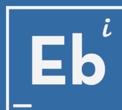
2023

BENEFITS GUIDE FORDLAND R-III



Educational BENEFITS

A JTS Financial Company

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WHAT YOU NEED TO KNOW

▶ Employees under contract who work a minimum of 30 hours per week, are eligible to enroll themselves and their qualified dependents in applicable Fordland School District employee benefits. Employees must be actively at work to enroll in benefits.

Checklist of what to bring for open enrollment for each dependent that you are enrolling in eligible benefits:

1. Social Security Number
2. Address
3. Date of Birth

Having these items will expedite the completion of all enrollment forms, beneficiary cards, etc.

If you are a current employee (not a new hire), please keep the following information in mind:

- You cannot make any changes until the annual "open enrollment period", which allows employees who may have previously declined to enroll the opportunity to enroll in new coverage. (Certain restrictions and limitations may apply to employees who initially declined coverage when they first became eligible to enroll.)
  - However, there are certain qualifying events that allow current employees to make benefit changes. These include, but are not limited to:
    - marriage, divorce, adoption or birth of child, death of a spouse or other eligible dependent.

You might see these boxes on certain pages. Here's what they mean:

EC Employer Contribution - your employer contributes a percentage to your product premiums

ER Employer Paid - your employer covers 100% of the cost of your product

NH New Hire Eligible - if you are a new hire for the district, you are eligible for this benefit

DISCLAIMER: This benefit summary is provided for illustrative purposes only and is simply an overview of your benefits. For a detailed explanation for each policy you should review a copy of the actual policy on file with the Human Resources Department or you may specifically request a copy of each policy from Educational Benefits.

WELCOME TO OPEN ENROLLMENT

GLOSSARY OF INSURANCE TERMS

Annual Maximum - the total dollar amount that a plan will pay for care incurred by an individual enrollee or family (under a family plan) in a specified benefit period.

Benefit Year - a period in which covered expenses are accrued and are counted toward the annual maximums, deductibles, and/or out-of-pocket limits.

Benefits - items or services covered under an insurance plan.

Beneficiary - a person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor or on the maturity of the policy.

Broker - an individual agent or agency who represents the buyer, rather than the insurance company, and tries to find the buyer the best policy. The broker can make specific recommendations about which plans best suit you and your family's needs.

COBRA - a federal law that may allow the insured to temporarily keep insurance coverages after employment ends.

Claim - a request for payment under an insurance plan. A claim will list the services rendered, the date of service, and an itemization of cost.

Coinsurance - insurance in which the insured is required to pay a fixed percentage of the cost of expenses after the deductible has been paid.

Copayment (Copay) - a fixed amount that the insured is required to pay before receiving the service.

Deductible - an out-of-pocket amount that an insured must pay prior to an insurance plan paying a claim.

Dependent - a child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Elimination Period - a period of continuous disability which must be satisfied before you are eligible to receive benefits.

Evidence of Insurability (EOI) - part of the application process for an insurance policy during which an applicant provides health information. Coverage does not become effective until approval of the EOI.

Flexible Spending Account (FSA) - a type of account that provides the account holder with specific tax advantages on qualified medical and/or dependent care expenses (ex. Medical Reimbursement, Dependent Care, and/or Limited Purpose FSA).

Guaranteed Issue - a predetermined benefit amount allowed by an insurance plan without requiring Evidence of Insurability (EOI). GI allows you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. This does not, however, preclude the application of the pre-existing condition exclusions.

Limited Purpose FSA - a type of account to be used with an HSA. It is reserved for the payment of dental and vision expenses only.

Long-Term Care - a range of services and supports you may need to meet your personal care needs in the event of a chronic illness or disability.

Medically Necessary - a covered health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient’s condition if omitted, in accordance with accepted standards of medical practice.

Network - the facilities, providers, and suppliers your insurance plan has contracted with to provide health care services (i.e. “in-network”).

Non-Preferred Provider - a provider who does not have a contract with your insurance carrier or plan to provide services to you. You’ll pay more to see a non-preferred provider (i.e. “out-of-network”).

Out-of-Pocket Maximum - the maximum amount of money you may pay for services in a benefit year.

Pre-Existing Condition - a medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the insurance company.

Premium/Rate - the amount you pay for your insurance premiums each month.

Qualifying Life Event (QLE) - a change in your situation that can make you eligible for a special enrollment period, allowing you to enroll in an insurance plan outside of the yearly open enrollment period (ex. loss of coverage, getting married or divorced, having a baby/adopting a child, or a death in the family).

