Accident Insurance Program

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

Underwritten by: National Teachers Associates Life Insurance Company (NTA Life)
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horacemann.com

SI-000003-TX (July 19)

UNCERTAIN ABOUT YOUR NEED FOR ACCIDENT INSURANCE?

CONSIDER THESE FACTS

In the next 10 minutes,

847 Americans will suffer an injury severe enough to require consultation with a medical professional.

More than 47.2 million visits to hospital emergency departments were due to accidents in 2017.

In 2017, unintentional injuries reached more than $1,034.4 billion in total costs.

HOME INJURIES

$314.9 Billion

= a $384,000 rebate on each new single-family home built.

PUBLIC INJURIES

$157.8 Billion

= a $17.4 million grant to each public library in the U.S.

WORK INJURIES

$164.6 Billion

= 54 times the amount of Amazon's 2017 profits.

VEHICLE CRASHES

$433.7 Billion

= purchasing 660 gallons of gasoline for each registered vehicle in the U.S.

Source: 2017 Data from National Safety Council Injury Facts, 2017 edition Center for Disease Control. U.S. Statistics.

ACCIDENT INSURANCE PROGRAM

TREATMENT BENEFITS	CLASSIC	ELITE
INJURY CARE BENEFITS		
Emergency Care Benefit Maximum 1 visit per Covered Injury & 2 visits per Calendar Year per Covered Person		
Emergency Room		
Adult	$150/visit	$225/visit
Child(ren)	$75/visit	$112.50/visit
Emergency Care Clinic		
Adult	$150/visit	$225/visit
Child(ren)	$75/visit	$112.50/visit
Not payable if the Emergency Care Benefit – Emergency Room is provided for the same Covered Accident		
Medical Practitioner		
Adult	$50/visit	$75/visit
Child(ren)	$25/visit	$37.50/visit
Not payable if the Emergency Care Benefit – Emergency Room or the Emergency Care Benefit – Emergency Care Clinic is provided for the same Covered Accident		
Diagnostic Imaging Benefit		
MRI, CT, PET	$400/imaging	$600/imaging
X-Ray, Ultrasound, Other	$100/imaging	$150/imaging
Maximum 1 image per Covered Injury & 2 images per Calendar Year per Covered Person		
HOSPITALIZATION & TRANSPORTATION BENEFITS		
Initial Hospital Confinement Benefit Maximum 1 day per Covered Injury & 1 day per Calendar Year per Covered Person	$1,800/day	$2,700/day
Continuing Hospital Confinement Benefit Maximum 30 days per Covered Injury & 60 days per Calendar Year per Covered Person. Not payable for any Period of Confinement or portion thereof covered by the Initial Hospital Confinement Benefit	$350/day	$525/day
Attending Physician Benefit Payable for any day of Hospital Confinement for which the Initial Hospital Confinement Benefit or the Continuing Hospital Confinement benefit is payable	$100/day	$150/day
Intensive Care Unit Confinement Benefit Maximum 15 days per Covered Accident & 30 days per Calendar Year per Covered Person	$650/day	$975/day

THIS IS AN ACCIDENT ONLY POLICY

TREATMENT BENEFITS	CLASSIC	ELITE
Stepdown Care Unit Confinement Benefit Maximum 15 days per Covered Injury & 30 days per Calendar Year per Covered Person	$300/day	$450/day
Ambulance Benefit		
Land	$300/trip	$450/trip
Air	$1,500/trip	$2,250/trip
Maximum 1 trip per Covered Injury & 2 trips per Calendar Year per Covered Person		
Alternative Emergency Transportation Benefit		
Adult	$50/trip	$75/trip
Child(ren)	$25/trip	$37.50/trip
Maximum 1 trip per Covered Injury & 2 trips per Calendar Year per Covered Person		
SURGICAL BENEFITS		
Surgery Benefit Maximum 1 surgery per Covered Person per Covered Injury & 2 surgeries per Calendar Year per Covered Person Not payable if the Surgery for Certain Internal Injuries Benefit is provided for the same Covered Accident	$150	$225
Surgery for Certain Internal Injuries Benefit Maximum 1 surgery per Covered Person per Covered Injury & 2 surgeries per Calendar Year per Covered Person	$1,000	$1,500
Blood, Plasma, and Platelets Benefit Maximum 1 benefit per Covered Accident & 2 benefits per Calendar Year per Covered Person	$600	$900
ACCIDENTAL DEATH BENEFITS		
Accidental Death Benefit		
Adult	$60,000	$90,000
Child(ren)	$15,000	$22,500
Common Carrier Accidental Death Benefit		
Adult	$120,000	$180,000
Child(ren)	$30,000	$45,000
Payable in lieu of the Accidental Death Benefit		

Insurance Policy Series GRA-3004-TX (1/15) and Optional Rider Form GR-3014-TX (1/15) (if selected). Premium and benefits will vary with the program selected. This brochure is only a summary. See your Policy for details on exclusions and limitations. Capitalized items are defined by your Policy. If the Owner is not satisfied with the policy for any reason, the Owner may return it to the Home Office or to the agent through whom it was purchased within 10 days after it is received. Once returned, premiums and fees will be refunded promptly. This policy is guaranteed renewable for life. If the premiums are paid on time, the Policy will not be canceled. Renewal premiums will be at the premium rates in effect on each Renewal Date. Premium rates may change, but only if they are changed for all policies in the same class.

OPTIONAL ACCIDENT ENHANCEMENT RIDER & DEFINITIONS

TREATMENT BENEFITS	CLASSIC	ELITE
At-Home Recovery Benefit Payable for any day of Hospital Confinement for which the Initial Hospital Confinement Benefit or the Continuing Hospital Confinement Benefit is payable	$400/day	$600/day
Transportation Benefit 1 round trip maximum for Qualified Covered Person Travel and 1 round trip maximum for Qualified Family Travel per Covered Injury		
Transportation Benefit - Common Carrier per round trip	$1,000	$1,500
Transportation Benefit - Car per round trip Not payable if the Transportation Benefit – Common Carrier is provided for the same Covered Injury for an individual	$0.50/mile	$0.75/mile
Family Member Lodging Benefit Maximum 30 days per Covered Injury & 2 Covered Injuries per Calendar Year	$150/day	$225/day

Accident means a sudden, unexpected, and unforeseen event which results in a Covered Person's Injury.

In order for an Accident to be a Covered Accident the Accident must result in payable benefits under the terms, conditions, exclusions, and limitations of the Policy.

Injury means bodily harm that is independent of disease or bodily infirmity. Bodily harm is not independent of disease or bodily infirmity if it is: (1) a recurrence, exacerbation, or aggravation of any bodily harm sustained prior to the Coverage Effective Date; (2) a recurrence, exacerbation, or aggravation of any condition for which diagnosis, treatment, or medical care was received prior to the Coverage Effective Date; or (3) pain of unknown origin.

In order for an Injury to be a Covered Injury, it must: (1) be sustained by a Covered Person; (2) be the result of an Accident that occurs while the insurance is in force; and **(3) result in the Covered Person receiving Emergency Care within 72 hours of the Accident.** Covered Injury does not include Injuries resulting from an unknown cause.

Qualified Covered Person Travel means travel by a Covered Person that is: (1) to and from a Hospital more than 100 miles from the Covered Person's home, within the U.S. and possessions or Canada; and (2) for the purpose of care or treatment for the Covered Person's Covered Injury which has been prescribed by a Medical Practitioner.

Qualified Family Travel means travel by a Covered Person's Family Member that is: (1) for the purpose of care or treatment for the Covered Person's Covered Injury which has been prescribed by a Medical Practitioner; and (2) to and from a Hospital more than 100 miles from the Covered Person's home, within the U.S. and possessions or Canada. The Hospital the Covered Person is seeking care or treatment at must also be more than 100 miles from the Family Member's home. When a Family Member is traveling without the company of the Covered Person, the Family Member must be over the age of 18.

EXCLUSIONS & LIMITATIONS

No benefits are provided for services or supplies that are not Medically Necessary or are attributable to a recurrence, exacerbation, or aggravation of any bodily harm sustained or any condition suffered by the Covered Person prior to the Coverage Effective Date of the Policy. This Policy does not provide benefits if the Covered Person's Injury is caused or contributed to by:

1. Suicide, attempted suicide, or an intentionally self-inflicted injury;
2. Any poison, gas, or fumes voluntarily absorbed, inhaled, or taken; or medical or surgical treatment of these acts;
3. Injury of a Covered Person resulting from the Covered Person's intoxication or being under the influence of any intoxicant;
4. The voluntary use or taking of any narcotic (unless taken or used as prescribed by a Medical Practitioner);
5. A Covered Person acting as a pilot or crew member in any aircraft; while a passenger in aircraft operated by the armed forces or used for training, practice, tests, experimental or exhibition or stunt purposes; or while a passenger (other than a fare-paying passenger) in any aircraft;
6. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Child that has resulted in a functional defect;
7. The Covered Person's commission or attempted commission of a felony; or being engaged in an illegal occupation; or while the Covered Person is incarcerated in a municipal, county, state, or federal correctional facility.
8. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; services in the armed forces or units auxiliary to it;
9. Engaging in parachuting, hang-gliding, mountaineering, bungee jumping, or similar activities;
10. Participation in competitive athletic contests of any type where compensation or monetary awards are received;
11. The use of any motor driven vehicle in a race, stunt show, or speed test;
12. Syncope, seizure, or Transient Ischemic Attack (TIA);
13. Any disease, sickness, infection, or other disorder, unless such condition is a Medical Complication initially treated by a Medical Practitioner within 72 hours of the Covered Injury;
14. Any bodily infirmity, mental infirmity, or psychiatric illness; or medical or surgical treatment therefor;
15. Diseases or conditions resulting from the bite or sting of an insect or spider; or
16. Infestation by any virus, bacteria, or microorganism including food poisoning unless such infestation is a Medical Complication initially treated by a Medical Practitioner within 72 hours of the Covered Injury.

