Tatum Municipal Schools

- FSAs
- Short Term Disability
- Hospital Indemnity
- Critical Illness
- Accident
- Permanent Life
- 403b Retirement Plans
- 457 Retirement Plans

2025 - 2026 Employee Benefit Guide

Plan Year: September 1, 2025 - August 31, 2026

IMPORTANT INFORMATION

Tatum Municipal Schools is pleased to offer our employees a wide variety of benefits to suit your needs. The information found within this book is designed to assist you in making important decisions regarding your benefits and provide you with important contact information.

BIS has been chosen by the district to implement our Cafeteria Plan as established by Section 125 of the Internal Revenue Code. Participation in the plan is voluntary.

Annual Enrollment

The **ANNUAL ENROLLMENT** for Tatum Municipal Schools will take place May 23rd for a September 1st effective date. ***ALL FULL TINE EMPLOYEES MUST ANNUALLY COMPLETE YOUR ENROLLMENT TO EITHER PARTICIPATE OR DECLINE THE PLAN DURING THE ANNUAL ENROLLMENT .*** Specific enrollment dates will be sent through your campus.

Benefit Effective Date

Benefits will become effective **September 1st** or upon approval of Evidence of Insurability, if required.

New Employees

New Employees will have 31 days, from their date of hire to enroll in benefits. This applies to the Cafeteria Plan, Health Insurance and Supplemental Benefits. Benefits will then become effective the first of the month following your date of hire.

Mid Year Changes

Once enrolled under the Cafeteria Plan, Mid-Year Changes can only be made based on an IRS Qualifying Event. Employees have 31 days after a Qualifying Event to make changes based on that event. It is the responsibility of the employee to notify your Administration Office of such changes.

Qualifying Events

IRS Qualifying Events include, but are not limited to: Change in Marital Status, Birth or Adoption of a Child, Death of a Dependent, Change of Employee's or Spouse's Employment, Entitlement to Medicare or Medicaid, FMLA Leave and COBRA Qualifying Event. Should you have specific questions regarding certain circumstances, please contact Burba Insurance Services for approval of changes. Please note that any change must correspond with the qualifying event you incur.

Contact Information and Table of Contents

Employee Benefits Portal

Tatum Municipal Schools Employee Benefits Portal has been designed to assist you with your benefit decisions.

To access please go to www.bisnm.com/Tatum

Tatum Municipal Schools

Welcome to Your Tatum Municipal Schools Benefits Portal

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Online Enrollment Guide

View *Online Enrollment Guide* above then click the *Online Enrollment Link* below to complete your benefit enrollment.

Please Note the Company Identifier for registration is Tatum MS

Online Enrollment Login

Need to Upload a File? (upload)

BIS
a Combined Benefits Group, Inc company

Toll-free: 800-894-9990
Toll-free Fax: 877-837-7171
BISNM.com

- Benefit Guide
- Section 125 Documents
- Flexible Spending Accounts
- Hospital Indemnity
- Critical Illness
- Short Term Disability
- Permanent Life Insurance
- Accident
- 403(b) & 457 Retirement Plans
- NMPSIA

Section 125 Cafeteria Plan

How the Plan Works

An IRS Section 125 Plan provides participants an opportunity to receive certain benefits on a pre-tax basis. Under your Employers' Plan, you may pay the premiums pre-tax for your medical, dental, vision and supplemental health plans. Flexible spending accounts are also offered for your health care and dependent care needs for you and your family.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a special account for healthcare and dependent care expenses. When you enroll in an FSA, you decide how much to contribute to each account for the entire Plan Year. This annual contribution is then deducted in equal amounts from your paycheck, before Federal & State income taxes and FICA taxes are deducted. These "pre-taxed" funds are automatically deposited in your account through payroll deduction. Unless you have a qualifying event under Section 125 regulations, your election amount will not change during the Plan year.

Managing Your Flexible Spending Accounts

There are two kinds of Flexible Spending Accounts:

- Health FSA
- Dependent Care FSA

You may choose to participate in both plans, depending on the options provided by your employer. Funds in these accounts cannot be co-mingled and the expenses must be incurred during your employer's plan year. Expenses in your flex account that are not incurred by the end of the plan year will be subject to the "use it or lose it" rules regulated by the Internal Revenue Service. Therefore, a decision as to how much you will contribute to your FSA accounts should be made carefully. Based on your Employer's flexible benefits plan year, you have a specified date or "run-off period" following the end of the plan year to submit your claims for reimbursement. If you do not exhaust your account balance, all funds still remaining in your account will be forfeited after this claim period ends. Check with the Plan Administrator to verify the last date that you may file claims to be reimbursed for your eligible FSA expenses.

Health Flexible Spending Account

A Health Care Flexible Spending Account (FSA) is designed to reimburse you for out-of-pocket health care expenses incurred by you or your eligible dependents that are not reimbursable by your medical, dental and vision insurance plans.

Flexible Spending Accounts

Eligible Health Expenses

These expenses may be incurred by you or your eligible dependents. Expenses include deductibles, coinsurance payments, office co-pays, orthodontics, glasses and contacts.

An eligible expense item must not be used for general health or cosmetic purposes. In some instances, you will be required to submit a letter of medical necessity from your health care provider to demonstrate a medical need.
Once enrolled in a health FSA, the entire annual election is available to you on the first day of the plan year. You must spend the funds by the end of the plan year or they will be forfeited from your account.

Special Health Care Expenses

IRS does not allow pre-payment of certain medical treatment programs that may span over multiple plan years. These include orthodontic and prenatal expenses. Reimbursement of the entire expense generally violates the IRS requirement that expenses must be “incurred” during the coverage period and cannot be paid in advance.

Orthodontic Expenses

IRS stipulates how orthodontic expenses can be reimbursed in a health care FSA. You should carefully plan when deciding on your annual election if it includes orthodontic expenses. Special planning should be considered if you are planning to take advantage of an up-front discount payment. Please remember, services must be performed and incurred within the current plan year. Reimbursement of a lump sum payment to a dentist may not be eligible for services. Also consider services that will be performed over more than one plan year. You will need to provide a copy of your contract with your dental provider, showing the initial deposit and monthly payments. This expense may be setup as a recurring expense throughout your plan year.

Prenatal Expenses

For maternity related expenses, payment cannot be advanced, but are reimbursed as they are incurred. Eligible charges may be reimbursed each time you are seen by your physician for prenatal care, but not in advance of the delivery.

Over The Counter (OTC) Items

The recently enacted Patient Protection and Affordable Care Act of 2010 changes the rules for the purchase of over-the-counter (OTC) products using Flexible Spending Accounts (FSA).

Effective for tax years January 1, 2011, over-the-counter medicines or drugs (e.g. Advil, Ibuprofen, and cough syrup) are not eligible for reimbursement under an FSA, HRA, or HSA without a doctor's prescription. Insulin is the only medicine that doesn't require a prescription.

Supplies you need for medical care (e.g. contact lens solutions, bandages for wounds, thermometers) will continue to be eligible for reimbursement. There are some medical items that may not be allowed unless you have a prescription or letter of necessity from a medical professional for a specific medical condition.

We recommend you retain copies of all OTC documentation for your records. Documentation for reimbursement must state the place of purchase, date, amount, item name, and purchases can be claimed within reasonable quantities. Treatment for eligible expenses cannot be for preventative purposes and items purchased for personal care are not eligible for reimbursement. For example: toothpaste, vitamins, supplements and herbal remedies, and other items used for personal hygiene cannot be claimed for reimbursement.

Examples of Eligible Expenses

In order to use your health care flexible spending account (FSA), the health care item or service needs to be considered "eligible." The Internal Revenue Service – better known as the IRS – has guidelines to determine which expenses are eligible and qualify for reimbursement from your FSA. Typically, an eligible expense must be a service or product that is purchased for medical care to help treat a medical condition or prevent a disease, among other things.