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 80 EPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$1,500	Not Covered
Family	$4,500	Not Covered
OUT-OF-POCKET LIMIT		
Individual	$5,000	Not Covered
Family	$11,500	Not Covered
COINSURANCE		
Coinsurance	80%	Not Covered
COVERED SERVICES		
Primary Care Office Visit	$30 Copay	Not Covered
Specialist Office Visit	$60 Copay	Not Covered
Emergency Room Visit	$300 Copay	$300 Copay
Urgent Care Clinic Visits	$75 Copay	$75 Copay
Inpatient Hospital Services	Ded. + 20% Coins.	Not Covered
Outpatient Surgical Services	Ded. + 20% Coins. for other outpatient services	Not Covered
PRESCRIPTIONS		
Generic	$15 Copay $37.50 Mail Order	Not Covered
Preferred Brand	$45 Copay $112.50 Mail Order	Not Covered
Non-Preferred Brand	$75 Copay + $100 Ded. $187.50 Mail Order	Not Covered
Specialty Drugs	$200 Copay + $100 Ded.	Not Covered

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 80 PPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$1,500	$3,000
Family	$4,500	$9,000
OUT-OF-POCKET LIMIT		
Individual	$5,000	$11,750
Family	$11,500	$26,500
COINSURANCE		
Coinsurance	80%	50%
COVERED SERVICES		
Primary Care Office Visit	$30 Copay	Ded. + 50% Coins.
Specialist Office Visit	$60 Copay	Ded. + 50% Coins.
Emergency Room Visit	$300 Copay	$300 Copay
Urgent Care Clinic Visits	$75 Copay	Ded. + 50% Coins.
Inpatient Hospital Services	Ded. + 20% Coins.	Ded. + 50% Coins.
Outpatient Surgical Services	Ded. + 20% Coins. for other outpatient services	Ded. + 50% Coins.
PRESCRIPTIONS		
Generic	$15 Copay $37.50 Mail Order	Ded. + 50% Coins.
Preferred Brand	$45 Copay $112.50 Mail Order	Ded. + 50% Coins.
Non-Preferred Brand	$75 Copay + $100 Ded. $187.50 Mail Order	Ded. + 50% Coins.
Specialty Drugs	$200 Copay + $100 Ded.	Ded. + 50% Coins.

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 70 EPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$2,500	Not Covered
Family	$7,500	Not Covered
OUT-OF-POCKET LIMIT		
Individual	$6,000	Not Covered
Family	$14,500	Not Covered
COINSURANCE		
Coinsurance	70%	Not Covered
COVERED SERVICES		
Primary Care Office Visit	$30 Copay	Not Covered
Specialist Office Visit	$60 Copay	Not Covered
Emergency Room Visit	$300 Copay	$300 Copay
Urgent Care Clinic Visits	$75 Copay	$75 Copay
Inpatient Hospital Services	Ded. + 30% Coins.	Not Covered
Outpatient Surgical Services	Ded. + 30% Coins. for other outpatient services	Not Covered
PRESCRIPTIONS		
Generic	$15 Copay $37.50 Mail Order	Not Covered
Preferred Brand	$45 Copay $112.50 Mail Order	Not Covered
Non-Preferred Brand	$75 Copay + $100 Ded. $187.50 Mail Order	Not Covered
Specialty Drugs	$200 Copay + $100 Ded.	Not Covered

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 70 PPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$2,500	$5,000
Family	$7,500	$15,000
OUT-OF-POCKET LIMIT		
Individual	$6,000	$13,750
Family	$14,500	$32,500
COINSURANCE		
Coinsurance	70%	50%
COVERED SERVICES		
Primary Care Office Visit	$30 Copay	Ded. + 50% Coins.
Specialist Office Visit	$60 Copay	Ded. + 50% Coins.
Emergency Room Visit	$300 Copay	$300 Copay
Urgent Care Clinic Visits	$75 Copay	Ded. + 50% Coins.
Inpatient Hospital Services	Ded. + 30% Coins.	Ded. + 50% Coins.
Outpatient Surgical Services	Ded. + 30% Coins. for other outpatient services	Ded. + 50% Coins.
PRESCRIPTIONS		
Generic	$15 Copay $37.50 Mail Order	Ded. + 50% Coins.
Preferred Brand	$45 Copay $112.50 Mail Order	Ded. + 50% Coins.
Non-Preferred Brand	$75 Copay + $100 Ded. $187.50 Mail Order	Ded. + 50% Coins.
Specialty Drugs	$200 Copay + $100 Ded.	Ded. + 50% Coins.

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 70 PPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$3,500	$7,000
Family	$10,500	$21,000
OUT-OF-POCKET LIMIT		
Individual	$6,000	$13,250
Family	$15,500	$33,500
COINSURANCE		
Coinsurance	70%	50%
COVERED SERVICES		
Primary Care Office Visit	$30 Copay	Ded. + 50% Coins.
Specialist Office Visit	$60 Copay	Ded. + 50% Coins.
Emergency Room Visit	$300 Copay	$300 Copay
Urgent Care Clinic Visits	$75 Copay	Ded. + 50% Coins.
Inpatient Hospital Services	Ded. + 30% Coins.	Ded. + 50% Coins.
Outpatient Surgical Services	Ded. + 30% Coins. for other outpatient services	Ded. + 50% Coins.
PRESCRIPTIONS		
Generic	$15 Copay Retail $37.50 Mail Order	Ded. + 50% Coins.
Preferred Brand	$45 Copay Retail $112.50 Mail Order	Ded. + 50% Coins.
Non-Preferred Brand	$75 Copay Retail + $100 Ded. $187.50 Mail Order	Ded. + 50% Coins.
Specialty Drugs	$200 Copay Retail + $100 Ded.	Ded. + 50% Coins.