This Policy pays benefits only for loss resulting from a Covered Injury which occurs while this Policy is in force and only up to the maximum limits shown on the Policy Benefits Schedule. If Emergency Care received is due to more than one Covered Injury resulting from the same Accident, benefits will be payable only for the Covered Injury with the greatest covered benefits.

This Policy does not provide benefits for a Covered Injury which occurs while a Covered Person is on active duty status in the armed forces. If we receive notice of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.

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Cancer Insurance Program

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

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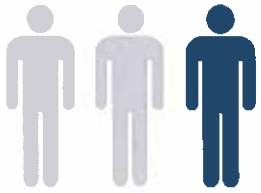
SI-000002-TX (July 19)

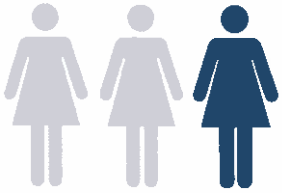
UNCERTAIN ABOUT YOUR NEED FOR CANCER INSURANCE?

CONSIDER THESE FACTS

According to the American Cancer Society,

The lifetime risk of developing cancer is greater than...

1 of 3 men 

1 of 3 women 

In 2019, about **1,762,450** new cancer cases were expected to be diagnosed in the U.S.

The overall cost for cancer treatment and recovery in the U.S. in 2019 was estimated at **$80.2 billion** for direct medical expenses.

Approximately **96,480 new cases** of melanoma were expected to be diagnosed in 2019 in the U.S.

About **268,600 new cases** of breast cancer were expected to occur among U.S. women in 2019.

In the U.S., Cancer is the **second most common cause of death** (exceeded only by cardiovascular disease).

Cancer is the **leading cause of death** by illness in children ages 1-14 in the U.S.

Source: Cancer Facts and Figures 2019 American Cancer Society. The above facts are presented for information only and do not imply coverage provided under this policy or endorsement of the American Cancer Society. The American Cancer Society does not endorse any product or service.

CANCER INSURANCE PROGRAM

TREATMENT BENEFITS	GREEN	GOLD
CANCER DIAGNOSIS, SCREENING, AND TESTING		
Express Payment Benefit Paid one time for a Covered Person upon first diagnosis of internal Cancer or melanoma. Not payable for Skin Cancer. Benefit is 50% larger for diagnosis in a covered Child.	$2,000/adult $3,000/child	$3,000/adult $4,500/child
Cancer Screening Wellness Benefit Paid once per Calendar Year for each Covered Person who receives a mammography exam, pap-smear lab, chest x-ray, colonoscopy, certain blood tests, or other wellness tests specified in the Policy.	$50/Year	$75/Year
National Cancer Institute (NCI) Benefits Paid once per Covered Person, for seeking NCI's opinion on the Covered Person's Cancer treatment.		
One-Time Consultation Benefit Not payable on same day as 2nd/3rd Surgical Opinion Benefit.	$500	$750
One-Time Transportation Benefit Payable only if NCI's Cancer center is more than 100 miles from the Covered Person's home. Not payable on same day as Covered Person and Family Transportation Benefit.	$200	$300
CANCER THERAPY [1]		
Inpatient/Outpatient Injected Chemotherapy Benefit Paid for each day a Covered Person receives Chemotherapy Treatment by injection, either during the first 60 Days of One Period of Confinement or at an Outpatient Care Facility.	$200/day of service	$300/day of service
In-Home Injected Chemotherapy Benefit Paid for self-injected Chemotherapy Treatment or Chemotherapy Treatment which is self-administered by pump.	$400/month	$600/month
Non-Hormonal Oral Chemotherapy Benefit Paid for oral Chemotherapy Treatment.	$800/month	$1,200/month
Radiation Benefit Paid for each day a Covered Person undergoes radiation therapy for the modification or destruction of Cancer, either during the first 60 Days of One Period of Confinement or at an Outpatient Care Facility.	$200/day of service	$300/day of service
Immunotherapy and Hormonal Therapy Benefit Paid for immunotherapy or hormonal therapy treatment of Cancer.	$400/month	$600/month
Blood, Plasma, Platelets Benefit Paid for each unit of blood, plasma, and platelets a Covered Person receives in connection with treatment of Cancer. Calendar Year maximum applies.	$50/unit 50 units/year	$75/unit 50 units/year

[1] Benefits not payable on same day as Experimental Treatment Benefit

TREATMENT BENEFITS

	GREEN	GOLD
HOSPITAL CONFINEMENT [1]		
Hospital Confinement Benefit Paid daily for the first 60 Days of One Period of Confinement.	$200/Day	$300/Day
Extended Hospital Confinement Paid daily for the 61st and later Days of One Period of Confinement. This benefit is paid in lieu of all Policy benefits except Waiver of Premium.	$600/Day	$900/Day
Private Duty Hospital Nurse Benefit Paid daily, for a nurse's 4-hour shift, during the first 60 Days of One Period of Confinement.	$100/Day	$150/Day
Hospital Drugs and Testing Benefit Paid for drugs and diagnostic tests administered to a Covered Person during One Period of Confinement. Calendar Year maximum applies.	$200/One Period of Confinement max $400/ Calendar Year	$300/One Period of Confinement max $600/ Calendar Year
TRANSPORTATION AND TRAVEL		
Ambulance Benefit Paid for 2 one-way trips to the Hospital for Cancer treatment, by ground or air ambulance, per One Period of Confinement.	$200/land trip $2,000/air trip	$300/land trip $3,000/air trip
Covered Person and Family Transportation Benefit Paid for 2 round trips of qualifying travel (over 100 miles away) for a Covered Person to receive Cancer treatment or for family members to visit the Covered Person during treatment. Calendar Year maximum applies.	$0.50/mile up to $1,000/ round trip	$0.75/mile up to $1,500/ round trip
Outpatient Lodging Benefit Paid for a hotel/motel room occupied by the Covered Person during qualifying treatment for Cancer at a Hospital or Outpatient Care Facility more than 100 miles from the Covered Person's home. Maximum 2 days per qualifying treatment. Maximum 90 days per Calendar Year.	$50/day	$75/day
Family Member Lodging Benefit Paid for one family member's hotel/motel room while visiting a Covered Person who is undergoing qualifying treatment for Cancer at a Hospital more than 100 miles from the Covered Person's home. Not payable if room is covered by the Outpatient Lodging Benefit. Maximum 14 days per qualifying treatment. Maximum 90 days per Calendar Year.	$50/day	$75/day
CANCER SURGERY		
2nd & 3rd Surgical Opinion Benefit Paid to give you peace of mind that a first opinion recommending surgery is appropriate. This benefit is not payable on the same day that the National Cancer Institute Evaluation/Consultation Benefit is paid.	$200/opinion	$300/opinion

[1] Benefits payable only while confined in Hospital for Cancer Treatment

TREATMENT BENEFITS

	GREEN	GOLD
Surgical Facility Benefit Paid when a Covered Person undergoes a Covered Surgery at a surgical facility (e.g., operating room) in a Hospital or Outpatient Care Facility. Not payable for Skin Cancer.	$200/facility	$300/facility
Surgeon's Fee Benefit Paid for surgery in or out of the Hospital, including surgery for Skin Cancer, up to the maximum amount described in the Policy, based on the severity of the operation as rated by the Federal Register.	up to $5,500/ operation	up to $8,250/ operation
Reconstructive Surgery Paid similarly if performed within 3 years of a Covered Surgery for which benefits were paid.		
Anesthesia Benefit Paid for anesthesia services and anesthesia drugs administered in connection with a Covered Surgery.	25% of Surgeon's Fee Benefit	25% of Surgeon's Fee Benefit
Bone Marrow Transplant Benefit Paid for the implantation of human bone marrow tissue, once per Covered Person, solely in connection with treatment of Cancer. Paid in lieu of the Surgical Facility Benefit, Surgeon's Fee Benefit, and Anesthesia Benefit.		
Inpatient Implantation Benefit	$10,000	$15,000
Outpatient Implantation Benefit	$5,000	$7,500
Donor Benefit (if not Covered Person)	$1,000	$1,500
Stem Cell Transplant Benefit Paid for peripheral stem cell transplant, once per Covered Person, solely in connection with treatment of Cancer. Paid in lieu of the Surgical Facility Benefit, Surgeon's Fee Benefit, and Anesthesia Benefit.	$8,000	$12,000
Surgically Implanted Prosthesis Benefit Paid for the surgical implantation of a prosthetic device made necessary as the direct result of a Covered Surgery. Maximum 2 devices per Covered Person.	$2000/device	$3000/device
CONTINUING CARE		
Annual Treatment Support Benefit Annual benefit paid for the first 5 years following the Calendar Year during which Cancer was First Diagnosed, if the Covered Person remains under the active care of a Physician for that Cancer. Designed to cover labs, blood work, urinalysis and other generalized care and screening.	$350/year	$525/year
Dental Services Benefit Paid once per Covered Person, if a Covered Person receives dental services because of tooth/jaw damage from Cancer treatment. Dental services must take place within 5 years of date Cancer is First Diagnosed.	$400	$600