As you shop for care and for health care items, use this as a helpful guide. This list does not include everything. In fact, the IRS may modify the guidelines from time to time, which may cause the list to change.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Breast reconstruction surgery (mastectomy-related)
- Chiropractor
- Contact lenses and solutions
- Cosmetic surgery, but only if necessary due to disfiguring trauma or disease
- Dental treatment (X-rays, cleanings, fillings, braces, extractions, etc.)
- Diagnostic devices (blood sugar test kits for diabetics)
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses and vision exams
- Eye surgery (laser eye surgery)
- Fertility treatment
- Hearing aids and batteries
- Hospital services
- Laboratory fees
- Operations/surgery (excluding unnecessary cosmetic surgery)
- ~~Over-the-counter drugs and items used solely to treat a medical condition (aspirin, pain relievers, cough suppressants, etc.)~~
- Physical therapy
- Psychiatric care (if the expense is for mental health care provided by a psychiatrist, psychologist or other licensed professional)
- Special education for learning disabilities
- Speech therapy

• Stop-smoking programs including nicotine gum or patches
• Vasectomy
• Weight-loss program to treat a specific disease diagnosed by a physician
• Wheelchair

Ineligible medical expenses examples:

• Advance payment for future medical care
• Amounts reimbursed from any other source (health coverage or another FSA)
• Cosmetic surgery (unless necessary due to disfiguring trauma or disease)
• Diaper service
• Electrolysis or hair removal
• Health insurance premiums (e.g., COBRA, AD&D, LTD, STD, long-term care, group and individual health insurance and Medicare premiums)
• Health club dues
• Household help
• Illegal operations and treatments
• Long-term care for medical expenses
• Maternity clothes
• Nutritional supplements, such as multi-vitamins, for general good health
• Personal use items, such as toothbrush, toothpaste, etc.
• Swimming lessons
• Teeth whitening

Dependent Care FSA

The Dependent Care Assistance account allows you to pay for "employment related expenses" that enable you and your spouse to be gainfully employed, seek employment, and/or be a fulltime student. In general, expenses must be for the "care" of a qualifying individual.

Reimbursement may also include eligible expenses for children or elder dependents that rely on you for their care.

Eligible DCAP Expenses

Some examples of eligible expenses include:

- care in and outside the home
- child-care/dependent care centers
- before and after school care
- nursery school and preschool expenses
- preschool tuition
- day care camps and facilities *(only for "care" and not primarily for educational purposes).*
- Adult day care expenses

Expenses for services provided outside the employee's home by dependent care centers must comply with state and local laws. Your care provider must report day care income on their taxes to be considered as eligible.

Dependent Care FSA must be for children under 13 years of age, unless they meet the qualifications of physically or mentally incapable of self-care.

DCAP Reimbursements

The total amount you choose to contribute should be based on your expected child and/or dependent care expenses during the plan year. A single parent, or employee that is married but filing separately is limited to $2,500 for the Plan year. If your spouse has a dependent care account through their employment, the two accounts cannot exceed $5,000 during a given plan year. IRS requires that the amount reimbursed to a participant must first be on deposit in their account. When a claim is filed we first verify that there are adequate funds in the account to =pay the entire claim. When sufficient funds are not available, participants are issued the maximum amount available in their account. The remainder of the reimbursement request is paid when additional funds are received through payroll deposits.

Ineligible Expenses

The following items are examples of expenses that are generally considered as ineligible for reimbursement in a Dependent Care FSA:

- Educational expenses, except where an eligible child attends preschool or nursery school
- Field trips, clothing
- Late payment or finance charges
- Payments for lessons
- Tuition expenses
- Overnight camps
- Kindergarten expenses

Submit valid documentation for Flex Expenses

Health Care Claims

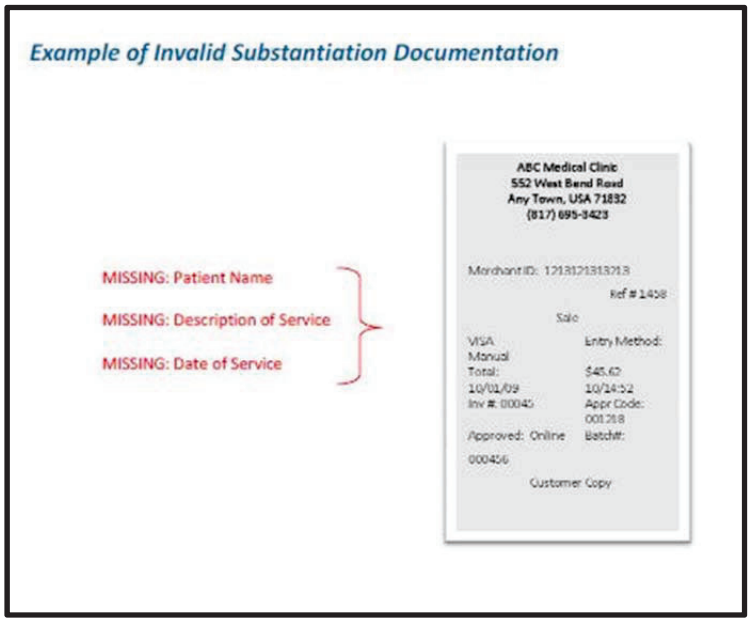
The Internal Revenue Service requires that **ALL** health care claims be documented for approval in order to be eligible for reimbursement. Valid substantiation documentation for health care expenses will have the following:

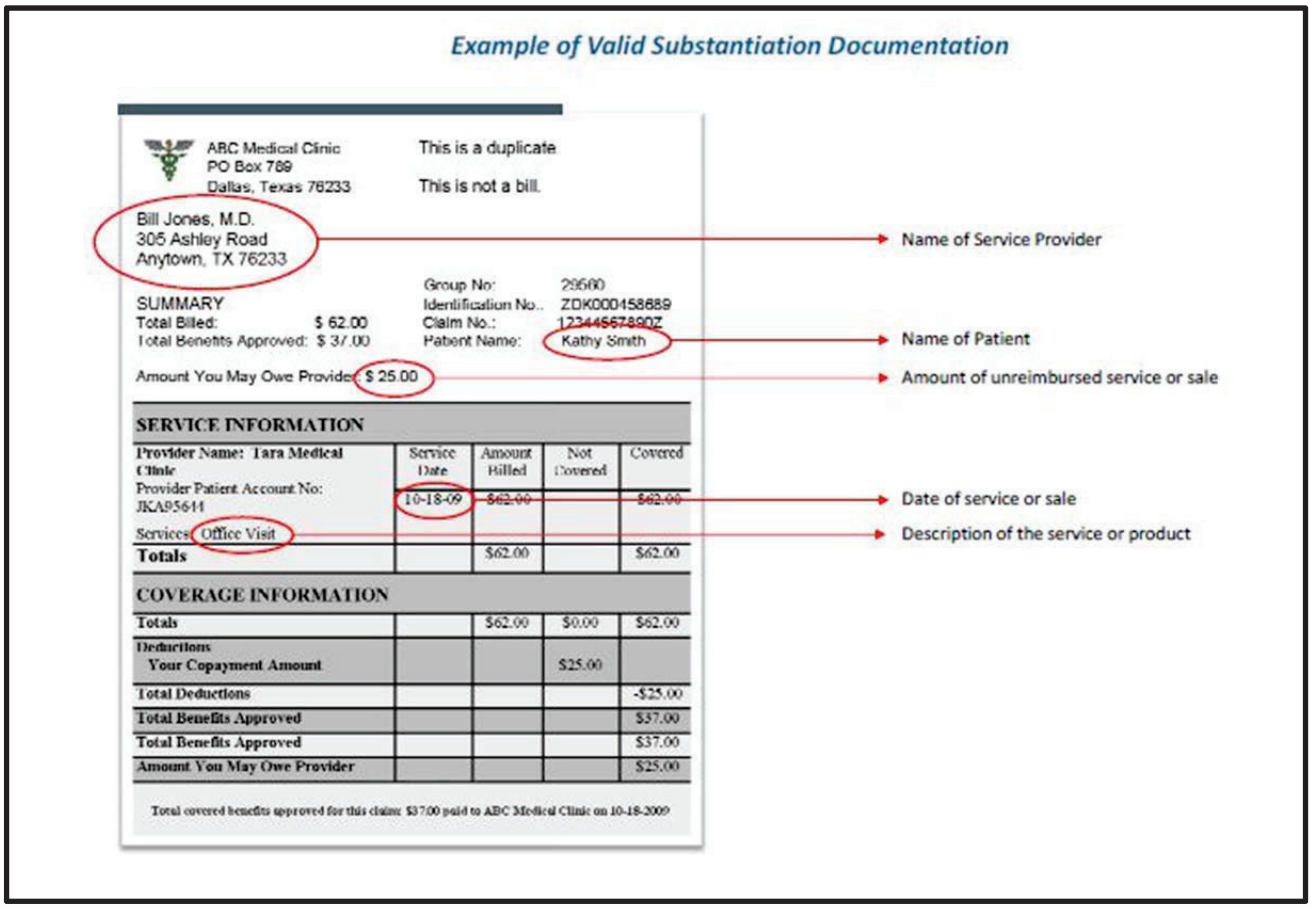
- Name of service provider
- Name of patient
- Date of service or sale
- Description of service or product
- Amount of unreimbursed service or *sale*