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 90 EPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$500	Not Covered
Family	$1,500	Not Covered
OUT-OF-POCKET LIMIT		
Individual	$2,000	Not Covered
Family	$4,500	Not Covered
COINSURANCE		
Coinsurance	90%	Not Covered
COVERED SERVICES		
Primary Care Office Visit	$20 Copay	Not Covered
Specialist Office Visit	$20 Copay	Not Covered
Emergency Room Visit	$200 Copay	$200 Copay
Urgent Care Clinic Visits	$75 Copay	$75 Copay
Inpatient Hospital Services	Ded. + 10% Coins.	Not Covered
Outpatient Surgical Services	Ded. + 10% Coins. for other outpatient services	Not Covered
PRESCRIPTIONS		
Generic	$15 Copay Retail $37.50 Mail Order	Not Covered
Preferred Brand	$45 Copay Retail $112.50 Mail Order	Not Covered
Non-Preferred Brand	$75 Copay Retail + $100 Ded. $187.50 Mail Order	Not Covered
Specialty Drugs	$200 Copay Retail + $100 Ded.	Not Covered

HEALTH INSURANCE

Health insurance covers you and your family for your basic health needs after you've met your coverage deductible (some benefits include copay after deductible). Coverage includes visits with a primary care physician, specialty physicians, inpatient/outpatient hospital care.

PARTNERS 90 PPO PLAN		
	In-Network	Out-of-Network
DEDUCTIBLES		
Individual	$500	$1,000
Family	$1,500	$3,000
OUT-OF-POCKET LIMIT		
Individual	$2,000	$4,000
Family	$4,500	$9,000
COINSURANCE		
Coinsurance	90%	60%
COVERED SERVICES		
Primary Care Office Visit	$20 Copay	Ded. + 40% Coins.
Specialist Office Visit	$20 Copay	Ded. + 40% Coins.
Emergency Room Visit	$200 Copay	$200 Copay
Urgent Care Clinic Visits	$75 Copay	Ded. + 40% Coins.
Inpatient Hospital Services	Ded. + 10% Coins.	Ded. + 40% Coins.
Outpatient Surgical Services	Ded. + 10% Coins. for other outpatient services	Ded. + 40% Coins.
PRESCRIPTIONS		
Generic	$15 Copay Retail $37.50 Mail Order	Ded. + 40% Coins.
Preferred Brand	$45 Copay Retail $112.50 Mail Order	Ded. + 40% Coins.
Non-Preferred Brand	$75 Copay Retail + $100 Ded. $187.50 Mail Order	Ded. + 40% Coins.
Specialty Drugs	$200 Copay Retail + $100 Ded.	Ded. + 40% Coins.

HEALTH INSURANCE RATES

$1,500 PARTNERS 80 EPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$115.00	$570.00	$685.00
Employee + Spouse	$835.00	$570.00	$1,405.00
Employee + Child(ren)	$595.00	$570.00	$1,165.00
Family	$1,419.00	$570.00	$1,989.00

$1,500 PARTNERS 80 PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$191.00	$570.00	$761.00
Employee + Spouse	$991.00	$570.00	$1,561.00
Employee + Child(ren)	$724.00	$570.00	$1,294.00
Family	$1,640	$570.00	$2,210.00

$2,500 PARTNERS 70 EPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$0.00	$570.00	$570.00
Employee + Spouse	$598.00	$570.00	$1,168.00
Employee + Child(ren)	$398.00	$570.00	$968.00
Family	$1,081.00	$570.00	$1,651.00

$2,500 PARTNERS 70 PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$63.00	$570.00	$633.00
Employee + Spouse	$727.00	$570.00	$1,297.00
Employee + Child(ren)	$506.00	$570.00	$1,076.00
Family	$1,264.00	$570.00	$1,834.00

$3,500 PARTNERS 70 PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$23.00	$570.00	$593.00
Employee + Spouse	$645.00	$570.00	$1,215.00
Employee + Child(ren)	$437.00	$570.00	$1,007.00
Family	$1,149.00	$570.00	$1,719.00

$500 PARTNERS 90 EPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$260.00	$570.00	$830.00
Employee + Spouse	$1,129.00	$570.00	$1,699.00
Employee + Child(ren)	$840.00	$570.00	$1,410.00
Family	$1,835.00	$570.00	$2,405.00

$500 PARTNERS 90 PPO PLAN			
COVERAGE TIER	MONTHLY RATES		
	EE Cost	ER Cost	Total Cost
Employee	$352.00	$570.00	$922.00
Employee + Spouse	$1,318.00	$570.00	$1,888.00
Employee + Child(ren)	$996.00	$570.00	$1,566.00
Family	$2,103.00	$570.00	$2,673.00

DENTAL INSURANCE

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES LOW PLAN	
PREVENTATIVE SERVICES (NO DEDUCTIBLE) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 80%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 0%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
CHILD ORTHODONTIA RIDER (DEDUCTIBLE APPLIES) Not Covered	Not Covered
ANNUAL MAXIMUM	In Network: $1,000 per person Out-of-Network: $1,000 per person
DEDUCTIBLE	In Network: $50 per person / $150 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$24.45
Employee + Spouse	$48.13
Employee + Child(ren)	$62.61
Family	$94.44

DENTAL INSURANCE

Having dental insurance contributes to your over all well-being. Dental insurance provides coverage for preventative, basic, and major services.