MOST BENEFITS AVAILABLE WHETHER OR NOT YOU ARE HOSPITAL CONFINED & WITHOUT REGARD TO ACTUAL COSTS

TREATMENT BENEFITS	GREEN	GOLD
Post-Hospitalization Extra Care Benefit Paid daily if the Covered Person uses any of the following within 14 days following One Period of Confinement for care and treatment of Cancer: Skilled Nursing Facility, private duty Nurse, home health care, physiotherapist services.	$100/day max. 30 days/ One Period of Confinement	$150/day max. 30 days/ One Period of Confinement
Hospice Benefit Paid daily for care provided by a licensed Hospice facility or service provider to a Covered Person who is Terminally Ill. Benefit reduces 50% on the 31st day of Hospice care. Lifetime maximum applies.	$100/day up to $12,000	$150/day up to $18,000
Non-Surgical Prosthesis Benefit Paid for prosthetic devices or related supplies, prescribed as a direct result of Cancer treatment, that do not require surgical implantation. Payable for such devices as special bras, ostomy pouches, wigs, and hairpieces.	$200/year	$300/year
PEACE OF MIND		
Pain Management and Alternative Care Benefit Paid for pain management or alternative care during Cancer treatment, such as acupuncture, counseling, anti-nausea medication, herbal medicine, and respiratory therapy. Not payable for Skin Cancer. Not payable for chiropractic care.	$50/month up to 12 months	$75/month up to 12 months
Experimental Treatment Benefit Paid for experimental Cancer treatment, consistent with National Cancer Institute-sponsored protocols, which modifies or destroys abnormal tissue. Not payable on same day as Inpatient/Outpatient Injected Chemotherapy Benefit, Radiation Benefit, or Bone Marrow Transplant Benefit.	$200/day	$300/day
Fertility Treatment Benefit Paid once per Covered Person if a Covered Person receives fertility treatment after Cancer is First Diagnosed due to risk of iatrogenic infertility.	$2,000	$3,000
Pet Boarding Benefit Paid for pet boarding services at a licensed kennel or veterinarian's office while that Covered Person (the pet owner) is Hospital confined for Cancer treatment. Daily benefit only, regardless of number of pets boarded.	$20/day	$30/day
Waiver of Premium Benefit Premiums are waived if the Primary Insured, before the age of 60, becomes Totally Disabled for more than 90 days as the result of a covered Cancer.		

Policy Form GRC-2005-TX (11/11). Premium and benefits vary with the benefit level selected. Hospital generally does not include a Hospice, convalescent home, or extended care facility.

QUESTIONS ABOUT EXCLUSIONS & LIMITATIONS? WE HAVE ANSWERS.

1. **What is the purpose for buying this insurance Policy?**

   This Policy is a SPECIFIED DISEASE INSURANCE POLICY. It provides insurance protection only for treatment of Cancer and, unless specifically noted in the Policy, does not cover any other disease or complication caused or contributed to by Cancer.

2. **Can I rely on the description of the benefits in this brochure?**

   Yes, however, space limits us to providing only general descriptions. READ YOUR POLICY CAREFULLY since only the Policy provisions, not this brochure, control. This brochure is only a summary of benefits, exclusions and limitations.

3. **Are the capitalized words I see throughout the brochure, like "Day" and "Hospital" capitalized for a reason?**

   Yes, critical definitions of capitalized words are contained in your Policy, along with a complete description of all exclusions and limitations.

4. **Can I decide to cancel the Policy at any time, and can you, the insurance company, cancel it as well?**

   You can cancel the Policy by sending written notice to us or by simply not paying the renewal premium at any time. However, elections to pay premiums through pre-tax deductions in an IRS Section 125 plan generally permit changes at the end of a plan year or after a qualifying event. We, the insurance company, cannot cancel the Policy and guarantee you the right to keep it in force by timely paying your premiums when due or during the Grace Period for your entire life. We do have the right to increase premiums, but only if we do so for all similar policies in your state.

5. **How do we resolve any dispute that might arise?**

   If the dispute is over claims, you have the right to have our Claims Appeal Committee review the matter. We have an excellent record at resolving disputes and misunderstandings.

6. **Can I send my Policy back and get my money back if after reading it I decide I don't want it?**

   Yes. If after receiving the Policy, you decide it's not the right fit for you then send it back to us within 10 days for a full refund and the Policy will be voided from its date of issue.

7. **When might a benefit for a covered disease not be payable to me?**

   FOR SPECIFIED DISEASE POLICIES, no coverage is provided for two years after the Policy's Coverage Effective Date (generally, the issue date) for a covered disease that is a Preexisting Condition. Generally, a Preexisting Condition is a condition, whether known or unknown, for which: (1) medical advice, consultation, or treatment was recommended by or received from a Physician within the two year period before the Coverage Effective Date; or (2) symptoms existed within the two year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. For Cancer that is First Diagnosed within the 30 days following the Coverage Effective Date for a Covered Person, the Express Payment Benefit will not be paid, and benefits will only be paid for any care and treatment of that condition which is received more than two years following the Coverage Effective Date. No benefits are provided for care or treatment that is not Medically Necessary. No benefits are provided for conditions that are not covered conditions under the Policy terms.

8. **Can I receive treatment anywhere in the world and be paid benefits?**

   Yes.

9. **Can I receive insurance protection for my spouse and children?**

   Yes. Instead of an Individual Plan, you may apply for a One Parent Plan to cover you and your eligible Children, or a Family Plan for you, your Spouse and Children as well. Additional premium applies. Each person must meet the underwriting standards to have coverage under the Policy.

10. **Is there any coverage for events before the Policy is issued or after the Policy lapses or terminates?**

    The Coverage is provided after the Coverage Effective Date for a Covered Person and until the Policy terminates (other than continuous Hospital confinement for up to 90 Days, as specified in the Policy).

Outstanding Features

- Provides payment of benefits directly to you or whomever you designate.
- Pays in addition to other insurance including HMO & PPO.
- Portable coverage that stays with you even if your career changes.
- Most of our insurance programs are guaranteed renewable for life.*

*Premium rates may change.

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Disability Income Insurance Program

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75-455 (5/20)

UNCERTAIN OF YOUR NEED FOR DISABILITY INCOME INSURANCE?

CONSIDER THESE FACTS

At the bottom line, your ability to earn income is your most important asset.

Everything you have now and everything in your plans for the future are dependent upon your ability to work and earn an income. If you're like most people, you probably have insurance to protect your home, car, and savings – but do you have insurance to protect your ability to earn an income?

An estimated 8,876,560 working Americans will experience a short-term disability (six months or less) due to illness, injury, or pregnancy in 2019.[1]

40% of U.S. homes have at least $6,275 in liquid savings. That is what it would take a family of four to replace income at the poverty level for three months.[2]

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

[1] Council for Disability Awareness, Disability Statistics updated March 28, 2018; RI Department of Labor and Training Labor Market Information October 2019; [2] Council for Disability Awareness, Disability Income Awareness Month 2019 Fact Sheet; [3] Social Security Administration, Basic Fact Sheet 2019.

4 OUT OF 10 AMERICAN ADULTS

indicate they can't pay an unexpected $400 bill without having to carry a balance on their credit card or borrow money from friends, family, or the bank.[4]

WORKERS' COMPENSATION DOES NOT COVER MOST DISABILITY CHALLENGES

Workers' Compensation only covers time away from work if the disabling illness or injury was directly work-related. In 2017, only one percent of American workers missed work due to an occupational illness or injury.[5]

[4] Council for Disability Awareness, Disability Income Awareness Month 2019 Fact Sheet; [5] Council for Disability Awareness, Disability Income Awareness Month 2019 Fact Sheet

DISABILITY INCOME INSURANCE PROGRAM

TREATMENT BENEFITS

	BASIC	CLASSIC	ELITE
INJURY CARE BENEFITS			
TOTAL DISABILITY BENEFIT When you become Totally Disabled while Gainfully Employed as a result of a covered Injury or Sickness, benefits are payable after the Elimination Period and up to six months, as shown in your policy. Benefits are prorated on a daily basis.	$1,000 - $1,900 per month ($33 - $63/day)	$2,000 - $2,900 per month ($66 - $96/day)	$3,000 - $4,000 per month ($100 - $133/day)
HOSPITAL DISABILITY BENEFIT While you are Hospital Confined due to a covered Injury or Sickness, benefits are payable after the Elimination Period and up to six months, as shown in your policy. Benefits are prorated on a daily basis.	$1,500 per month ($50/day)	$3,000 per month ($100/day)	$4,500 per month ($150/day)
PHYSICIAN CONSULTATION Benefit payable for consultation with a Physician due to a covered Sickness or Injury, such as a physician's office or hospital emergency room visit, for the purpose of obtaining a diagnosis, treatment, or medical advice, whether or not Hospital Confined. This benefit is payable for up to two visits per calendar year.	$30/visit	$60/visit	$90/visit
CHILDBIRTH BENEFIT Lump sum benefit payable when you deliver a child during or at the end of the third trimester. Any Total Disability Benefit payment received for a Total Disability due to Complications of Pregnancy will be deducted from this benefit.	$1,000	$2,000	$3,000
WAIVER OF PREMIUM If you become Totally Disabled as a result of a covered Injury or Sickness for 90 or more consecutive days, premiums due under this Policy will be waived during the period of Total Disability.			

Pays In Addition To Any Other Insurance
including sick leave, workers' compensation and social security.

Coverage For Sickness Or Injury
on or off the job, anywhere in the world.

Hospital does not include any institution, or part thereof, that is used primarily as a clinic (except in FL), convalescent home, nursing or rest home, home for the aged; or any facility primarily affording custodial educational or rehabilitative care.

Insurance Policy Series ICCI6 GRD-6005 (8/16) and state specific versions. Premium and Benefits will vary with the coverage selected Eligibility for benefits is dependent on health, income, and additional company underwriting standards.

