unit confinement
Maximum of 30 days per covered person per confinement

Re-confinement for the same or related condition within 90 days of discharge is considered a continuation of a previous confinement.

For more information,
talk with your
benefits counselor.

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EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, war, or giving birth within the first nine months after the effective date of the rider. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition. A pre-existing condition is a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within the 12 months before the effective date of the rider.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to rider numbers R-DHC7000 and R-EIC7000 (including state abbreviations where used, for example: R-DHC7000-TX and R-EIC7000-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy or rider provisions will control.

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Term Life Insurance



Life insurance protection when you need it most

Life insurance needs change as life circumstances change. You may need different coverage if you're getting married, buying a home or having a child.

Term life insurance from Colonial Life provides protection for a specified period of time, typically offering the greatest amount of coverage for the lowest initial premium. This fact makes term life insurance a good choice for supplementing cash value coverage during life stages when obligations are higher, such as while children are younger. It's also a good option for families on a tight budget — especially since you can convert it to a permanent cash value plan later.

With this coverage:

- A beneficiary can receive a benefit that is typically free from income tax.
- The policy's accelerated death benefit can pay a percentage of the death benefit if the covered person is diagnosed with a terminal illness.
- You can convert it to a Colonial Life cash value insurance plan, with no proof of good health, to age 75.
- Coverage is guaranteed renewable up to age 95 as long as premiums are paid when due.
- Portability allows you to take it with you if you change jobs or retire.

Talk with your
Colonial Life
benefits counselor
to learn more.

ColonialLife.com

Spouse coverage options	Dependent coverage options
Two options are available for spouse coverage at an additional cost: <ol style="list-style-type: none">1. Spouse Term Life Policy: Offers guaranteed premiums and level death benefits equivalent to those available to you —whether or not you buy a policy for yourself.2. Spouse Term Life Rider: Add a term rider for your spouse to your policy, up to a maximum death benefit of \$50,000; 10-year and 20-year are available (20-year rider only available with a 20- or 30-year term policy).	<p>You may add a Children's Term Life Rider to cover all of your eligible dependent children with up to \$20,000 in coverage each for one premium.</p> <p>The Children's Term Life Rider may be added to either the primary or spouse policy, not both.</p>

If the insured dies by suicide, whether sane or insane, within two years (one year in ND) from the coverage effective date or the date of reinstatement, we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. Product may vary by state. For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

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7-19 | NS-16570-1



Whole Life Insurance



Talk with your
Colonial Life
benefits counselor
to learn more.

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Life insurance that comes with guarantees – because life doesn't

You can't predict the future, but you can rest easier knowing you have life insurance with lifelong guarantees.

Whole life insurance provides guaranteed features – cash value accumulation, premium rates and a death benefit (minus any loans and loan interest) – that help ensure those benefits will be there to help protect your family's way of life.

With this coverage:

- Life insurance benefits for the beneficiary are typically tax-free.
- You have three opportunities to purchase additional coverage with no proof of good health required if you are 50 or younger with the Guaranteed Purchase Option Rider.
- The policy's built-in terminal illness accelerated death benefit provides up to 75% of the policy's death benefit (up to \$150,000) if you're diagnosed with a terminal illness.¹
- A \$3,000 immediate claim payment that can help your designated beneficiary pay for funeral costs or other expenses.
- You can take the policy with you even if you change jobs or retire; with no increase in premium.
- Paid-Up at Age 70 or Paid-Up at Age 100
These two plan options allow you to select what age your premium payments will end. You can choose to have your policy paid up when you reach age 70 or 100.

¹ Any payout would reduce the death benefit. Benefits may be taxable as income. Individuals should consult with their legal or tax counsel when deciding to apply for accelerated benefits.

If the insured dies by suicide, whether sane or insane, within two years (one year in ND) from the coverage effective date or the date of reinstatement, we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. Product may vary by state. For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

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ADDITIONAL BENEFITS



Virginia Association of Counties Group Self Insurance Risk Pool (VACORP) Short and Long Term Disability

Group Short Term Disability (STD) program provided for its participant by the Sponsor and administered by Anthem Life Insurance Company helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

Group Long Term Disability (LTD) insurance from Anthem Life Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

Please refer to the plan summary document and your employee handbook for specific plan details, eligibility definitions, limitations, and exclusions

Questions about your VACORP Short and Long Term Disability can be directed to:
1-844-404-2111 or www.vacorp.org/hybrid-disability/

General Notice of COBRA Continuation Coverage Rights
**** Continuation Coverage Rights Under COBRA ****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Wendy Livingston at 804-733-2700. Applicable documentation will be required i.e. court order, certificate of coverage etc.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Prince George County Public Schools
Attn: Wendy Livingston
Phone: 804-733-2700
Email: wlivingston@pgs.k12.va.us

COBRA Administrator for Health, Dental and Vision Coverage

Interactive Medical Systems
PO Box 1349
Wake Forest, NC 27588

Physical Address:

11635 Northpark Dr.
Suite 330
Wake Forest, NC 27588
(800) 426-8739

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my application(s) for insurance submitted during the current enrollment and eligibility for benefits under any insurance issued including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application(s), I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Non-health information including earnings or employment history deemed appropriate by Colonial to evaluate my application may be disclosed by any person or organization that has these records about me, including my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial obtains pursuant to this authorization will be used for the purpose of evaluating my application(s) for insurance or eligibility for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution and a copy is as valid as the original. A copy will be included with my contract(s) and I or my authorized representative may request access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract(s) or the contract itself. If revoked, Colonial may not be able to evaluate my application(s) for insurance or eligibility for benefits as necessary to issue my contract(s). I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Underwriting Department, P.O. Box 1365, Columbia, SC 29202.