Invalid Substantiation

A sales receipt normally shows only the date and amount of a transaction. These receipts do not provide the patient's name, a description of the service or show the actual date the service was performed.

A "sales" receipt is not valid substantiation documentation based on IRS guidelines.





Dependent care claims

Valid substantiation documentation for dependent care claims may be in the form of a receipt from the day care provider that shows:

- Provider name and information
- Dependent's name
- Date span of service (i.e., January 1 -31, 2010)
- Amount of reimbursement

Flex Debit Card

The Flex Card is an automatic way to pay for qualified health care expenses. It is not a credit card, but can be used to pay for your eligible health flexible spending account (FSA) purchases[1]. The value of the participant's annual contribution is loaded on the Card, and amounts of qualified purchases will be automatically deducted from your account. The Card may be used for eligible flexible spending account (FSA) expenses as determined by Section 213(d) of the Internal Revenue code.

You may use the Card for co-pays at hospitals, physician offices, pharmacies, dental offices, vision service locations, and wherever they accept MasterCard® or Visa® cards. Only eligible expenses incurred during the current plan year and/or grace period can be claimed as eligible expenses.

Substantiation of Flex Card purchases

Many purchases do not require receipts and can be automatically substantiated by one of the following IRS approved methods:

IIAS Approved	*If you purchase your FSA eligible item at a merchant utilizing the Inventory Information Approval System, the charge is fully substantiated without the need for submission of a receipt or further review.*
Co-Payment	*If the dollar amount on your Flex Card transaction at a health care provider equals the dollar amount of the co-payment for the service under your major medical plan, the charge is fully substantiated with no need for submission of a receipt or further review.*
Recurring Expense	*If you use your Flex Card for recurring medical expenses, the charge is substantiated with no need for submission of a receipt or further review. Please note that an initial receipt request will be made to establish the expense as recurring.*

Receipt Request *You will be required to submit itemized receipts for the following flex card debit purchases:*

- *All FSA eligible items purchased at a 90% Rule Merchant*
- *All transactions at a health care provider that does not equal your co-pay amount*
- *Some dental procedures and vision care products and expenses*

You will receive a "Receipt Request" letter notification if you are required to submit receipts to substantiate a Flex Card purchase

Reasons your Flex Card may be declined

Your Flex Card may be declined for the following reasons:

- *Merchants do not Accept Master Card or Visa*
- *Ineligible Medical Expense*
- *Non IIAS Merchant*
- *Non-Medical Facility*
- *The expense is greater than you available FSA fund balance*
- *Your Flex Card has been inactivated due to outstanding receipt requests for substantiation*
- *Merchant is attempting to process your Flex Card as a debit card instead of a credit card*
- *Merchant is experiencing problems with their system.*

Termination of Employment

Health Care FSA

When you terminate employment, your participation in the plan ends and you will no longer be able to incur expenses for reimbursement. Your salary reductions will end; however you may still file claims for dates of service incurred before your termination as long as they are within your eligible plan year.

Dependent Care FSA

If you have not received reimbursement for all contributions made into your DCAP upon your termination of employment, you may continue to incur expenses during the plan year and submit claims reimbursement. Generally you may submit claims through the plan year run-off period until all your contributions are used.

COBRA

COBRA does not apply to DCAP. However, COBRA may apply to your Health Care FSA account and allow you to continue participation in your URM, thus allowing you to receive reimbursement for medical expenses incurred after your employment termination if you terminate employment and you have contributed more into your Health Care FSA than you have received in benefits.

Short-Term Disability Insurance

VOLUNTARY

Sun Life

COMMON CAUSES OF DISABILITY

- Pregnancy
- Injuries
- Joint disorders
- Back disorders
- Digestive disorders

PROTECTS YOUR INCOME WHEN YOU CAN'T WORK.

If you're unable to work because of a covered disability, Short-Term Disability insurance replaces a portion of your income in addition to providing other services and benefits that help you return to work.

PROVIDES YOU WITH A WEEKLY CHECK.

After your claim is approved, you will receive a check for your benefits that helps you pay everyday expenses like your mortgage or rent, childcare and groceries.

BENEFITS (You can purchase this coverage at a group rate.)	
Weekly benefit after your claim is approved	Get a weekly check of **$100** to **$1,000**, in any **$50** increment you choose, to replace a portion of your income-up to **60%** of your Total Weekly Earnings. No medical questions are asked up to the Guaranteed Issue amount of **$1,000**.
When benefits begin	Benefits begin on the first day of disability if you are unable to work due to an injury and as soon as **8 days** from the date you are unable to work due to an illness.
Benefits may be paid for	Up to **4 weeks**, as long as you are still unable to work due to a covered disability.
Additional plan information	This plan provides a benefit for covered disabilities resulting from illness or injury that are not work-related.

SHORT-TERM DISABILITY FAST FACTS

1 in 4 workers *will miss up to 3 months of work due to disability during their career.*[1]

More than three-quarters *of workers are living paycheck to paycheck.*[2]

TATUM MUNICIPAL SCHOOLS

All Eligible Employees

POLICY # 977415

Sun Life Assurance Company of Canada

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Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability Application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

How do I file a Short-Term Disability claim?

If you become disabled after the effective date of coverage, check with your employer to make sure you are eligible for benefits. You can file a claim with us by downloading forms from our website. We'll ask you and your doctor to provide information about your medical condition and your expected recovery.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the policy's definition of disability. Generally, disability is defined as your inability to perform some or all of your job duties due to your injury, illness or pregnancy and may require that you have also had a certain percentage of earnings loss due to your disability. Please see your Certificate for details.

What if I have a pre-existing condition?

If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Can I work while I'm disabled?

Your plan is designed to encourage and support your return to work. If you are able to work part-time, for example, you may receive part of your benefit while working.

Will income from other sources affect my benefit?

Your benefit may be reduced by Social Security benefits; disability benefits from retirement, government plans or state disability income such as California SDI; state paid family and medical leaves; other group disability plans; no-fault benefits, salary continuance or sick leave; and return-to-work earnings. For more information or to determine if this coverage is appropriate for you, contact your benefits administrator.

How is my benefit taxed?

If you or your employer pays for all or part of the cost of coverage on a pre-tax basis, all or part of your benefit amount will be Form W-2 taxable income. In these situations, FICA tax deductions may reduce the amount we will pay you.