EXCLUSIONS & LIMITATIONS

Generally, no benefits are payable for loss if the Sickness or Injury is caused or contributed to by:

- Participation in a riot or insurrection
- Alcoholism or drug addiction [1, 10, 18]
- Mental or Nervous Disorder(s) [2, 3, 18]
- War or any act of war (whether declared or undeclared)
- The Insured acting as a pilot or crew member in any aircraft
- While a passenger (other than a fare-paying passenger) in any aircraft
- Attempted suicide or intentionally self-inflicted injury (while sane or insane)
- The Insured's legal intoxication as defined by the state law where the loss occurs [4, 5, 11, 12, 19]
- Legal incarceration for more than seven days in a municipal, county, state, or federal correctional facility [5, 6, 18, 19]
- The voluntary use or taking of any narcotic, barbiturate, or other drug (unless administered on the advice of a Physician) [7, 11]
- While a passenger in aircraft operated by the armed forces or used for training, practice, tests, experiment, exhibition, or stunt purposes
- Legal detainment of more than seven days where the period of legal detainment results in the inability of the Insured to be Gainfully Employed [2, 5, 11, 12, 18, 19]
- Active duty status in the armed forces
- Cosmetic surgery, (does not include reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly resulting in a functional defect) [8]
- In FL, DC, ND and SD, the voluntary taking, absorption, or inhalation of any poison, gas, or fumes, or the medical treatment of any of these acts [16]
- The commission or attempted commission of a felony, or engaging in an illegal occupation

In CA, DC, DE, FL, ND and SD, benefits for Sickness are not payable if the Sickness is First [20] Manifested and First [20] Occurs during the 30 days following the Coverage Effective Date.

PREEXISTING CONDITIONS. **Coverage is not provided until one year after the Policy's Coverage Effective Date for a Preexisting Condition. If you request and we, the insurance company, approve a change to the Policy that increases Policy or rider benefits, the increase in benefits will not cover Preexisting Conditions for the Insured for a one year period after the Coverage Effective Date of such increase in benefits.** In FL, the Preexisting Condition exclusion does not apply to breast cancer if the Insured has been free from breast cancer for more than two years prior to the Coverage Effective Date. A Preexisting Condition is a condition for which: (1) medical advice or treatment was recommended by or received from a Physician within the two-year [13] period before the Coverage Effective Date; or (2) symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment [14, 15]

MULTIPLE INJURIES OR SICKNESSES THAT OCCUR AT THE SAME TIME. The Policy does not pay concurrent benefits for multiple injuries or sicknesses that occur at the same time during a Total Disability.

PREGNANCY. The Insured is not eligible for the Total Disability Benefit, Hospital Disability Benefit, or Waiver of Premium Benefit attributable to child birth or pregnancy (other than Complications of Pregnancy) **In FL, the Childbirth benefit is not available if conception occurs during the first 30 days following the Coverage Effective Date. In CA, DE, DC, ND and SD, the child birth benefit is not available if the birth occurs during the first 300 days following the Coverage Effective Date.**

RENEWABILITY & CANCELLABILITY

The Policy is guaranteed renewable until Age 70, which means we cannot cancel the Policy and guarantee you the right to keep the Policy in force until Age 70 by timely paying your premiums when due or during the Grace Period. We do have the right to increase premiums, but only if we do so for all similar policies in your state.

If you decide you no longer want your Policy after reading it, you can send it back to us within 30 days [9] after receipt. You will be issued a full refund and the Policy will be voided from its original Issue Date. After 30 days [9] of initial Policy receipt, you can cancel the Policy by simply not paying the renewal premium at any time. However, elections to pay premiums through pre-tax deductions in an IRS Section 125 plan generally may only be changed at the end of a plan year or after a qualifying event.

Words capitalized throughout this brochure like "Injury" and "Insured" are defined in the Policy, along with a complete description of exclusions and limitations. READ THE POLICY CAREFULLY AS IT CONTROLS. THIS BROCHURE IS ONLY A SUMMARY.

[1] In DC: Alcoholism only [2] Not applicable in FL [3] In DE: Mental or emotional disorders [4] In DC, FL and ND: Injury resulting from alcohol, an intoxicant, or being under the influence of alcohol or an intoxicant [5] Not applicable in DE [6] In DC, FL, ND and SD: incarceration in a municipal, county, state or federal correctional facility [7] In DC, the voluntary use of any illegal drugs, the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and intentional misuse of prescription drugs [8] In CA, DE, DC, FL, ND and SD: medical treatment or elective procedure that is not medically necessary, including but not limited to cosmetic surgery [9] 10 days in CA, DC, DE, FL, ND and SD [10] For SD, the treatment of alcoholism and drug addiction [11] Not applicable in SD [12] Not applicable in ND [13] One year in SD [14] In ND Preexisting Condition means a condition for which medical advice or treatment was received from a Physician within the two year period before the Coverage Effective Date [15] In CA, Preexisting Condition means a condition for which: (1) medical treatment, care or services for a diagnosed condition or prescribed medication for a diagnosed condition was received in the two year period immediately prior to the Coverage Effective Date; or (2) symptoms existed within the one-year period before the Coverage Effective Date that would cause an prudent person to seek medical advice or treatment; and (3) the Total Disability caused or substantially contributed to by the condition begins in the first year after the Coverage Effective Date. A Complication of Pregnancy is not considered a Preexisting Condition unless the Total Disability related to the Complication of Pregnancy began before the Coverage Effective Date [16] In CA, The voluntary taking, absorption, or inhalation of any gas or the medical treatment of any of these acts [17] In CA, Injury resulting from an intoxicant, or being under the influence of any intoxicant [18] Not applicable in CA [19] Not Applicable in DC [20] First not applicable in SD

Heart Insurance Program

Underwritten by: National Teachers Associates Life Insurance Company (NTA Life)
4949 Keller Springs Rd • Addison, Texas 75001 • P.O. Box 802207 - Dallas, Texas 75380 • 888.671.6771 • ntalife.com

horacemann.com

This is not a Policy of Workers' Compensation insurance. The Employer does not become a subscriber to the Workers' Compensation system by purchasing this policy, and if the Employer is a non-subscriber, the Employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The Employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

SI-000001-TX (July 19)

UNCERTAIN ABOUT YOUR NEED FOR HEART INSURANCE?
CONSIDER THESE FACTS

Cardiovascular Disease

Remains the #1 significant cause of death in the U.S.

Cardiovascular Disease*	Cancer	Chronic Lower Respiratory Disease	Accidents	Alzheimer's Disease	Diabetes Mellitus
807,775	591,699	147,101	136,053	93,541	76,488

In 2014, nearly **1 of every 3** deaths in America (30.8%) was related to Cardiovascular Disease. On average, Cardiovascular Disease caused **1 death every 1 minute 19 seconds among females in the U.S.**

*Cardiovascular Disease includes congenital cardiovascular disease.

Cardiovascular risk factors include heredity, increasing age, high cholesterol, smoking, lack of exercise, overweight, diabetes, stress and high blood pressure.

Source: National Center for Health Statistics and National Heart, Lung and Blood Institute 2014.

$918 billion is the projected direct medical costs of Cardiovascular Disease in 2030, up from $396 billion in 2012.

92.1 million estimated American adults now suffer from at least one type of Cardiovascular Disease.

2,200 Americans die of Cardiovascular Disease each day, averaging 1 death every 40 seconds.

43.9% of the U.S. population is projected to have some form of Cardiovascular Disease by 2030.

795,000 estimated people experience a new or recurrent stroke each year, averaging 1 stroke every 40 seconds in the U.S.

Source: Heart and Stroke Facts: Heart Disease and Stroke Statistics 2017 update, American Heart Association.
The above facts are presented for information only and do not imply coverage under this policy or endorsement of the American Heart Association. The American Heart Association does not endorse any product or service.

BENEFITS AVAILABLE
IN OR OUT OF HOSPITAL

TREATMENT BENEFITS	GREEN	GOLD
Initial Occurrence Paid once per Covered Person upon a Physician's diagnosis of the **first Heart Attack** or **Stroke**, or for the first confinement for a Day in a Hospital due to **Heart** or **Carotid Artery Disease**. (Not payable solely due to occurrence of TIA.)	$1,500	$2,000
Heart Screening Wellness Benefit Paid for any combination of wellness exams and tests specified in your Policy to evaluate the heart or cardiovascular system for (example Lipid profiles and resting EKG). *No lifetime maximum!*	$50/ Calendar Year	$75/ Calendar Year
Diagnostic or Emergency Room ("ER") Procedures Paid for evaluation of symptoms of a Covered Condition for care in an ER or for Diagnostic Procedures listed in your Policy. *No lifetime maximum!*	$150/ Calendar Year	$200/ Calendar Year
Ambulance Paid for 2 one-way trips by ground and 2 one-way trips by air to or from a Hospital per year to evaluate symptoms of a Covered Condition. Calendar Year maximum applies. *No lifetime maximum!*	$100/trip-Ground $300/trip-Air	$125/trip-Ground $450/trip-Air
Surgical Facility Paid for a day of use of an operating room facility for a covered surgery. *No lifetime maximum!*	$200/ surgical facility	$300/ surgical facility
Primary Surgeon's Fee Paid for primary surgeon up to the maximum amount described in the Policy based on the severity of the operation as rated in the Federal Register. *No lifetime maximum!*	Up to $5,000 for the most costly surgeries	Up to $7,500 for the most costly surgeries
Assistant Surgeon's Fee Paid for one Assistant Surgeon (if any). *No lifetime maximum!*	25% of Primary Surgeon's Fee Benefit	25% of Primary Surgeon's Fee Benefit
2nd & 3rd Surgical Opinions Paid to help give you peace of mind that a first opinion recommending surgery is appropriate. *No lifetime maximum!*	$50/ opinion	$75/ opinion
Anesthesia Paid to cover professional fees of an anesthesiologist or anesthetist and anesthesia directly charged by the Hospital or Outpatient Care Facility. Paid only in connection with a covered surgery. *No lifetime maximum!*	25% of Primary Surgeon's Fee Benefit	25% of Primary Surgeon's Fee Benefit
Implanted Cardiac Device Paid for implanted pacemaker or similar electronic device to regulate heart rhythm. *No lifetime maximum!*	$500/ Calendar Year	$750/ Calendar Year