You may refuse to sign this form; however, Colonial may not be able to issue your coverage. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, or Conservator.

(Printed name of individual
subject to this disclosure)

(Social Security
Number)

(Signature)

(Date Signed)

If applicable, I signed on behalf of the proposed insured as _____ (indicate relationship). If legal Guardian, Power or Attorney Designee, or Conservator.

(Printed name of legal representative)

(Signature of legal representative)

(Date Signed)

Notice of Insurance Information Practices

We collect Non Public Information (NPI) about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) will affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Our affiliated companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs. This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

If you believe NPI we have about you is incorrect, please write us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

If we decide not issued coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

To receive our complete privacy notice, including more information about our information-sharing, access and correction practices, write to our parent company: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. For additional information about our commitment to privacy, visit www.coloniallife.com.
NIP

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU.

Information regarding your insurability will be treated as confidential. Colonial or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (617) 426-3660.

Colonial or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

YES! I want to keep my Colonial Life Coverage.



My premiums are no longer being payroll-deducted.

Complete this form and mail it today — along with a check for your premium payment.

Name: _____ Daytime Telephone Number: (____) _____

Mailing Address: _____ Social Security Number or Date of Birth: _____

City: _____ State: _____ Zip: _____

Policy number(s) to be continued:

_____, _____, _____, _____

Which Colonial Life & Accident Insurance do you want to continue? (check one or more)

☐ Accident ☐ Disability ☐ Hospital Income ☐ Cancer or Critical Illness ☐ Life

Please choose one of the following payment options:

☐ 1. Deduct premiums monthly from my bank account.

☐ 1st-5th ☐ 6th-10th ☐ 11th-15th ☐ 16th-20th ☐ 21st-26th

Your draft will occur on one of the dates within the range you have selected. Please include a voided check or

Routing # _____ and Account # _____

Signature of bank account owner

☐ 2. Bill me directly. (choose one of the following)

☐ Quarterly

(Submit a payment 3 times your monthly premium)

☐ Semi-annually

(Submit a payment 6 times your monthly premium)

☐ Annually

(Submit a payment 12 times your monthly premium)

Date: _____

Policy Owner's Signature: _____

Return To:

Colonial Life & Accident Insurance Company
P.O. Box 1365
Columbia, South Carolina 29202
1.800.325.4368 (phone)
1.800.561.3082 (fax)

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

CONTACT INFORMATION:

AMERIFLEX - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

- **Customer Service:** 1-888-868-3539
- **Website:** www.myameriflex.com
- **Claims Mailing Address:** P.O. Box 269009, Plano, TX 75026

MANAGE YOUR ACCOUNT ONLINE OR DOWNLOAD THE MYAMERIFLEX MOBILE APP

- Check your Balance
- Submit a Claim
- Check Claim Status
- Mark Your Card Lost or Stolen

ANTHEM - HEALTH INSURANCE

- **Customer Service:** 1-800-582-6941
- **LiveHealthOnline:** www.livehealthonline.com or 1-844-784-8409
- **24/7 NurseLine:** 1-800-337-4770
- **Website:** www.anthem.com

DELTA - DENTAL INSURANCE

- **Customer Service:** 1-800-237-6060
- **Website:** www.deltadentalVA.com

HSA BANK - HEALTH SAVINGS ACCOUNT

- **Customer Service:** 1-800-357-6246
- **Website:** www.hsabank.com

ANTHEM BLUE VIEW - VISION INSURANCE

- **Customer Service:** 1-800-552-2682
- **Website:** www.anthem.com

COLONIAL LIFE

VISIT COLONIALLIFE.COM TO SET UP YOUR PERSONAL ACCOUNT

- **Website:** www.coloniallife.com
- **Customer Service & Wellness Screenings:** 1-800-325-4368
- **Claims Fax:** 1-800-880-9325
- **TDD for hearing impaired customers call:** 1-800-798-4040

If you wish to file a Wellness/Cancer Screening claim for a test performed within the past 18 months, you need the name and date of the test performed as well as your doctor's name and phone number. Colonial also needs to know if this is for you or another covered individual and their name and social security number. You may:

- **FILE BY PHONE!** Call 1-800-325-4368 and provide the information requested by Colonial's Automated Voice Response System, 24 hours per day, 7 days a week, or
- **SUBMIT ON THE INTERNET** using the Wellness Claim Form at www.coloniallife.com, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "Wellness Test." Fax this to Colonial at 1-800-880-9325 or MAIL to PO Box 100195, Columbia, SC 29202

If your Wellness/Cancer Screening test was more than 18 months ago, you must fax or mail Colonial a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.
Please Note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

When you terminate employment, you have the opportunity to continue your Colonial coverage either through direct billing or automatic payment through your bank account. Please contact Colonial at 1-800-325-4368 to request the continuation of benefits form.

TO VIEW YOUR BENEFITS ONLINE

Visit [www.piercegrupbenefits.com/
princegeorgecountypublicschools](http://www.piercegrupbenefits.com/princegeorgecountypublicschools)

For additional information concerning plans offered to employees of Prince George County Public Schools, please contact our Pierce Group Benefits Service Center at 1-800-387-5955