DENTAL SERVICES HIGH PLAN	
PREVENTATIVE SERVICES (No Deductible) 100%	• Routine Periodic Exams • X-rays • Fluoride Treatment • Cleaning • Sealants
BASIC SERVICES (DEDUCTIBLE APPLIES) 90%	• Fillings • Root Planing & Scaling • Simple Extractions • Non-surgical Periodontics • Oral Surgery
MAJOR SERVICES (DEDUCTIBLE APPLIES) 60%	• Inlays • Onlays • Crowns • Bridges • Dentures • Surgical Periodontics • Implants • Root Canal
CHILD ORTHODONTIA RIDER (DEDUCTIBLE APPLIES) 50%	$1,500 Lifetime Maximum
ANNUAL MAXIMUM	In Network: $1,500 per person Out-of-Network: $1,000 per person
DEDUCTIBLE	In Network: $25 per person / $75 per family Out-of-Network: $50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$38.49
Employee + Spouse	$78.76
Employee + Child(ren)	$97.01
Family	$141.77

Vision insurance is offered to help people see by providing affordable access to high-quality eye care and eyewear. An individual or family vision insurance plan saves you money on frames, lenses, contacts, eye exams and more.

VISION SERVICES LOW PLAN	
Exam Copay	$10
Materials Copay	$25
CONTACTS	
Elective Allowance	$100 allowance
Contact Lens Evaluation, Fitting, & Follow-Up Care Copay	$60 maximum
LENSES	
Single Vision Allowance	Covered in full after $25 Copay
Bifocal Allowance	Covered in full after $25 Copay
Trifocal Allowance	Covered in full after $25 Copay
Lenticular	Covered in full after $25 Copay

SERVICES	FREQUENCY
Exam	12 months
Frames	24 months
Spectacle Lenses	12 months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months

COVERAGE TIER	MONTHLY RATES
Employee	$6.25
Employee + Spouse	$12.38
Employee + Child(ren)	$12.12
Family	$18.45

Vision insurance is offered to help people see by providing affordable access to high-quality eye care and eyewear. An individual or family vision insurance plan saves you money on frames, lenses, contacts, eye exams and more.

VISION SERVICES HIGH PLAN	
Exam Copay	$15
Materials Copay	$15
CONTACTS	
Elective Allowance	$130 allowance
Contact Lens Evaluation, Fitting, & Follow-Up Care Copay	$60 maximum
LENSES	
Single Vision Allowance	Covered in full after $15 Copay
Bifocal Allowance	Covered in full after $15 Copay
Trifocal Allowance	Covered in full after $15 Copay
Lenticular	Covered in full after $15 Copay

SERVICES	FREQUENCY
Exam	12 months
Frames	12 months
Spectacle Lenses	12 months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months

COVERAGE TIER	MONTHLY RATES
Employee	$8.65
Employee + Spouse	$17.09
Employee + Child(ren)	$16.75
Family	$25.48

EMPLOYER PAID

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

GROUP TERM LIFE INSURANCE

Your needs vary greatly upon age, number of dependents, dependents' ages and your financial situation. Term Life is designed to provide benefits to your designated beneficiary for loss of life. AD&D insurance covers you and your beneficiaries in the event of an accidental loss of life. Fordland pays $20,000 towards all eligible employee's group term life insurance.

EMPLOYEE BENEFIT	
Amount	$20,000
AD&D Benefit	$20,000

Your needs vary greatly upon age, number of dependents, dependents' ages and your financial situation. Term Life is designed to provide benefits to your designated beneficiary for loss of life. AD&D insurance covers you and your beneficiaries in the event of an accidental loss of life.

	EMPLOYEE	SPOUSE	DEPENDENT
Minimum Amount	$10,000	$5,000	$2,000
Maximum Amount	$500,000	$250,000	$10,000
Amount	$500,000 in increments of $10,000, not to exceed 5x annual earnings	$250,000 in increments of $5,000, not to exceed 50% of employee amount	Child(ren): Birth through 26: $10,000 in increments of $2,000
Guaranteed Issue	$200,000: Through Age 69 $0.00: Age 70+	$50,000: Through Age 69 $0.00: Age 70+	-
Group Term Life Benefit Reduction	Benefits reduce to 65% upon the person's attainment of age 65-69, and 50% at age 70+		-
Benefit Features	Portability Conversion Privilege Waiver of Premium	-	-

The Universal Life policy provides permanent life insurance protection with a premium that never increases due to age or a specified term. Life Insurance is a promise to your family to help protect their future. The death benefit can be used any way you or your family sees fit.