COVERED CONDITIONS: HEART DISEASE, CAROTID ARTERY DISEASE, HEART ATTACK, STROKE, AND, EXCEPT AS TO THE INITIAL OCCURRENCE BENEFIT, TRANSIENT ISCHEMIC ATTACK ("TIA")

BENEFITS AVAILABLE

WHILE IN HOSPITAL

TREATMENT BENEFITS	GREEN	GOLD
Hospital Confinement Paid for each of the first 60 Days of One Period of Confinement that you are an Inpatient in a Hospital for a Covered Condition. *No lifetime maximum!*	$200/ Day	$300/ Day
Extended Hospital Confinement Paid in lieu of all other benefits (except the Heart Transplant Benefit) while Hospital confined for the 61st and later Days of One Period of Confinement that you are an Inpatient in a Hospital. *No lifetime maximum!*	$300/ Day	$400/ Day
Heart Transplant Paid for implantation of a natural human heart once per Covered Person.	$20,000	$30,000
Hospital Medications Paid for each One Period of Confinement up to twice a year. *No lifetime maximum!*	$400/ Confinement	$600/ Confinement
Private Duty Nurse Paid for a minimum 4-hour daily shift during the first 60 Days you are in the Hospital, if ordered by your Physician. *No lifetime maximum!*	$75/Day	$100/Day
Attending Physician Paid daily during the first 60 Days you are in the Hospital for visits by a Physician other than the surgeons. *No lifetime maximum!*	$50/Day	$75/Day
Blood, Plasma, & Platelets Paid for each unit of blood, plasma, and platelets during the first 60 Days of One Period of Confinement. Maximum 25 units per Calendar Year. *No lifetime maximum!*	$30/Unit	$40/Unit
Physiotherapy Paid for up to 15 days treatment by a registered physiotherapist during the first 60 Days for each One Period of Confinement. *No lifetime maximum!*	$50/Day	$75/Day
Electrocardiogram or Echocardiogram Paid for either procedure during the first 60 Days of One Period of Confinement. *No lifetime maximum!*	$150/ Confinement	$200/ Confinement
Oxygen Paid for the use of oxygen and related equipment during the first 60 Days of One Period of Confinement. *No lifetime maximum!*	$150/ Confinement	$200/ Confinement
Transportation Paid for actual charges of 2 one-way trips per One Period of Confinement for you and paid for one family member's coach air, train, and bus tickets, or one car mileage allowance. Your travel must be more than 100 miles from your home, within the U.S. and possessions or Canada, and treatment must be prescribed by your Physician. *No lifetime maximum!*	33¢/ Mile Up to $500/ Confinement	50¢/ Mile Up to $750/ Confinement

Policy series GRH-1001-TX (9/06). Premium and benefits vary with the plan selected.

See back page for important FAQs regarding exclusions and limitations.

BENEFITS AVAILABLE
WHILE IN HOSPITAL

TREATMENT BENEFITS	GREEN	GOLD
Family Member Lodging: Paid for hotel or motel up to 14 days per trip for one family member of a Hospital confined Covered Person per One Period of Confinement. Travel must be more than 100 miles from the Covered Person's home and within the U.S. and possessions or Canada. *No lifetime maximum!*	$50/Day	$75/Day
Post-Hospital Continuing Care: Paid for up to 30 days per One Period of Confinement for services that begin within the first 14 days after Hospital discharge. Payable only through the 180th day after Hospital discharge for: overnight confinement in a Skilled Nursing Facility or rehabilitation facility, services of a private duty Nurse for a minimum 4-hour daily shift at home, or a registered physiotherapist other than while Hospital confined. *No lifetime maximum!*	$50/day	$75/day

Outstanding Features

- ✓ Provides payment of benefits directly to you or whomever you designate.
- ✓ Portable coverage that stays with you even if your career changes.
- ✓ Pays in addition to other insurance including HMO & PPO.
- ✓ Most of our insurance programs are guaranteed renewable for life.*

*Premium rates may change.

QUESTIONS ABOUT EXCLUSIONS & LIMITATIONS? WE HAVE ANSWERS.

1. **What is the purpose for buying this insurance Policy?**

   As a SPECIFIED DISEASE INSURANCE POLICY, this Policy provides insurance protection only for treatment of the named diseases and does not cover any other disease or complication caused or contributed to by the named covered disease. The Policy is designed to supplement comprehensive health insurance and is valuable when purchased as an addition to comprehensive health insurance. This Policy will not provide benefits equal to major medical coverage and is not a Medicare Supplement Policy.

2. **Can I rely on the description of the benefits in this brochure?**

   Yes, however, space limits us to providing only general descriptions. READ YOUR POLICY CAREFULLY since only the Policy provisions, not this brochure, control. This brochure is only a summary of benefits, exclusions and limitations.

3. **Are the capitalized words I see throughout the brochure, like "Day" and "Hospital" capitalized for a reason?**

   Yes, critical definitions of capitalized words are contained in your Policy, along with a complete description of all exclusions and limitations.

4. **Can I decide to cancel the Policy at any time, and can you, the insurance company, cancel it as well?**

   You can cancel the Policy by simply not paying the renewal premium at any time. However, elections to pay premiums through pre-tax deductions in an IRS Section 125 plan generally permit changes at the end of a plan year or after a qualifying event. We, the insurance company, cannot cancel the Policy and guarantee you the right to keep it in force by timely paying your premiums when due or during the Grace Period for your entire life. We do have the right to increase premiums, but only if we do so for all similar policies in your state.

5. **How do we resolve any dispute that might arise?**

   If the dispute is over claims, you have the right to have our Claims Appeal Committee review the matter. We have an excellent record of resolving disputes and misunderstandings. Please consult the Policy for more information.

6. **Can I send my Policy back and get my money back if after reading it I decide I don't want it?**

   Yes. Simply send it back to us within 10 days for a full refund and the Policy will be voided from its date of issue.

7. **When might a benefit for a Covered Condition not be payable to me?**

   A Covered Condition considered a Preexisting Condition under the Policy will not be eligible for benefits for 2 years after the Coverage Effective Date, as defined in the Policy. A Covered Condition that is First Manifested or First Occurs within the 30 days following the Coverage Effective Date will only be eligible for benefits for any care and treatment of such condition received more than 2 years following the Coverage Effective Date. A Preexisting Condition is a condition, whether known or unknown, for which: (1) medical advice or treatment was recommended by or received from a Physician within the 1 year period before the Coverage Effective Date; or (2) symptoms existed within the 1 year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. No benefits are provided for care or treatment that is not Medically Necessary. No benefits are provided for conditions that are not Covered Conditions under the Policy terms.

8. **Can I receive treatment anywhere in the world and be paid benefits?**

   Under the Policy provisions, benefits are not available for treatment received outside of Canada or the United States and its possessions.

9. **Can I receive insurance protection for my spouse and children?**

   Yes. Instead of an Individual Plan, you may elect a One Parent Plan to cover you and your eligible Children, or a Family Plan for you, your Spouse and Children as well. Additional premium applies. Each person must meet the underwriting standards to have coverage under the Policy.

10. **Is there any coverage for events before the Policy is issued or after the Policy lapses or terminates?**

    Coverage is provided after the Coverage Effective Date for a Covered Person and until the Policy terminates (other than continuous Hospital confinement for up to 90 Days as specified in the Policy).

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Hospital Insurance Program

Underwritten by: National Teachers Associates Life Insurance Company (NTA Life)
4949 Keller Springs Rd • Addison, Texas 75001 • P.O. Box 802207 - Dallas, Texas 75380 • 888.671.6771 • ntalife.com
NTA Life underwrites Horace Mann Supplemental Insurance products.

horacemann.com

SI-000008TX (June 21)

HOSPITAL INSURANCE PROGRAM

BENEFITS PAYABLE TO YOU (OR WHOMEVER YOU DESIGNATE) WHEN A COVERED PERSON IS TREATED AT A HOSPITAL TO HELP YOU COVER PLANNED AND UNPLANNED COSTS

TREATMENT BENEFITS	CLASSIC	ELITE
Hospital Inpatient Admission Benefit [1]		
Payable for the first day a Covered Person is confined in a Hospital due to a covered Injury or Sickness.		
Primary Insured	$750/day	$1,000/day
Children	$375/day	$500/day
Maximum per Covered Person	Once per Calendar Year	Once per Calendar Year
Daily Inpatient Hospital Confinement Benefit [1]		
Payable daily when a Covered Person is confined in a Hospital due to a covered Injury or Sickness. Not payable for the same day as the Hospital Inpatient Admission Benefit.		
Primary Insured	$150/Day	$200/Day
Children	$75/Day	$100/Day
Maximum per Covered Person	31 Days per Period of Hospital Confinement	31 Days per Period of Hospital Confinement
Observation Benefit		
Payable for any part of a day or more of a Covered Person's confinement in an Observation Unit for a covered Injury or Sickness. Not payable for the same day as the Daily Inpatient Hospital Confinement Benefit or Hospital Inpatient Admission Benefit. Not payable for treatment in an Emergency Care Facility or Outpatient Care Facility.		
Primary Insured	$75/admission	$100/admission
Children	$37.50/admission	$50/admission
Maximum per Covered Person	2 admissions per Calendar Year	2 admissions per Calendar Year
Pregnancy Benefit [1]		
Payable when a Covered Person is confined in a Hospital due to pregnancy or childbirth resulting from pregnancy. Payable in lieu of the Daily Inpatient Hospital Confinement Benefit, the Hospital Inpatient Admission Benefit, and the Observation Benefit that would otherwise have been payable during a Covered Person's confinement in a Hospital due to pregnancy or childbirth. Not payable for confinement in a Hospital due to Complications of Pregnancy.		
Primary Insured	$1,500/pregnancy	$2,000/pregnancy
Children	$750/pregnancy	$1,000/pregnancy
Maximum per Covered Person	Once per pregnancy	Once per pregnancy

NO LIFETIME MAXIMUM on benefits.