The group disability insurance policies described in this advertisement provide disability income insurance only.

1. Realitycheckup.org, Council for Disability Awareness, 2018

2. "Living Paycheck to Paycheck is a Way of Life for Majority of U.S. Workers," CareerBuilder.com, Aug. 2017.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Short-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; operation of a motorized vehicle while intoxicated. We will not pay a benefit for any accident or sickness covered by Worker's Compensation or similar law; or for any work-related illness or injuries unless otherwise stated previously; or if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.).

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVBH-EE-8384 SLPC 29579

Rates

Employee - Coverage and **semi-monthly** cost for Short-Term Disability.

Rates are effective as of September 1, 2025.

The chart below shows possible coverage amounts and their **semi-monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Weekly coverage amounts	Age and cost										
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$100	1.60	1.77	1.81	1.68	0.86	0.96	0.98	1.24	1.74	1.63	1.66
$150	2.40	2.65	2.72	2.52	1.28	1.43	1.47	1.86	2.60	2.45	2.48
$200	3.20	3.53	3.62	3.36	1.71	1.91	1.96	2.48	3.47	3.26	3.31
$250	4.00	4.41	4.53	4.20	2.14	2.39	2.45	3.10	4.34	4.08	4.14
$300	4.80	5.30	5.43	5.04	2.57	2.87	2.94	3.72	5.21	4.89	4.97
$350	5.60	6.18	6.34	5.88	2.99	3.34	3.43	4.34	6.07	5.71	5.79
$400	6.40	7.06	7.24	6.72	3.42	3.82	3.92	4.96	6.94	6.52	6.62
$450	7.20	7.94	8.15	7.56	3.85	4.30	4.41	5.58	7.81	7.34	7.45
$500	8.00	8.83	9.05	8.40	4.28	4.78	4.90	6.20	8.68	8.15	8.28
$550	8.80	9.71	9.96	9.24	4.70	5.25	5.39	6.82	9.54	8.97	9.10
$600	9.60	10.59	10.86	10.08	5.13	5.73	5.88	7.44	10.41	9.78	9.93
$650	10.40	11.47	11.77	10.92	5.56	6.21	6.37	8.06	11.28	10.60	10.76
$700	11.20	12.36	12.67	11.76	5.99	6.69	6.86	8.68	12.15	11.41	11.59
$750	12.00	13.24	13.58	12.60	6.41	7.16	7.35	9.30	13.01	12.23	12.41
$800	12.80	14.12	14.48	13.44	6.84	7.64	7.84	9.92	13.88	13.04	13.24
$850	13.60	15.00	15.39	14.28	7.27	8.12	8.33	10.54	14.75	13.86	14.07
$900	14.40	15.89	16.29	15.12	7.70	8.60	8.82	11.16	15.62	14.67	14.90
$950	15.20	16.77	17.20	15.96	8.12	9.07	9.31	11.78	16.48	15.49	15.72
$1,000	16.00	17.65	18.10	16.80	8.55	9.55	9.80	12.40	17.35	16.30	16.55

MedChoice™ Group Limited Benefit Hospital Indemnity Insurance

New Mexico Schools - HSA Compatible

Summary of Benefits	Plan 1
Hospital Admission Benefit	$1,500 per day; maximum of 4 day(s)
Hospital Confinement Benefit	$50 per day; maximum of 5 day(s)

Plan 1 - HSA Compatible				
Monthly Premiums*				
	Individual	Individual & Spouse	Individual & Child(ren)	Individual & Family
Ages 18+	$14.91	$36.54	$22.54	$46.71

* Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice. The premium and amount of benefits vary dependent upon the Plan selected at time of application.

Benefits

Benefits are per day, up to the maximum number of days per calendar year, per covered person. Benefit amounts may vary based upon place of service. Benefits will only be paid for a covered loss incurred while covered under the certificate. A covered person means a person who is eligible for coverage under the policy and for whom coverage is in force. An eligible dependent means your lawful spouse and/or your child (natural, adopted or step) who is under 26 years of age and/or any minor under your charge, care and control, who has been placed for adoption and is under 26 years of age.

Hospital Admission Benefit - Pays a benefit when a covered person is admitted and confined as an inpatient in a hospital due to an injury or covered sickness. APL will not pay this benefit for outpatient treatment, emergency room treatment or a stay less than 18 hours in an observation unit. This benefit is only payable once per period of confinement. A hospital is not an institution, or part thereof, used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Hospital Confinement Benefit - Pays a per day benefit when a covered person is confined as an inpatient to a hospital due to an injury or covered sickness.

Exclusions

No benefits are payable for any loss resulting from or caused, whether directly or indirectly by: hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs within six months after the certificate effective date unless due to an emergency; war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of your written request.); dental treatment or routine vision services unless due to injury and if performed within 12 months of the date of the covered accident or due to congenital defect or birth anomaly of a covered newborn child; an intentionally self-inflicted injury or sickness; committing, or attempting to commit, an illegal act that is defined as a felony (felony is as defined by the law of the jurisdiction in which the act takes place); an injury or sickness incurred while engaging in an illegal occupation; cosmetic care, except when the hospital confinement is due to medically necessary reconstructive plastic surgery (medical necessary reconstructive plastic surgery is defined as: surgery to restore a normal bodily function, surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect or birth anomaly, breast reconstruction following mastectomy); being intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions (intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred); experimental treatment, drugs or surgery, except in connection with an approved cancer clinical trial; immunizations; artificial insemination, in vitro fertilization, test tube fertilization, sterilization, tubal ligation or vasectomy, and reversal thereof; participation in any sport for pay or profit; mental and emotional disorders without demonstrable organic disease; alcoholism or drug addiction treatment; services for which payment is not legally required, except for: Medicaid; treatment of non-service connected disabilities in Veterans Administration hospitals and care rendered to armed services retirees and dependents in military medical facilities of the United States Government; voluntary abortion except, with respect to you or your covered eligible dependent spouse: where you or your dependent spouse's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion; pregnancy of an eligible dependent child; participating in a riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly (this does not include a loss which occurs while acting in a lawful manner within the scope of authority); participation in a contest of speed in power driven vehicles, parachuting or hang gliding; air travel except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member; sex changes; a diagnosis or treatment received outside the United States, or its territories, that cannot be confirmed by a physician licensed and practicing in the United States. The covered person, at his or her own expense, is responsible for obtaining such confirmation.

MedChoice™ Group Limited Benefit Hospital Indemnity Insurance

New Mexico Schools - HSA Compatible

Summary of Benefits	Plan 1
Hospital Admission Benefit	$2,000 per day; maximum of 4 day(s)
Hospital Confinement Benefit	$50 per day; maximum of 5 day(s)

Plan 1 - HSA Compatible				
Monthly Premiums*				
	Individual	Individual & Spouse	Individual & Child(ren)	Individual & Family
Ages 18+	$19.44	$47.62	$29.29	$60.74

* Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice. The premium and amount of benefits vary dependent upon the Plan selected at time of application.

Benefits

Benefits are per day, up to the maximum number of days per calendar year, per covered person. Benefit amounts may vary based upon place of service. Benefits will only be paid for a covered loss incurred while covered under the certificate. A covered person means a person who is eligible for coverage under the policy and for whom coverage is in force. An eligible dependent means your lawful spouse and/or your child (natural, adopted or step) who is under 26 years of age and/or any minor under your charge, care and control, who has been placed for adoption and is under 26 years of age.

Hospital Admission Benefit - Pays a benefit when a covered person is admitted and confined as an inpatient in a hospital due to an injury or covered sickness. APL will not pay this benefit for outpatient treatment, emergency room treatment or a stay less than 18 hours in an observation unit. This benefit is only payable once per period of confinement. A hospital is not an institution, or part thereof, used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Hospital Confinement Benefit - Pays a per day benefit when a covered person is confined as an inpatient to a hospital due to an injury or covered sickness.