GUARANTEED ISSUE* (new hires only)	ELIGIBILITY
EMPLOYEE - $150,000	To be eligible for insurance, an employee must satisfy all of the following requirements: - be age 16 through 80. - be on active service, performing in the usual manner all of the regular duties of his or her occupation at one of the places of business where he or she normally works or at some location directed by the employer; and - be continuously employed for the amount of time and working the minimum number of hours per week as you require to be eligible for benefits. These requirements will be defined on the Life and Health Group Application and Agreement.
SPOUSE - $25,000	To be eligible for insurance, a spouse (or equivalent as defined by state law or otherwise agreed upon between you and us) must satisfy all of the following requirements: - must be age 16 through 65. - must be legally married to the employee as determined by the laws of the state in which the employee resides or meet the eligibility requirements required by the group to be benefit eligible. - must not be disabled. - must not be eligible as an employee under the group policy.
CHILD - $25,000	To be eligible for universal life insurance, a child must satisfy all of the following requirements: - must be under the age of 26. - must be an employee's natural child, stepchild, grandchild, legally adopted child or child for whom adoption proceedings have begun, or a child for whom the employee has been appointed legal guardian. - must not be disabled. - must not be eligible as an employee under the group policy.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

ACCIDENT INSURANCE

Accident insurance helps pay for unexpected healthcare expenses due to injuries that occur every day – from the soccer field to the ski slope and the highway in-between. Accident insurance provides benefits due to covered accidents for initial care, injuries, and follow-up care.

BENEFITS	PLAN A	PLAN B	PLAN C
Ambulance Transportation	$300 Ground $1,500 Air	$350 Ground $1,750 Air	$400 Ground $2,000 Air
Blood/Plasma/Platelets	$200	$300	$400
Chiropractic Services (Limit 12 per calendar year per family)	$35 per session, 6 sessions maximum	$50 per session, 6 sessions maximum	$50 per session, 6 sessions maximum
Coma	$10,000	$15,000	$20,000
Concussion	$300	$300	$400
Dental Injury	$450 for Crown; $150 for Extraction	$600 for Crown; $200 for Extraction	$600 for Crown; $200 for Extraction
Diagnostic Examination	$200 per CT/MRI scan	$250 per CT/MRI scan	$300 per CT/MRI scan
Burns			
Second Degree Burns			
Less than 10%	$200	$250	$300
At least 10%, but less than 25%	$400	$500	$600
At least 25%, but less than 35%	$800	$1,000	$1,200
35% or more	$1,600	$2,000	$2,400
Third Degree Burns			
Less than 10%	$1,600	$2,000	$2,400
At least 10%, but less than 25%	$3,200	$4,000	$4,800
At least 25%, but less than 35%	$6,400	$8,000	$9,600
35% or more	$12,800	$16,000	$19,200
Skin Graft	50%	25%	25%
Dislocations (Surgical / Non-Surgical)			
Ankle	$3,600 / $1,800	$4,800 / $2,400	$6,000 / $3,000
Collarbone	$3,600 / $1,800	$4,800 / $2,400	$6,000 / $3,000
Elbow	$1,800 / $900	$2,400 / $1,200	$3,000 / $1,500
Finger	$600 / $300	$800 / $400	$1,000 / $500
Foot	$3,600 / $1,800	$4,800 / $2,400	$6,000 / $3,000
Hand	$1,800 / $900	$2,400 / $1,200	$3,000 / $1,500
Hip	$9,600 / $4,800	$12,800 / $6,400	$16,000 / $8,000
Knee	$6,000 / $3,000	$8,000 / $4,000	$10,000 / $5,000
Lower Jaw	$1,800 / $900	$2,400 / $1,200	$3,000 / $1,500
Shoulder	$1,800 / $900	$2,400 / $1,200	$3,000 / $1,500
Toe	$600 / $300	$800 / $400	$1,000 / $500
Wrist	$1,800 / $900	$2,400 / $1,200	$3,000 / $1,500

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

ACCIDENT INSURANCE CONT.

BENEFITS	PLAN A	PLAN B	PLAN C
Partial Dislocation (Amount of benefit for non-surgical dislocation)	25%	25%	25%
Multiple Dislocations (Percent of highest benefit for any one dislocation among all dislocations sustained)	100%	100%	100%
Emergency Treatment	$201	$250.50	$300
Epidural Anesthesia Injections	$200 per injection, 2 maximum	$300 per injection, 2 maximum	$400 per injection, 2 maximum
Eye Injury	$200 for removal of foreign object, $400 for surgical repair	$250 for removal of foreign object, $500 for surgical repair	$300 for removal of foreign object, $600 for surgical repair
Fractures (Surgical / Non-Surgical)			
Ankle	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Arm	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Bones of Face	$1,200 / $600	$1,500 / $750	$1,800 / $900
Coccyx	$1,200 / $600	$1,500 / $750	$1,800 / $900
Collarbone	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Elbow	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Finger	$400 / $200	$500 / $250	$600 / $300
Foot	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Hand	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Hip	$12,800 / $6,400	$16,000 / $8,000	$19,200 / $9,600
Kneecap	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Leg	$6,400 / $3,200	$8,000 / $4,000	$9,600 / $4,800
Jaw	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Nose	$1,200 / $600	$1,500 / $750	$1,800 / $900
Pelvis	$6,400 / $3,200	$8,000 / $4,000	$9,600 / $4,800
Rib	$1,200 / $600	$1,500 / $750	$1,800 / $900
Shoulder Blade	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Skull (Except bones of face or nose -Depressed)	$20,000 / $10,000	$25,000 / $12,500	$30,000 / $15,000
Skull (Simple)	$6,000 / $3,000	$7,500 / $3,750	$9,000 / $4,500
Sternum	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Toe	$400 / $200	$500 / $250	$600 / $300
Vertebrae	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Vertebral Column	$6,400 / $3,200	$8,000 / $4,000	$9,600 / $4,800
Wrist	$2,400 / $1,200	$3,000 / $1,500	$3,600 / $1,800
Chip Fractures (Amount of benefit for non- surgical fracture)	25%	25%	25%