Insurance Policy Series PO-CM-HP8002-TX (2/20). Premiums and benefits vary with the program selected.

[1] The Covered Person must be billed as an inpatient by the Hospital. Not payable for treatment in an Emergency Care Facility, Outpatient Care Facility, or confinement in an Observation Unit.

UNCERTAIN OF YOUR NEED FOR HOSPITAL INSURANCE?

CONSIDER THESE FACTS

Spending for emergency room **COSTS MORE THAN DOUBLED PER PERSON**, from 2008 to 2017.

Health Care Cost Institute, HCCI claims database 2008-2017

OPTIONAL ENHANCED HOSPITAL INSURANCE RIDER

Optional Rider Form Series RD-CM-HP102-TX (2/20).

TREATMENT BENEFITS

Advanced Imaging Benefit	
Payable for an Advanced Imaging procedure, such as a CT scan or MRI, the Covered Person receives for a covered Injury or Sickness.	**$100**/ image
Maximum per Covered Person	2 images per Calendar Year
Ambulance Benefit	
Payable for transport to an Emergency Room by ground or air ambulance for a covered Injury or Sickness provided the Covered Person is charged by a licensed professional ambulance company. Maximum 1 trip per day and 2 trips per Calendar Year.	
Ground Ambulance	**$200**/trip
Air Ambulance	**$2,000**/trip
Emergency Care Benefit	
Payable for a Covered Person's care or treatment for a covered Injury or Sickness received in an Emergency Room or Urgent Care Facility. Maximum 2 visits per Calendar Year.	
Emergency Care Benefit - Emergency Room	
Primary Insured	**$100**/visit
Children	**$50**/visit
Emergency Care Benefit – Urgent Care Facility	
Primary Insured	**$50**/visit
Children	**$25**/visit

NO LIFETIME MAXIMUM on benefits.

The Hospital Insurance Program is HSA-compatible. However, the benefits available under the Enhanced Hospital Insurance Rider are not considered HSA-compatible and should not be elected by individuals intending to make contributions to an HSA account.

QUESTIONS ABOUT EXCLUSIONS & LIMITATIONS? WE HAVE ANSWERS

1. **What type of coverage is this and who can be covered?**

   This Policy is a HOSPITAL INDEMNITY INSURANCE POLICY. It provides insurance protection for treatment in a Hospital due to a covered Injury or Sickness. This Policy is designed to supplement comprehensive health insurance and will not provide benefits equal to major medical coverage. We offer an Individual Plan and a One Parent Plan to provide coverage for you and your Children. Additional premium applies. Each person applying for coverage must meet the underwriting standards to have coverage under this Policy. READ YOUR POLICY CAREFULLY. The Policy provisions, not this brochure, control. This brochure is only a summary of benefits, exclusions, and limitations. Critical definitions of capitalized words are contained in your Policy and Riders. Coverage is provided after the Coverage Effective Date for a Covered Person.

2. **Can I cancel this policy at any time? Can the insurance company cancel it as well?**

   You can cancel this Policy at any time by simply not paying the renewal premium. However, elections to pay premiums through pre-tax deductions in an IRS Section 125 plan may, generally, only be changed at the end of a plan year or after a qualifying event. We, the insurance company, guarantee you the right to keep the Policy in force by timely paying your premiums when due or during the Grace Period until the Primary Insured reaches age 70 and cannot cancel the Policy. We do have the right to increase premiums, but only if done so for all similar policies in your state.

3. **Can I send my policy back and get a refund if I decide I don't want the coverage?**

   Yes. Send it back to Us within 30 days for a full refund and the Policy will be voided from its date of issue.

4. **When might a benefit for an injury or sickness not be payable to me?**

   No coverage is provided for the first year after the Policy's Coverage Effective Date (generally, the issue date) for a Preexisting Condition. If you request and We approve a change to the Policy that increases Policy or Rider benefits, the increase in benefits will not cover Preexisting Conditions for a Covered Person for a one-year period after the Coverage Effective Date of such increase in benefits. A Preexisting Condition is a condition for which: (1) medical advice or treatment was recommended by or received from a Medical Practitioner within the one-year period before the Coverage Effective Date; or (2) symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. Generally, no benefits are provided if the Injury or Sickness is caused or contributed to by: (1) Suicide, attempted suicide or an intentionally self-inflicted injury, while sane; (2) War or any act of war (whether declared or undeclared); (3) Participation in a riot or insurrection; (4) Active duty status in the armed forces, including auxiliary units; (5) The voluntary use or taking of any narcotic or other illegal substance (unless taken or used as prescribed by a Medical Practitioner); (6) The Covered Person's legal intoxication as defined by the state law where the loss occurred (unless taken or used as prescribed by a Medical Practitioner); (7) Alcoholism or drug addiction; (8) Any poison, gas, or fumes voluntarily absorbed, inhaled, or taken; (9) The commission or attempted commission of a felony, or engaging in an illegal occupation; (10) Vasectomy, tubal ligation, sex change surgery, and the reversal thereof, or surgery to remove an organ or gland that shows no signs of cancer in an attempt to prevent development of cancer in that organ or gland; or (11) Cosmetic Surgery, except that "cosmetic surgery" does not include reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly resulting in a functional defect. **No benefits are payable for losses incurred during the 30 days after the Coverage Effective Date of this Policy for normal pregnancy or childbirth, other than covered Complications of Pregnancy.** Additionally, a Covered Person is not eligible for the Daily Inpatient Hospital Confinement Benefit, the Hospital Inpatient Admission Benefit, and the Observation Benefit attributable to pregnancy or childbirth (other than Complications of Pregnancy). This Policy does not provide concurrent benefits for multiple Injuries or Sicknesses that occur during the same Period of Hospital Confinement.

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Supplemental Insurance

Additional protection in the event of an unexpected illness or accident

Underwritten by: National Teachers Associates Life Insurance Company (NTA Life)
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SI-000005 (July 19)

OUR INSURANCE PROGRAMS PROVIDE IMPORTANT COVERAGE.

CONSIDER THESE FACTS

INSURANCE COVERAGE FOR:

47%

MEDICAL COSTS

- Hospital Room & Board
- Drugs & Medicine
- Surgeon & Other Unforeseen Expenses

Calculated from Total Cost of Coronary Heart Disease. Cardiovascular Disease

CANCER

1 of 2 men and 1 of 3 women...

have a lifetime risk of developing invasive Cancer.

Cancer Facts and Figures 2017, American Cancer Society.

HEART & STROKE

An estimated 92.1 million...

American adults now suffer from at least one type of Cardiovascular Disease. Risk factors include Family History, High Blood Pressure, High Blood Cholesterol, and Obesity.

Heart Disease and Stroke Statistics 2017 update, American Heart Association.

ACCIDENT

In the next 10 minutes...

847 people will suffer an accident severe enough to require consultation with a medical professional.

2017 Data from National Safety Council Injury Facts, 2017 edition Center for Disease Control. U.S. Statistics.

DISABILITY INCOME

More than 1 in 4...

working Americans will miss up to 3 months of work due to illness, injury or pregnancy during their career.

2019 Council for Disability Awareness, realitycheckup.org

53%

NON-MEDICAL COSTS

- Loss of Income
- Transportation Costs
- Food & Lodging
- Long Convalescence (Recovery)
- Child Care Expenses
- Deductible & Co-Insurance
- Forced Liquidation of Tangible Assets
- Other Unforeseen Expenses

A Costly Burden For America-Projections Through 2035. 2017, American Heart Association.

Are you as protected as you think?

Sure, you have major medical insurance, but is that enough? Supplemental Insurance can help cover out-of-pocket costs.

How could your lifestyle change?

Your hobbies, travel plans, and the assets you've built up are important to your lifestyle. We want to help you maintain the life you've worked hard to build.

What about dependents?

Are there family members that depend on your support? If you're ill or injured can they continue their lifestyle?

How far will your savings go?

A severe injury or illness could have you out of work for an extended time. How will your current responsibilities be impacted?

Outstanding Features

- Provides payment of benefits directly to you or whomever you designate.
- Pays in addition to other insurance including HMO & PPO.
- Portable coverage that stays with you even if your career changes.
- Most of our insurance programs are guaranteed renewable for life.*

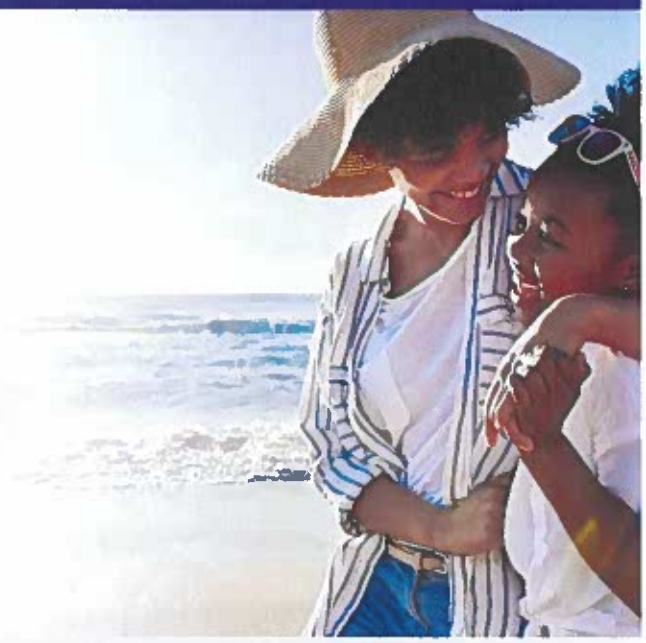
*Premium rates may change.