Exclusions

No benefits are payable for any loss resulting from or caused, whether directly or indirectly by: hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs within six months after the certificate effective date unless due to an emergency; war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of your written request.); dental treatment or routine vision services unless due to injury and if performed within 12 months of the date of the covered accident or due to congenital defect or birth anomaly of a covered newborn child; an intentionally self-inflicted injury or sickness; committing, or attempting to commit, an illegal act that is defined as a felony (felony is as defined by the law of the jurisdiction in which the act takes place); an injury or sickness incurred while engaging in an illegal occupation; cosmetic care, except when the hospital confinement is due to medically necessary reconstructive plastic surgery (medical necessary reconstructive plastic surgery is defined as: surgery to restore a normal bodily function, surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect or birth anomaly, breast reconstruction following mastectomy); being intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions (intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred); experimental treatment, drugs or surgery, except in connection with an approved cancer clinical trial; immunizations; artificial insemination, in vitro fertilization, test tube fertilization, sterilization, tubal ligation or vasectomy, and reversal thereof; participation in any sport for pay or profit; mental and emotional disorders without demonstrable organic disease; alcoholism or drug addiction treatment; services for which payment is not legally required, except for: Medicaid; treatment of non-service connected disabilities in Veterans Administration hospitals and care rendered to armed services retirees and dependents in military medical facilities of the United States Government; voluntary abortion except, with respect to you or your covered eligible dependent spouse: where you or your dependent spouse's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion; pregnancy of an eligible dependent child; participating in a riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly (this does not include a loss which occurs while acting in a lawful manner within the scope of authority); participation in a contest of speed in power driven vehicles, parachuting or hang gliding; air travel except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member; sex changes; a diagnosis or treatment received outside the United States, or its territories, that cannot be confirmed by a physician licensed and practicing in the United States. The covered person, at his or her own expense, is responsible for obtaining such confirmation.

MedChoice™ Group Limited Benefit Hospital Indemnity Insurance

New Mexico Schools - HSA Compatible

Summary of Benefits	Plan 1
Hospital Admission Benefit	$2,500 per day; maximum of 4 day(s)
Hospital Confinement Benefit	$50 per day; maximum of 5 day(s)

Plan 1 - HSA Compatible				
Monthly Premiums*				
	Individual	Individual & Spouse	Individual & Child(ren)	Individual & Family
Ages 18+	$23.97	$58.69	$36.04	$74.77

* Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice. The premium and amount of benefits vary dependent upon the Plan selected at time of application.

Benefits

Benefits are per day, up to the maximum number of days per calendar year, per covered person. Benefit amounts may vary based upon place of service. Benefits will only be paid for a covered loss incurred while covered under the certificate. A covered person means a person who is eligible for coverage under the policy and for whom coverage is in force. An eligible dependent means your lawful spouse and/or your child (natural, adopted or step) who is under 26 years of age and/or any minor under your charge, care and control, who has been placed for adoption and is under 26 years of age.

Hospital Admission Benefit - Pays a benefit when a covered person is admitted and confined as an inpatient in a hospital due to an injury or covered sickness. APL will not pay this benefit for outpatient treatment, emergency room treatment or a stay less than 18 hours in an observation unit. This benefit is only payable once per period of confinement. A hospital is not an institution, or part thereof, used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Hospital Confinement Benefit - Pays a per day benefit when a covered person is confined as an inpatient to a hospital due to an injury or covered sickness.

Exclusions

No benefits are payable for any loss resulting from or caused, whether directly or indirectly by: hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs within six months after the certificate effective date unless due to an emergency; war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of your written request.); dental treatment or routine vision services unless due to injury and if performed within 12 months of the date of the covered accident or due to congenital defect or birth anomaly of a covered newborn child; an intentionally self-inflicted injury or sickness; committing, or attempting to commit, an illegal act that is defined as a felony (felony is as defined by the law of the jurisdiction in which the act takes place); an injury or sickness incurred while engaging in an illegal occupation; cosmetic care, except when the hospital confinement is due to medically necessary reconstructive plastic surgery (medical necessary reconstructive plastic surgery is defined as: surgery to restore a normal bodily function, surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect or birth anomaly, breast reconstruction following mastectomy); being intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions (intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred); experimental treatment, drugs or surgery, except in connection with an approved cancer clinical trial; immunizations; artificial insemination, in vitro fertilization, test tube fertilization, sterilization, tubal ligation or vasectomy, and reversal thereof; participation in any sport for pay or profit; mental and emotional disorders without demonstrable organic disease; alcoholism or drug addiction treatment; services for which payment is not legally required, except for: Medicaid; treatment of non-service connected disabilities in Veterans Administration hospitals and care rendered to armed services retirees and dependents in military medical facilities of the United States Government; voluntary abortion except, with respect to you or your covered eligible dependent spouse: where you or your dependent spouse's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion; pregnancy of an eligible dependent child; participating in a riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly (this does not include a loss which occurs while acting in a lawful manner within the scope of authority); participation in a contest of speed in power driven vehicles, parachuting or hang gliding; air travel except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member; sex changes; a diagnosis or treatment received outside the United States, or its territories, that cannot be confirmed by a physician licensed and practicing in the United States. The covered person, at his or her own expense, is responsible for obtaining such confirmation.

Termination of Certificate

Your insurance coverage under the certificate, including any attached riders, will end on the earliest of these dates: the date the policy terminates; the end of the grace period if the premium remains unpaid; the date you no longer qualify as an insured or the date of your death.

Termination of Coverage

Your insurance coverage under the policy and/or attached riders for a covered person will end as follows: the date the policy terminates; the date the certificate terminates; the end of the grace period if the premium remains unpaid; the end of the certificate period in which we receive a written request from you to terminate the covered person's coverage; the date a covered person no longer qualifies as an insured or eligible dependent or the date of the covered person's death. APL may end coverage of any covered person who submits a fraudulent claim.

COBRA Continuation of Coverage

This plan may be continued in accordance with the Consolidated Omnibus Reconciliation Act of 1986.

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Group Critical Illness Insurance

Underwritten by MetLife

Plan Features

- Pays regardless of other coverage
- Portable (take it with You)

Choose from flexible benefit options including:

- Heart Attack and Stroke
- Coronary Bypass Surgery
- Major Organ Transplant
- Cancer
- End Stage Renal Failure
- Alzheimer's Dementia
- Diabetes

All benefits may not be available to you. Please see Rate Quote for benefits offered.

Benefits

Heart Attack Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Heart Attack.

Heart Transplant Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person:

- demonstrates Heart Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the whole heart.

Heart Transplant under this Policy includes a Heart Lung Transplant.

Stroke Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Stroke.

Coronary By Pass Surgery Benefit
We will pay 25% of the Face Amount when We receive Proof of Loss showing that a Covered Person has undergone a covered Coronary Artery Bypass Surgery.

Angioplasty
We will pay 10% of the Face Amount when We receive Proof of Loss showing that a Covered Person has undergone Angioplasty.

Invasive Cancer or Malignant Melanoma Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Invasive Cancer.

Carcinoma in Situ Benefit
We will pay 25% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Carcinoma in Situ.

Major Organ Transplant Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person:

- demonstrates Major Organ Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing Major Organ.

Major Organ Transplant does not include:

- Heart Transplant; or
- Heart Lung Transplant.

End Stage Renal Failure Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from End Stage Renal Failure.

Loss of Vision, Speech or Hearing Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Loss of Vision; Loss of Speech; or Loss of Hearing.

Coma Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from a Coma.

Severe Burns Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person has suffered Severe Burns caused by an Accident.

Permanent Paralysis Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Permanent Paralysis caused by an Accident.

Occupational HIV Benefit
We will pay 100% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Occupational HIV.