RELIANCE STANDARD
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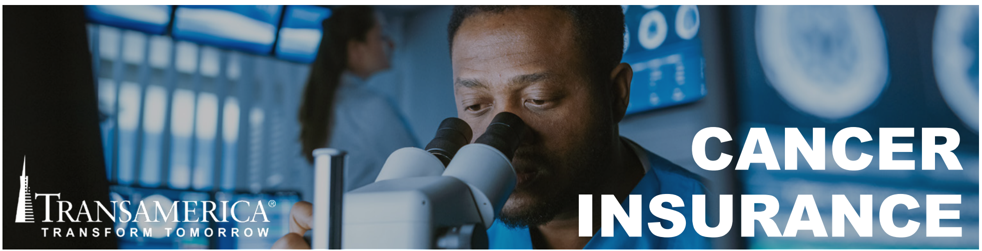
ACCIDENT INSURANCE CONT.

BENEFITS	PLAN A	PLAN B	PLAN C
Multiple Fracture (Amount of the highest benefit for any one fracture among all fractures sustained)	100%	100%	100%
Initial Hospital Admission	$1,000	$1,500	$2,000
Initial ICU Hospital Admission	$2,000	$3,000	$4,000
Hospital Confinement	$200 per day, 365 days maximum	$300 per day, 365 days maximum	$400 per day, 365 days maximum
ICU Confinement	$400 per day, 30 days maximum	$600 per day, 30 days maximum	$800 per day, 30 days maximum
Lacerations No Sutures Required	$50	$62.50	$75
Sutures Required (Total length of all sutured Lacerations) Less than 2" long 2" but less than 6" long 6" long or greater	 $100 $400 $800	 $125 $500 $1,000	 $150 $600 $1,200
Lodging	$200 per day up to 30 days if more than 100 miles from residence	$300 per day up to 30 days if more than 100 miles from residence	$400 per day up to 30 days if more than 100 miles from residence
Medical Appliances	$200	$300	$400
Organized Youth Sports Benefit (% of benefit amount, excluding the AD&D benefit, if applicable)	25%	25%	25%
Paralysis Benefits	$20,000 quadriplegia; $10,000 paraplegia / hemiplegia	$25,000 quadriplegia; $12,500 paraplegia / hemiplegia	$30,000 quadriplegia; $15,000 paraplegia / hemiplegia
Physical Therapy	$100 per session; 10 sessions maximum	$125 per session; 10 sessions maximum	$150 per session; 10 sessions maximum
Physician Office Visit	$100 Initial, $100 Follow-up	$125 Initial, $125 Follow-up	$150 Initial, $150 Follow-up
Prosthesis	$500 for one, $1,000 for two or more	$750 for one, $1,500 for two or more	$1,000 for one, $2,000 for two or more

BENEFITS	PLAN A	PLAN B	PLAN C
Rehabilitation Facility Confinement	$100 per day, 30 days maximum	$125 per day, 30 days maximum	$150 per day, 30 days maximum
Surgery Benefits Abdominal or Thoracic Exploratory Surgery (no repair) Knee Cartilage (surgically repaired) Ruptured Disc (surgically repaired) Rotator Cuff (one surgically repaired) Rotator Cuff (two or more surgically repaired) Tendon or Ligament (one surgically repaired) Tendon or Ligament (two or more surgically repaired)	 $2,000 $200 $600 $1,000 $600 $1,200 $600 $1,200	 $2,500 $250 $750 $1,500 $750 $1,500 $750 $1,500	 $3,000 $300 $900 $1,800 $900 $1,800 $900 $1,800
Transportation	$300, if more than 100 miles from residence	$450, if more than 100 miles from residence	$600, if more than 100 miles from residence
X-rays (per covered accident)	$50	$75	$100
Accidental Death Benefit	Employee: $25,000 Spouse: $12,500 Child(ren): $5,000	Employee: $30,000 Spouse: $15,000 Child(ren): $7,500	Employee: $50,000 Spouse: $25,000 Child(ren): $12,500
Accidental Death on Common Carrier	100% of benefit	100% of benefit	100% of benefit
Accidental Dismemberment Single Loss Thumb/Finger/Toe Catastrophic Loss Speech 2+ Thumb/Finger/Toe Two or more losses except the loss of fingers, thumbs or toes	 50% of benefit 1% of benefit 100% of benefit 100% of benefit 3% of benefit 100% of benefit	 50% of benefit 1% of benefit 100% of benefit 100% of benefit 3% of benefit 100% of benefit	 50% of benefit 1% of benefit 100% of benefit 100% of benefit 3% of benefit 100% of benefit
Wellness	$50	$75	$100