Horace Mann | NTA Life a Horace Mann company

HealthEquity | FSA

FLEXIBLE SPENDING ACCOUNT

FSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible medical expenses. FSAs help members realize significant savings on healthcare costs. Don't think of it as money deducted from your paycheck—think of it as money added to your wallet.



Annual tax saving potential[1]

(when you contribute the max)

$855

2022 IRS Contribution Limit
$2,850

Expect remarkable.

- Mobile-optimized[2] account management, with easy claims and reimbursement
- Step-by-step on-screen tutorials in the member dashboard
- Help Center with comprehensive user guides and how-to articles
- 24/7 call or chat with our 100% US-based Member Services team

866.735.8195 | HealthEquity.com/learn

Save big on thousands of eligible medical expenses, including:

Pain relievers | Doctor visits | Dental cleaning | Sleep aids | Eyeglasses/ contacts | Cold/cough medicine | Chiropractic care | Insulin testing supplies

See the full list at **HealthEquity.com/qme**

HealthEquity | DCFSA

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

DCFSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible dependent care expenses. A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare.

Annual tax saving potential[1]

(when you contribute the max)

$1,500

2022 IRS Contribution Limit

$5,000[3]

Expect remarkable.

- Mobile-optimized[2] account management, with easy claims and reimbursement
- Step-by-step on-screen tutorials in the member dashboard
- Help Center with comprehensive user guides and how-to articles
- 24/7 call or chat with our 100% US-based Member Services team

866.735.8195 | HealthEquity.com/learn

Save big on eligible dependent care expenses, including:

- Daycare
- Nursery School
- Preschool
- Summer Day Camp
- Before or After School Programs
- Elder Daycare

NTA Life®

a Horace Mann company

Critical Illness Program

Underwritten by: National Teachers Associates Life Insurance Company
P.O. Box 802207 - Dallas, Texas 75380–2207 • 888.671.6771 • ntalife.com

BR-1092 (6/23)

UNCERTAIN OF YOUR NEED FOR CRITICAL ILLNESS INSURANCE?

CONSIDER THESE FACTS

Every 40 seconds,

someone in the United States has a heart attack.[1]

[1]Source: Heart Disease Facts, 2021, Center for Disease Control.

CRITICAL ILLNESS PROGRAM

Benefits payable to you (or whomever you designate) when a covered person is Diagnosed with a covered Critical Illness, to help you cover planned and unplanned costs. Exclusions and limitations may vary by state. See Policy and Rider(s) for comprehensive list of exclusions and limitations. Not all conditions are paid equally. For a complete list of covered Critical Illnesses, please refer to form BR-1089 (12/22).

BENEFITS	CLASSIC	ELITE
CRITICAL ILLNESS BENEFIT		
Payable when Diagnosed with a covered Critical Illness [2]		
Primary Insured	Up to $15,000	Up to $25,000
Spouse	Up to $15,000	Up to $25,000
Child	Up to $15,000	Up to $25,000
Lifetime Maximum per Covered Person	300% of Critical Illness Benefit Amount	500% of Critical Illness Benefit Amount
RECURRENCE BENEFIT		
Payable when Diagnosed with a Critical Illness for which the covered person previously received benefits under the Critical Illness Benefit [3]		
Primary Insured	Up to $15,000	Up to $25,000
Spouse	Up to $15,000	Up to $25,000
Child	Up to $15,000	Up to $25,000
ADDITIONAL OCCURRENCE BENEFIT		
Payable if after a Critical Illness Benefit for one Critical Illness is paid, the Covered Person is Diagnosed with a different Critical Illness [4]		
Same as initial benefit amount applicable to the Critical Illness	Up to $15,000	Up to $25,000
TRANSPORTATION BENEFIT		
Vehicle Transportation	$0.50/mile	$0.75/mile
Maximum benefit per round trip	$1,000/round trip	$1,500/round trip
Common Carrier Transportation	$1,000/round trip	$1,500/round trip
FAMILY MEMBER LODGING BENEFIT		
Daily benefit amount	$75/day	$100/day
Maximum benefit per Covered Person	30 days/ Calendar Year	30 days/ Calendar Year
AMBULANCE BENEFIT		
Payable for 1 one-way trip to a Hospital for Critical Illness Diagnosis or Treatment, by ground or by air ambulance, per Diagnosed Critical Illness	$200/land trip $2,000/air trip	$300/land trip $3,000/air trip

[2] The benefit payable is based on a percentage of the Critical Illness Benefit Amount in effect for the Covered Person, unless otherwise noted in the Benefits Schedule. [3] The Recurrence of the Critical Illness must be Diagnosed at least 1 year after the date of Diagnosis of the Critical Illness which the benefit was previously paid. [4] The subsequent condition must occur and be Diagnosed at least 180 days after the date of Diagnosis for the most recently Diagnosed Critical Illness.

Insurance Policy Series PO-CM-CI7001 (2/22) and state specific versions. Premiums and benefits vary with the program selected.

CRITICAL ILLNESS PROGRAM

In 2022, the total national cost of caring for people living with Alzheimer's and other dementias is projected to reach **$321 billion**.[1]

[1]Source: 2022 Alzheimer's Disease Facts and Figures. 2022 Alzheimer s Association

About 1 in 6 children aged 3-17 were **diagnosed with a developmental disability** between 2009-2017.[2]

[2]Source: Centers for Disease Control and PreventionCenters for Disease Control and Prevention Data and Statistics on Autism Spectrum Disorder | CDC. Sep 25th, 2020.

OPTIONAL RIDERS

BENEFITS	CLASSIC	ELITE
CANCER RIDER[3]		
Invasive Cancer Benefit Payable when a Covered Person is first Diagnosed with Invasive Cancer. *Not payable for Skin Cancer or Non-Invasive Cancer.*	$15,000	$25,000
Non-Invasive Cancer Benefit Payable when a Covered Person is first Diagnosed with Non-Invasive Cancer (In Situ). *Not payable for Skin Cancer or Invasive Cancer.*	$4,500	$7,500
Skin Cancer Benefit Payable when Skin Cancer is Diagnosed in a Covered Person.	$300	$500
INFECTIOUS DISEASE RIDER[3]		
Infectious Disease Benefit Payable when Diagnosed with an Infectious Disease and Hospital Confined for 7 or more consecutive days for Treatment.	$15,000	$25,000
COVID-19 Benefit Payable when Hospital Confined for 7 or more consecutive days for the Diagnosis and Treatment of COVID-19.	$7,500	$12,500
VALUE RIDER[3]		
Initial Value Benefit Payable, less any claims paid under the Policy or other Riders during the Initial Benefit Period, after the Value Rider has been in force for 10 years.	$3,000	$5,000
Recurring Value Benefit Payable, less any claims paid under the Policy or other Riders during the Recurring Benefit Period, after the Value Rider has been in force for the duration of the Recurring Benefit Period.	$3,000	$5,000

[3]Optional Rider Form Series RD-CM-C100 (2/22), RD-CM-ID100 (2/22), RD-CM-VR100 (2/22) and state specific versions.

QUESTIONS ABOUT EXCLUSIONS & LIMITATIONS? WE HAVE ANSWERS

1. WHAT IS THE PURPOSE FOR BUYING THIS INSURANCE POLICY/RIDER?

This Policy is a CRITICAL ILLNESS INSURANCE POLICY (may be called a LIMITED BENEFIT POLICY, a LIMITED POLICY, or a SPECIFIED DISEASE POLICY in other states). It provides insurance coverage only for the Diagnosis of a Critical Illness. This Policy is designed to supplement comprehensive health insurance and will not provide benefits equal to major medical coverage.

2. CAN I RELY ON THE DESCRIPTION OF THE BENEFITS IN THIS BROCHURE?

This brochure is only a summary of benefits and exclusions and limitations. Space limits Us to providing only general descriptions. READ YOUR POLICY CAREFULLY since only the Policy provisions (and rider provisions), not this brochure, control.

3. ARE THE CAPITALIZED WORDS I SEE THROUGHOUT THE BROCHURE, LIKE "CRITICAL ILLNESS" AND "DIAGNOSED" CAPITALIZED FOR A REASON?

Yes, important definitions of capitalized words are contained in your Policy and (optional) rider, along with a complete description of all exclusions and limitations.

4. CAN I DECIDE TO CANCEL THE POLICY AT ANY TIME, AND CAN THE INSURANCE COMPANY CANCEL IT AS WELL?

You can cancel the Policy by sending written notice to Us or by simply not paying the renewal premium at any time. However, elections to pay premiums through pre-tax deductions in an IRS Section 125 plan generally may only be changed at the end of a plan year or after a qualifying event. We, the insurance company, cannot cancel the Policy and guarantee you the right to keep it in force by timely paying your premiums when due or during the Grace Period for your entire life. We do have the right to increase premiums, but only if We do so for all similar policies in your state.

5. HOW DO WE RESOLVE ANY DISPUTE THAT MIGHT ARISE?

If the dispute is over claims, you have the right to have Our Claims Appeal Committee review the matter. Any unresolved dispute concerning your Policy will be governed by the Dispute Resolution Program in the Policy (in AL, DE, ID, MI, MS, NV, TN, WI).

6. CAN I RETURN MY POLICY AND GET MY MONEY BACK IF AFTER READING IT I DECIDE I DON'T WANT IT?

Yes. Send it back to Us within 10 days for a full refund and the Policy will be voided from its date of issue.