Alzheimer's Dementia Benefit
We will pay 25% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Alzheimer's Dementia.

Amyotrophic Lateral Sclerosis (ALS)
We will pay 25% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Amyotrophic Lateral Sclerosis (ALS).

Benign Brain Tumor
We will pay 25% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Benign Brain Tumor.

Loss of Independent Living Benefit
We will pay 25% of the Face Amount for a Covered Person when We receive Proof of Loss showing that a Covered Person suffers from Loss of Independent Living. This benefit is payable only once per lifetime per Covered Person.

Diabetes Benefit
We will pay 10% of the Face Amount when We receive Proof of Loss showing that a Covered Person suffers from Type I or Type II Diabetes. This benefit is payable one time per lifetime per Covered Person.

Additional Occurrence Benefit
We pay one additional benefit upon the diagnosis of a covered condition for which benefits have not been previously paid. The diagnosis must be separated from any other critical illness by at least six months.

Recurrence Benefit
With the exception of Diabetes and Loss of Independent Living, We will pay this Benefit one time if a Covered Person is diagnosed for a second time with one of the named Critical Illnesses for which We paid a Benefit before. The Benefit is 25% of the Face Amount, and subject to the following:

- the second diagnosis must follow the first diagnosis of the same Critical Illness by more than 12 months;
- the Covered Person must not have received treatment during a 12 consecutive month period between the two diagnoses; and
- the second diagnosis must take place while the Covered Person's coverage is in effect.

For the purposes of this Benefit, "treatment" does not include: preventative medications in the absence of disease; or, routine scheduled follow-up visits to a Physician.

When this Benefit is paid, it ends for the Covered Person. No Recurrence Benefit will be paid thereafter for recurrence of any Critical Illness of the Covered Person.

Health Screening Benefit
We will pay the amount shown on the schedule, if during a Calendar Year, a Covered Person has one or more of the following tests performed

- Bone Marrow Testing
- CA-125 (blood test for ovarian cancer)
- Chest x-ray
- Flexible Sigmoidoscopy
- Mammography (including breast ultrasound)
- PSA (blood test for prostate cancer)
- Biopsy for Skin Cancer
- Electrocardiogram (EKG) (including stress EKG)
- Blood Test for Triglycerides
- Fasting blood glucose test
- CA 15-3 (blood test for breast cancer)
- CEA (blood test for colon cancer)
- Colonoscopy
- Hemoccult stool analysis
- Pap Smear (including ThinPrep Pap Test)
- Serum Protein Electrophoresis (test for myeloma)
- Stress test (bike or treadmill)
- Lipid Panel (total cholesterol count)
- Oral Cancer Screening using ViziLite, OraTest or other or other Current Dental Terminology
- Serum cholesterol test to determine level of HDL and LDL

Waiver of Premium Benefit
We will waive Premiums from the first day of Total Disability when Your Total Disability:

- starts while the Policy and Your Certificate are in force or in the Grace Period;
- starts before Your 60th birthday; and
- continues without interruption for at least 90 days.

Waiver will start on the first day of Total Disability. We will waive Premiums:

- as they fall due while You remain Totally Disabled; and
- using the mode of Premium payment that was in effect when Total Disability began; and
- for the period of time shown on the Certificate Schedule.

You will be required to pay premiums to keep Your coverage in effect until Your Total Disability is established according to the terms of the Benefit above.

Spouse Coverage is 50% of the Face Amount/ Child Coverage is 25% of the Face Amount. The Face Amount Reduces by 50% at Age 70. Payment of Benefits Shall Not Exceed 300% of the Face Amount. Subject to the Recurrence Benefits, payment of Benefits within a Benefit Group will not exceed 100% of the Face Amount.

Payment Of Benefits

We will pay Benefits when We receive Proof of Loss acceptable to Us. Benefits are subject to the Benefit Conditions, Limitations and Exclusions provision.

Benefit Conditions, Limitations and Exclusions

A Critical Illness must be diagnosed after the effective date of coverage and during the lifetime of the Covered Person while the Certificate is in force. When a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the greater of the two.

No Benefits of the Policy will be paid for loss that is contributed to, caused by, or occurs during:

- any intentionally self-inflicted injury;
- suicide, or attempted suicide, while sane or insane;
- active duty military service;
- participation in the commission or attempted commission of a felony;
- being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless administered on, and taken in accordance with, the instructions of a Physician;
- psychosis; or
- alcoholism or drug addiction.

Pre-Existing Condition Limitation

Any loss due to a Pre-existing Condition will not be covered if the loss begins within 12 months after the Covered Person's Effective Date of Insurance. However, Benefits may be paid for a loss due to a Pre-existing Condition of a Covered Person who was covered by a Replaced Policy; an by the Policy on its Initial Effective Date.

Pre-existing Condition means a medical condition, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Effective Date of Insurance for each Covered Person or during the 12 months immediately preceding an increase in benefits for each Covered Person under this Certificate.

- Heart Attack
- Stroke
- Invasive Cancer
- Carcinoma in Situ
- Coma
- End-Stage Renal Failure
- Loss of Vision, Speech or Hearing
- Severe Burns
- Permanent Paralysis
- Occupational HIV
- Alzheimer's Dementia
- Diabetes (Type I or II)

Pre-existing Condition also means any of the following which a Physician has treated or for which a Physician has advised treatment (by transplant, bypass surgery, medication or otherwise) of the Covered Person within 12 months before the Covered Person's Effective Date of Insurance:

- failure of the liver, kidney(ies), pancreas, or lung(s);
- failure of the heart; or
- coronary artery disease.

Benefits for Invasive Cancer or Carcinoma in Situ will not be payable based on a Tentative Diagnosis unless confirmed by a Clinical Diagnosis or a Pathological Diagnosis.

Pre-existing Condition also means a condition causing Total Disability which a Physician has treated or for which a Physician has advised treatment of the Employee within 12 months before the Employee's Effective Date of Insurance.

Termination Of Insurance – Covered Persons

Subject to the Portability provisions, all insurance ends on the earliest of the following dates:

- the date the Policy terminates;
- the date of termination of any section or part of the Policy with respect to insurance under such section or part;
- the premium due date that coincides with or next follows the date that the Employee ceases to be a member of an eligible class;
- any premium due date, if premium remains unpaid by the end of the grace period;
- the Policy Anniversary Date that coincides with or next follows the date that the Covered Person reaches the Maximum Renewal Age shown on the Certificate Schedule;
- the date that a Spouse reaches age 70;
- the date that a Child reaches Age 26; or
- Covered Person's death.

If a Recurrence Benefit is paid for a Covered Person, the Recurrence Benefit for that person ends. When Your coverage ends, insurance on other persons covered by this Certificate will also end. Termination of insurance on a Covered Person or of the Policy is without prejudice to claims that occur or start prior to the date of termination.

Covered Persons

Covered Person
means an eligible Employee or Eligible Dependent who is covered under the Policy. Persons eligible for coverage are shown on the Schedule.

Child (Children)
means the Covered Employee's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Covered Employee is a party to a proceeding in which the adoption of such child by the Covered Employee is sought); a child for whom the Covered Employee is required by a court order to provide medical support, and grandchildren who are dependent on the Covered Employee for federal income tax purposes at the time of application.

Child does not include a:

- person not meeting the above Child definition;
- Child living outside of the United States (unless living with you); or
- Child on active military duty for a period in excess of 30 days.

Eligible Dependents
means a Spouse, His or Her Child(ren) and the Child(ren) of an Eligible Employee. We must approve eligibility of the Spouse and Child(ren) of an Employee. Each such person must meet the Eligibility requirements shown in the Schedule. If a Child is covered by the Policy, the Child's Eligibility will not end if the Child is and remains:

- unmarried;
- incapable of self-sustaining employment due to mental incapacity or physical handicap; and
- chiefly dependent on the Employee or Spouse for support.