COVERAGE TIER	MONTHLY RATES		
	PLAN A	PLAN B	PLAN C
Employee	$19.75	$25.87	$32.90
Employee & Spouse	$27.96	$34.80	$41.55
Employee & Child(ren)	$31.25	$40.58	$50.97
Family	$39.65	$49.56	$59.71



Cancer insurance helps those diagnosed with cancer to stay focused on recovery by alleviating some of the financial burden associated with the cost of cancer treatment.

	PLAN 1	PLAN 2
HOSPITAL AND RELATED BENEFITS		
Continuous Hospital Confinement (daily)	$100	$100
Government or Charity Hospital (daily)	$100	$100
Private Duty Nursing Services (daily)	$100	$100
Extended Care Facility (daily)	$100	$100
At Home Nursing (daily)	$100	$100
Hospice Care Center (daily)	$100	$100
RADIATION, CHEMOTHERAPY AND RELATED BENEFITS		
Radiation/Chemotherapy for Cancer (every 12 months)	$10,000	$20,000
Blood, Plasma, and Platelets (every 12 months)	$10,000	$20,000
Magnetic Resonance Imaging (MRI) Scan	$100	$100
Hematological Drugs	$1,000	$1,000
SURGERY AND RELATED BENEFITS		
Surgery Inpatient Outpatient	 $1,000 $1,500	 $5,000 $7,500
Anesthesia (% of Surgery Benefit)	25%	25%
Ambulatory Surgical Center (daily)	$150	$750
Second Opinion	$100	$500
Blood, Plasma, Blood Components, Bone Marrow, and Stem Cell Transplant	$10,000	$20,000
MISCELLANEOUS BENEFITS		
Inpatient Drugs & Medicines (daily)	$15	$15
Physician's Attendance (daily)	$20	$20
Ambulance (per confinement)	$100	$100
Non-Local Transportation (per trip or mile)	Coach Fare or $0.40/mile	Coach Fare or $0.40/mile
Outpatient Lodging (daily)	$100	$100
Family Member Lodging (daily), and Transportation (per trip or mile)	$100	$100

Cancer insurance helps those diagnosed with cancer to stay focused on recovery by alleviating some of the financial burden associated with the cost of cancer treatment.

MISCELLANEOUS BENEFITS (CONT.)		
Physical or Speech Therapy (daily)	$50	$50
New or Experimental Treatment (every 12 months)	$10,000	$20,000
Prosthesis	$500	$2,500
Hair Prosthesis (every 2 years)	$50	$250
Anti-Nausea Drugs (every 12 months)	$1,000	$1,000
Waiver of Premium (Employee Only)	Yes	Yes
OPTIONAL BENEFITS		
Cancer Initial Diagnosis (one time)	$3,000	$3,000
Wellness (yearly)	$100	$100

MONTHLY RATES	LOW PLAN	HIGH PLAN
Employee	$21.47	$38.33
Single Parent Family	$24.37	$42.92
Family	$37.07	$66.62

DID YOU KNOW?

1.7 MILLION
new cases of cancer are diagnosed annually.

(American Cancer Society, 2017)

13%
of all new cancer diagnoses are for "RARE FORMS"

(American Cancer Society, 2017)

Critical Illness insurance pays a lump sum benefit directly to you and your covered dependents upon diagnosis of a covered critical illness.

BENEFIT DESCRIPTION	BENEFIT
Heart Category Heart Attack Stroke Aneurysm	Percent of Principal Sum 100% 100% 100%
Organ Category Major Organ Failure	Percept of Principal Sum 100%
Quality of Life Category ALS/Lou Gehrig's Disease Advanced Alzheimer's Disease Advanced MS Advanced Parkinson's Disease Loss of Sight Loss of Hearing Loss of Speech	Percent of Principal Sum 50% 50% 50% 50% 100% 100% 100%
Lifetime Category Maximum (Category Recurrence)	100% of Insurance Amount
Diagnosis Child Cerebral Palsy Cleft Lip or Palate Cystic Fibrosis Downs' Syndrome Muscular Dystrophy Spina Bifida Type 1 Diabetes	100%
Subsequent Occurrence Benefit	100% of benefit if diagnosed 6 months or later
Benefit Waiting Period	None
Pre-existing Period	None
Benefit Reduction	None
Guarantee Issue Employee Spouse Child	 $30,000 $30,000 $15,000
Maximum Principal Sum Employee Spouse Child Spouse and Child Principal Sum cannot exceed Employee Principal Sum	 $30,000 $30,000 $15,000
Employee Coverage	Choose from a benefit of $5,000 to a maximum of $30,000 in $5,000 increments
Spouse Coverage	Choose from a benefit of $5,000 to a maximum of $30,000 in $5,000 increments, not to exceed 100% of approved employee amount
Dependent Coverage	50% of approved employee amount up to a maximum of $15,000
Cancer Benefit	100%

HOSPITAL INDEMNITY INSURANCE

The hospital indemnity policy helps offer you financial protection in the event that you or your dependents are admitted to the hospital. Benefits provide you with assistance in paying your deductible and co-payments associated with inpatient expenses.