7. WHEN MIGHT A BENEFIT FOR A COVERED DISEASE NOT BE PAYABLE TO ME?

Benefits are only payable for any disease or condition that is Diagnosed when the Covered Person's insurance under the Policy is in force. No benefits are payable for diseases or conditions that are not specifically named or described in the Policy or Rider(s). Diagnosis, care, or treatment for any covered Critical Illness must be made or received while the Covered Person is covered under the Policy for benefits to be payable. Benefits are not payable for any disease of condition caused or contributed to by: an act of war, declared or undeclared;[1] intentionally self-inflicted injuries; committing a felony or illegal occupations; participation in a riot or insurrection;[2] alcoholism, drug addiction, intoxication, or being under the influence of any narcotic;[3,5] full-time active duty of the armed forces; Diagnosis or Treatment provided by a Family Member;[4,6] or complications arising from surgical malpractice of another Critical Illness that has been paid benefits under the Policy. For the Cancer Rider, if Cancer is first Diagnosed within 30 days following the Rider Effective Date for a Covered Person, benefits will not be payable for that specific condition until 2 years after the Rider Effective Date.

8. CAN I BE DIAGNOSED ANYWHERE IN THE WORLD AND BE PAID BENEFITS?

No, the Diagnosis of any Critical Illness must occur in the United States, its possessions, or Canada.[7]

9. CAN I RECEIVE INSURANCE PROTECTION FOR MY SPOUSE AND CHILDREN?

Yes. An Individual Plan provides coverage for you and your eligible Children. A Family Plan provides coverage for you, your Spouse, and your eligible Children. Additional premium applies. Each person must meet the underwriting standards to have coverage under the Policy.

10. IS THERE ANY COVERAGE FOR EVENTS BEFORE THE POLICY IS ISSUED OR AFTER THE POLICY LAPSES OR TERMINATES?

No, coverage is provided only while the Policy and any attached Rider(s) are in force. This Policy and any attached Rider(s) will only pay benefits for the conditions which are specifically named or described in the Benefits Schedule and Diagnosed when the Covered Person is covered under this Policy. Additionally, no benefits are payable for any loss that results from, or is caused or contributed to by, a Preexisting Condition for the one-year period after the Covered Person's Coverage Effective Date. Any increase in benefits will be subject to the same Preexisting Conditions limitations for a one-year period after the Coverage Effective Date of such increase in benefits. Generally, a Preexisting Condition is a condition for which: (a) medical advice, consultation, or treatment was recommended by or received from a Medical Practitioner within the one-year period before the Coverage Effective Date;[8] or (b) symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis or treatment.

Exclusions and limitations may vary by state. Please see the Policy and Rider(s) for comprehensive list of exclusions and limitations.

[1] In OK add: "while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer." [2] In TX, "participation in a riot or insurrection" does not apply. [3] In OK, "under the influence of drugs" does not apply. [4] In AZ, "Diagnosis or Treatment by a Family Member" does not apply. [5] In TX, "drug addiction, intoxication, or being under the influence of any narcotic" does not apply. [6] In TX, "Diagnosis or Treatment provided by a Family Member, including a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, grandparents, aunts, uncles, children or grandchildren" applies. [7] In TX, "the Diagnosis of any Critical Illness must occur in the United States, its possessions, or Canada" does not apply. [8] In TX, "consultation" does not apply.

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CRITICAL ILLNESS BENEFIT OVERVIEW

CRITICAL ILLNESSES	CLASSIC	ELITE
CORE		
Angioplasty	$3,750	$6,250
Coronary Artery Disease	$3,750	$6,250
End-Stage Renal Failure	$15,000	$25,000
Heart Attack	$15,000	$25,000
Major Organ Failure	$15,000	$25,000
Stem Cell/Bone Marrow Transplant	$15,000	$25,000
Stroke	$15,000	$25,000
Sudden Cardiac Arrest	$15,000	$25,000
ENHANCED		
Heart Valve Surgery	$7,500	$12,500
Pulmonary Embolism	$3,750	$6,250
Transient Ischemic Attack (TIA)	$3,750	$6,250
Benign Brain Tumor	$15,000	$25,000
Coma	$15,000	$25,000
Loss of Hearing	$15,000	$25,000
Loss of Sight	$15,000	$25,000
Loss of Speech	$15,000	$25,000
Major Burns	$15,000	$25,000
Occupational Hepatitis	$15,000	$25,000
Occupational HIV	$15,000	$25,000
Permanent Paralysis	$15,000	$25,000
PROGRESSIVE		
Advanced Alzheimer's Disease	$15,000	$25,000
Advanced Parkinson's Disease	$15,000	$25,000
Amyotrophic Lateral Sclerosis (ALS)	$15,000	$25,000
Multiple Sclerosis	$15,000	$25,000
CHILDHOOD CONDITIONS		
Autism Spectrum Disorder - DSM-V Severity Level 3	$7,500	$12,500
Autism Spectrum Disorder - DSM-V Severity Level 2	$3,750	$6,250
Autism Spectrum Disorder - DSM-V Severity Level 1	$1,500	$2,500
Cerebral Palsy	$15,000	$25,000
Cleft Lip/Palate	$15,000	$25,000
Congenital Heart Illnesses	$15,000	$25,000
Cystic Fibrosis	$15,000	$25,000
Down Syndrome	$15,000	$25,000
Muscular Dystrophy	$15,000	$25,000
Other Congenital Chromosomal Abnormalities	$15,000	$25,000
Other Congenital Metabolic Disorders	$15,000	$25,000
Other Major Congenital Structural Defects	$15,000	$25,000
Sickle Cell Anemia	$15,000	$25,000
Spina Bifida	$15,000	$25,000
Type 1 Diabetes	$15,000	$25,000

WOODSBORO INDEPENDENT SCHOOL DISTRICT

2024 Renewal Summary

Policy 160-755643

Thank you for allowing Standard Insurance Company to provide quality products to support your employees' insurance needs. We are pleased to renew your policy with continued coverage and services.

We have carefully reviewed the current composition of your organization and evaluated the experience of your dental and vision policy. Based upon this review and application of rate factors appropriate for your industry classification, we are renewing your policy at the existing premium rates as indicated in the chart below. These rates are guaranteed until November 1, 2025.

Division 1/Class 1

Dental Coverage

Product & Services	Through 10/31/2024	Effective 11/1/2024
Employee	$48.88 per member	$48.88 per member
Employee & One Dependent	$83.12 per member	$83.12 per member
Employee & Two or more Dependents	$118.72 per member	$118.72 per member

Division 2/Class 2

Vision Coverage

Product & Services	Through 10/31/2024	Effective 11/1/2024
Employee	$9.92 per member	$9.92 per member
Employee & One Dependent	$17.96 per member	$17.96 per member
Employee & Two or more Dependents	$30.44 per member	$30.44 per member

If you have any questions about your rates or our review process our Employee Benefits Sales and Service office at 972-943-1615 is available to serve your needs. We value your business and welcome the opportunity to provide continued assistance to you.

Sincerely yours,

Group Insurance Underwriter
Employee Benefit Services
Standard Insurance Company

WOODSBORO INDEPENDENT SCHOOL DISTRICT

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Dental Plan Summary **Effective Date: 11/1/2024**

Plan Benefit	
Type 1 (Preventive)	100%
Type 2 (Basic)	80%
Type 3 (Major)	50%
Waiting Period	None
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	No Family Maximum
Maximum *(per person)*	$1,000 per calendar year
Allowance	90% usual and customary
Annual Eye Exam	None
Annual Open Enrollment	Included

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period) • Bitewing X-rays (1 per benefit period) • Cleaning (2 per benefit period) • Fluoride for Children 13 and under (1 per benefit period) • Sealants (age 15 and under) • Space Maintainers	• Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Fillings for Cavities • Restorative Composites • Simple Extractions	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Complex Extractions • Anesthesia

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Your provider network is Classic Network.

Dental Network

In Texas, our network and plans are referred to as the Ameritas Dental Network.

WOODSBORO INDEPENDENT SCHOOL DISTRICT

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on November 1. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

Prior Extraction Limitation

Your policy has a prior extraction limitation, also known as the "missing tooth clause". This means that if you had a tooth extracted prior to enrolling in your plan with The Standard, we may or may not pay for any benefits towards replacing that tooth. Please review your policy or contact Customer Service for details.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Customer Service

Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to locate the nearest network provider, view plan benefit information and more.

Call Center: 800.547.9515

- Service representative hours:
  5 a.m. to 10 p.m. Pacific Monday through Thursday
  5 a.m. to 4:30 p.m. Pacific Friday
- Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

WOODSBORO INDEPENDENT SCHOOL DISTRICT

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

WOODSBORO INDEPENDENT SCHOOL DISTRICT

Group Vision Insurance

Help protect your eye health with coverage for exams, glasses and contacts.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered vision care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 11/1/2024**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	Not covered
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates	Out of Network
	(Other than Costco)	
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	Not covered
Solid Plastic Dye	$15 (except Pink I & II)	Not covered
Plastic Gradient Dye	$17	Not covered
Photochromatic Lenses (Glass & Plastic)	$31-$82	Not covered
Scratch Resistant Coating	$17-$33	Not covered
Anti-Reflective Coating	$43-$85	Not covered
Ultraviolet Coating	$16	Not covered

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

WOODSBORO INDEPENDENT SCHOOL DISTRICT

Additional Balanced Care Vision I Choice Network Features	
Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Vision Plan Participant Service

Balanced Care Vision I from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 800.877.7195

- Service representative hours: 5 a.m. to 7 p.m. Pacific Monday through Friday, 6 a.m. to 2:30 p.m. Pacific Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at:
www.standard.com/services

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