However, in no event will Eligibility or coverage of any Child continue beyond the date that the Employee's coverage ends.The Employee must furnish Us with proof of physical or mental incapacity within 31 days after the Child's Eligibility would otherwise end. Thereafter, We may require proof, but not more frequently than annually.

Portability

On the date the Policy terminates or the date the Named Insured ceases to be Actively at Work as an Employee and is not Totally Disabled, Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated.
The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

*****All benefits may not be available to you. Please see Rate Quote for benefits offered.*****

This sales brochure is not a contract. It is intended only as a brief description of the policy provisions in the planning of your program. The benefits are determined by the terms and conditions of the policy and certificate alone.

This is not a medicare supplement policy. If you are eligible for medicare, see the medicare supplement buyer's guide available from the company.

In all cases, consult your certificate for full details.

Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact us.
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New Mexico Schools

Group Critical Illness - Monthly Rates

Effective Date - 10/01/2021

Situs State - NM

Non-Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$5.70	$9.36	$6.58	$10.23
36 - 49	$11.77	$18.63	$12.55	$19.41
50 - 59	$26.07	$41.15	$26.83	$41.91
60 - 64	$40.39	$62.10	$41.04	$62.75
65 +	$45.32	$69.54	$45.94	$70.15

Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$8.26	$13.28	$9.13	$14.15
36 - 49	$19.31	$30.07	$20.08	$30.85
50 - 59	$44.87	$70.12	$45.63	$70.88
60 - 64	$68.89	$105.04	$69.54	$105.69
65 +	$75.64	$115.21	$76.26	$115.83

Benefit Face Amount

Benefit	Employee	Spouse	Child
Heart	$10,000	$5,000	$2,500
Cancer	$10,000	$5,000	$2,500
Other	$10,000	$5,000	$2,500
Recurrence	$2,500	$1,250	$625
Health Screening	$50	$50	$50

Benefit Details	
Recurrence Benefit	25%
Recurrence Waiting Period	12 Months
Vascular Benefits	
Heart Attack	100%
Heart Transplant	100%
Stroke	100%
Coronary Bypass	25%
Angioplasty	10%
Cancer Benefits	
Invasive Cancer	100%
Malignant Melanoma	100%
Cancer in Situ	25%

Other Benefits	
Major Organ Transplant	100%
End Stage Renal Failure	100%
Coma	100%
Loss of Sight	100%
Loss of Speech or Hearing	100%
Paralysis	100%
Severe Burns	100%
Occupational HIV	100%
Amyotrophic Lateral Sclerosis	25%
Benign Brain Tumor	25%
Alzheimer's Dementia	25%
Loss of Independent Living	25%
Diabetes	0%

Residents of most states will be covered by the situs state plan. Residents of certain states will be covered by a state specific certificate of insurance due to these states having extraterritorial laws.

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New Mexico Schools

Group Critical Illness - Monthly Rates

Effective Date - 10/01/2021

Situs State - NM

Non-Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$10.15	$16.21	$11.60	$17.65
36 - 49	$21.94	$34.05	$23.18	$35.29
50 - 59	$50.02	$78.06	$51.24	$79.28
60 - 64	$78.25	$119.14	$79.25	$120.14
65 +	$88.12	$134.01	$89.05	$134.94

Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$15.25	$24.04	$16.70	$25.49
36 - 49	$37.01	$56.93	$38.25	$58.17
50 - 59	$87.63	$136.00	$88.84	$137.21
60 - 64	$135.26	$205.02	$136.26	$206.02
65 +	$148.75	$225.37	$149.68	$226.30

Benefit Face Amount

Benefit	Employee	Spouse	Child
Heart	$20,000	$10,000	$5,000
Cancer	$20,000	$10,000	$5,000
Other	$20,000	$10,000	$5,000
Recurrence	$5,000	$2,500	$1,250
Health Screening	$50	$50	$50

Benefit Details	
Recurrence Benefit	25%
Recurrence Waiting Period	12 Months
Vascular Benefits	
Heart Attack	100%
Heart Transplant	100%
Stroke	100%
Coronary Bypass	25%
Angioplasty	10%
Cancer Benefits	
Invasive Cancer	100%
Malignant Melanoma	100%
Cancer in Situ	25%

Other Benefits	
Major Organ Transplant	100%
End Stage Renal Failure	100%
Coma	100%
Loss of Sight	100%
Loss of Speech or Hearing	100%
Paralysis	100%
Severe Burns	100%
Occupational HIV	100%
Amyotrophic Lateral Sclerosis	25%
Benign Brain Tumor	25%
Alzheimer's Dementia	25%
Loss of Independent Living	25%
Diabetes	0%

Residents of most states will be covered by the situs state plan. Residents of certain states will be covered by a state specific certificate of insurance due to these states having extraterritorial laws.

Underwritten by:
Metropolitan Life Insurance Company

Administered by:
BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

P.O. Box 161690 - Austin, Texas 78716 - (800) 845-7519

New Mexico Schools

Group Critical Illness - Monthly Rates

Effective Date - 10/01/2021

Situs State - NM

Non-Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$14.60	$23.06	$16.62	$25.07
36 - 49	$32.11	$49.46	$33.82	$51.17
50 - 59	$73.98	$114.98	$75.64	$116.65
60 - 64	$116.11	$176.17	$117.46	$177.52
65 +	$130.91	$198.49	$132.15	$199.73

Tobacco

Issue Age	EE	EE + SP	EE + CH	Family
18 - 35	$22.25	$34.81	$24.28	$36.82
36 - 49	$54.71	$83.78	$56.42	$85.49
50 - 59	$130.38	$201.87	$132.05	$203.54
60 - 64	$201.62	$304.99	$202.97	$306.34
65 +	$221.87	$335.52	$223.11	$336.76

Benefit Face Amount

Benefit	Employee	Spouse	Child
Heart	$30,000	$15,000	$7,500
Cancer	$30,000	$15,000	$7,500
Other	$30,000	$15,000	$7,500
Recurrence	$7,500	$3,750	$1,875
Health Screening	$50	$50	$50

Benefit Details	
Recurrence Benefit	25%
Recurrence Waiting Period	12 Months
Vascular Benefits	
Heart Attack	100%
Heart Transplant	100%
Stroke	100%
Coronary Bypass	25%
Angioplasty	10%
Cancer Benefits	
Invasive Cancer	100%
Malignant Melanoma	100%
Cancer in Situ	25%

Other Benefits	
Major Organ Transplant	100%
End Stage Renal Failure	100%
Coma	100%
Loss of Sight	100%
Loss of Speech or Hearing	100%
Paralysis	100%
Severe Burns	100%
Occupational HIV	100%
Amyotrophic Lateral Sclerosis	25%
Benign Brain Tumor	25%
Alzheimer's Dementia	25%
Loss of Independent Living	25%
Diabetes	0%

Residents of most states will be covered by the situs state plan. Residents of certain states will be covered by a state specific certificate of insurance due to these states having extraterritorial laws.

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U.S. Business Intermediary and Producer Compensation Notice

Metropolitan Life Insurance Company, herein called MetLife, enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products *("Products")* with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products *(each an "Intermediary")*. MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business *(number of products sold or dollar value of premium)* with MetLife. In addition, supplemental compensation may be payable to your Intermediary. Under MetLife's current supplemental compensation plan (SCP), the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period, or other defined period; (2) the amount of premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products inforce through your Intermediary during a one-year period; (4) the block growth of the products inforce through your Intermediary during a one-year period; (5) premium growth during a one-year period; or (6) a flat amount, fixed percentage or sliding scale of the premium for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife *(e.g., insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, participation in an insurer panel, or reinsurance arrangements)*.

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Website at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

Non-U.S. Coverage

When providing you with information concerning a group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a MetLife affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MetLife or any other insurer that is not a member of MAXIS GBN. Please note that while MetLife is a member of MAXISGBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.