BENEFITS	STANDARD	HIGH
Hospital Room & Board Benefits (180 Daily Benefits per Coverage Year)	$100	$200
Hospital Critical Care Unit Benefits Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$200	$400
Hospital Admission Benefit (Three Daily Benefit per Coverage Year)	$1,000	$1,500
Hospital Critical Care Admission Benefit (One Daily Benefit per Coverage Year)	$1,000	$1,500
Nursery Admission Benefit (One Daily Benefit per Coverage Year)	$200	$500
Nursery Confinement Benefit (Ten Daily Benefit per Coverage Year)	$50	$100
Non-Insurance Services		
On-Call Travel Assistance	Included	Included

COVERAGE TIER	STANDARD MONTHLY PREMIUM	HIGH MONTHLY PREMIUM
Employee	$18.88	$38.38
Employee + Spouse	$33.82	$68.54
Employee + Child(ren)	$26.33	$53.42
Family	$40.75	$82.45

NOTE: THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

The high cost of emergent and non-emergent transportation results in unexpected out of pocket expenses. MASA protects members from these expenses related to emergency air transportation and ground ambulance charges.

ANY GROUND. ANY AIR. ANYWHERE. ™

BENEFITS	PLATINUM	EMERGENT PLUS
Cost	$39/month	$14/month
Family Included	Yes	Yes
Emergent Ground Transportation (U.S. & Canada)	Yes	Yes
Emergent Air Transportation (U.S. & Canada)	Yes	Yes
Repatriation (Worldwide)	Yes	Yes
Non-Emergent Interfacility Transportation (Worldwide)	Yes	Yes
Return Transportation (Worldwide)	Yes	No
Vehicle Return (Basic Coverage Area)	Yes	No
Organ Transplant Transportation (U.S. & Canada)	Yes	No
Pet Return (Basic Coverage Area)	Yes	No
Minor Children/Grandchildren Return (Basic Coverage Area)	Yes	No
Mortal Remains Transportation (Worldwide)	Yes	No

- Global Reach Emergent Plus (US 50/ Canada), Platinum (up to worldwide)
- Leading company in the Industry
- The only plans that cover at home and away
- MASA steps in where insurance falls short by helping protect families against uncovered costs
- MASA also provides many benefits not covered by insurance
- Any Ground. Any Air. Any-where TM Simply contact 911 for Emergency Transport
- Covers any of the 1,500+ Air Ambulances in US with 300 different Provider Companies
- Covers any of the 21,000 Ground Ambulance Providers in the US
- US Based Support, Local Reps, Simple Enrollment, Easy Claims, and Online access

Wellness Benefit

Draw on the protection provided by your benefits

The Wellness Benefit[1] will pay you the amount shown on the Schedule of Benefits for one health screening test performed during a twelve month period for you and your dependents[2], if applicable, provided:

- You and your dependents were covered under the policy at the time the test was performed and
- Any preventative health screening test not already performed at any time during the same twelve month period.

Examples of health screening tests covered under the policy:

(New) Any preventative health screenings, including, but not limited to, tests, diagnostic procedures,routine examinations and immunizations.

Testing
ALT/AST (liver function test) Blood test
for triglycerides
Bone marrow test
Breast cancer blood test - CA15-3
Colon Cancer blood test - CEA
Ovarian cancer blood test - CA125
COVID-19 diagnostic test
Fasting blood glucose test Genetic test
PAP test
PSA (prostate cancer blood test)
Serum cholesterol test (HDL and LDL)
Serum protein electrophoresis (blood test for myeloma)
Stress test (bicycle or treadmill)

Procedure
Biopsy for cancer
Breast ultrasound
Chest X-ray
Colonoscopy
Dental exam
Echocardiogram
Electrocardiogram

Diagnostic
Annual physical
Bone density
Eye exam
Flexible sigmoidoscopy
Hearing exam
Hemoccult stool analysis
Hepatitis screening
HIV screening Immunizations
Mammography
Mental health screening
Skin cancer screening
Ultrasound screening

Filing a claim is Fast and Easy! Visit www.rslclaims.com

1. Referred to as a Health Screening Benefit in NH and WA
2. Only one Wellness Benefit will be paid in a twelve month period per covered individual, subject to a maximum of four per family.

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This brochure is not a contract. The availability of the described feature may vary by state. It is not available in CT, ID, MI, MN, NM, NH, NY, ND and WY for Group Accident. It is not available in MI for Critical Illness. Critical illness coverage is provided by policy series LRS-9537-0118, et al. Accident coverage is provided by policy series LRS-9547-0318, et al. Hospital indemnity coverage is provided by policy series LRS-9572-0519, et al. It is not available for ID, KS and NM for group hospital indemnity.

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NOTES

NOTES

Educational BENEFITS
A JTS Financial Company

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