L1020008870[exp1221][All States][DC,GU,MP,PR,VI]

Accident Insurance

Benefits that may help cover costs such as those not covered by your medical plan.

Accident Insurance Benefits

With MetLife, you'll have a choice of two plans (called the "Low Plan" and the "High Plan") that provide payments in addition to any other insurance payments you may receive[1]. Here are just some of the covered events/services[2].

		LOW PLAN			HIGH PLAN		
BENEFIT	BENEFIT LIMITS	EMPLOYEE	SPOUSE	CHILD	EMPLOYEE	SPOUSE	CHILD
ACCIDENTAL DEATH BENEFITS CATEGORY							
Basic Accidental Death	N/A	$25,000	$12,500	$5,000	$50,000	$25,000	$10,000
Accidental Death Common Carrier		$75,000	$37,500	$15,000	$150,000	$75,000	$30,000
ACCIDENTAL DISMEMBERMENT/FUNCTIONAL LOSS/PARALYSIS BENEFITS CATEGORY							
Basic Dismemberment/Functional Loss Benefit							
Loss of one finger or one toe	N/A	$750	$750	$750	$1,000	$1,000	$1,000
Loss of one arm or one leg		$10,000	$10,000	$10,000	$15,000	$15,000	$15,000
Loss of one hand or one foot		$10,000	$10,000	$10,000	$15,000	$15,000	$15,000
Loss of two or more fingers or toes		$1,500	$1,500	$1,500	$2,000	$2,000	$2,000
Loss of sight in one eye		$10,000	$10,000	$10,000	$15,000	$15,000	$15,000
Loss of hearing in one ear		$10,000	$10,000	$10,000	$15,000	$15,000	$15,000
Catastrophic Dismemberment/Functional Loss Benefit							
Loss of both arms or both legs or one arm and one leg	N/A	$20,000	$20,000	$20,000	$40,000	$40,000	$40,000
Loss of both hands or both feet or one hand and one foot		$20,000	$20,000	$20,000	$40,000	$40,000	$40,000
Loss of sight in both eyes		$20,000	$20,000	$20,000	$40,000	$40,000	$40,000
Loss of hearing in both ears		$20,000	$20,000	$20,000	$40,000	$40,000	$40,000
Loss of ability to speak		$20,000	$20,000	$20,000	$40,000	$40,000	$40,000
Paralysis Benefit							
Two Limbs (paraplegia or hemiplegia)	N/A	$10,000	$10,000	$10,000	$20,000	$20,000	$20,000
Four Limbs (quadriplegia)		$20,000	$20,000	$20,000	$40,000	$40,000	$40,000

		LOW PLAN	HIGH PLAN
BENEFIT	BENEFIT LIMITS	ALL COVERED PERSONS	ALL COVERED PERSONS
ACCIDENTAL INJURY BENEFITS CATEGORY			
Fracture Benefit (Closed)			
Face or Nose (except mandible or maxilla)	If more than one bone is fractured,	$1,000	$2,000

MetLife

ADF# AI664.14

Accident Insurance

Skull Fracture - depressed (except bones of face or nose)	the amount we will pay for all fractures combined will be no more than 2 times the highest Fracture Benefit.	$4,000	$5,000
Skull Fracture - non depressed (except bones of face or nose)		$2,000	$2,500
Lower Jaw, Mandible (except alveolar process)		$750	$1,000
Upper Jaw, Maxilla (except alveolar process)		$1,000	$2,000
Upper Arm between Elbow and Shoulder (humerus)		$1,000	$2,000
Shoulder Blade (scapula), Collarbone (clavicle, sternum)		$750	$1,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)		$750	$1,000
Rib		$750	$1,000
Finger, Toe		$100	$200
Vertebrae, Body of (excluding vertebral processes)		$1,500	$2,000
Vertebral Process		$500	$750
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)		$1,500	$2,000
Hip, Thigh (femur)		$4,000	$5,000
Coccyx		$500	$750
Leg (tibia and/or fibula)		$1,500	$2,000
Kneecap (patella)		$500	$750
Ankle		$500	$750
Foot (except toes)		$500	$750
Chip Fracture		25%	25%
Fracture Benefit (Open)			
Face or Nose (except mandible or maxilla)	If more than one bone is fractured, the amount we will pay for all fractures combined will be no more than 2 times the highest Fracture Benefit.	$2,000	$4,000
Skull Fracture - depressed (except bones of face or nose)		$8,000	$10,000
Skull Fracture - non depressed (except bones of face or nose)		$4,000	$5,000
Lower Jaw, Mandible (except alveolar process)		$1,500	$2,000
Upper Jaw, Maxilla (except alveolar process)		$2,000	$4,000
Upper Arm between Elbow and Shoulder (humerus)		$2,000	$4,000
Shoulder Blade (scapula), Collarbone (clavicle, sternum)		$1,500	$2,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)		$1,500	$2,000
Rib		$1,500	$2,000
Finger, Toe		$200	$400
Vertebrae, Body of (excluding vertebral processes)		$3,000	$4,000

Accident Insurance

Vertebral Process		$1,000	$1,500
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)		$3,000	$4,000
Hip, Thigh (femur)		$8,000	$10,000
Coccyx		$1,000	$1,500
Leg (tibia and/or fibula)		$3,000	$4,000
Kneecap (patella)		$1,000	$1,500
Ankle		$1,000	$1,500
Foot (except toes)		$1,000	$1,500
Chip Fracture		25%	25%
Dislocation Benefit (Closed)			
Lower Jaw	If more than one joint is dislocated, the amount we will pay for all dislocations combined will be no more than 2 times the highest Dislocation Benefit.	$750	$1,000
Collarbone (sternoclavicular)		$1,000	$1,500
Collarbone (acromioclavicular and separation)		$750	$1,000
Shoulder (glenohumeral)		$750	$1,000
Rib		$750	$1,000
Elbow		$750	$1,000
Wrist		$750	$1,000
Bone or Bones of the Hand (other than fingers)		$750	$1,000
Hip		$4,000	$5,000
Knee (except patella)		$2,000	$2,500
Ankle - Bone or bones of the Foot (other than toes)		$750	$1,000
One Toe or Finger		$100	$200
Partial Dislocation		25%	25%
Dislocation Benefit (Open)			
Lower Jaw	If more than one joint is dislocated, the amount we will pay for all dislocations combined will be no more than 2 times the highest Dislocation Benefit.	$1,500	$2,000
Collarbone (sternoclavicular)		$2,000	$3,000
Collarbone (acromioclavicular and separation)		$1,500	$2,000
Shoulder (glenohumeral)		$1,500	$2,000
Rib		$1,500	$2,000
Elbow		$1,500	$2,000
Wrist		$1,500	$2,000
Bone or Bones of the Hand (other than fingers)		$1,500	$2,000
Hip		$8,000	$10,000
Knee (except patella)		$4,000	$5,000
Ankle - Bone or bones of the Foot (other than toes)		$1,500	$2,000

Accident Insurance

One Toe or Finger		$200	$400
Partial Dislocation		25%	25%
Burn Benefit			
2nd Degree w/ less than 10% of surface skin burnt	1 time per accident; Unlimited time(s) per calendar year	$75	$100
2nd Degree 10-25% surface skin burnt		$150	$200
2nd Degree 25-35% surface skin burnt		$500	$750
2nd Degree 35% or more of surface skin burnt		$1,000	$1,500
3rd Degree w/ less than 10% of surface skin burnt		$1,000	$1,500
3rd Degree 10-25% surface skin burnt		$1,500	$2,000
3rd Degree 25-35% surface skin burnt		$5,000	$7,500
3rd Degree 35% or more of surface skin burnt		$10,000	$15,000
Concussion Benefit			
Concussion	1 time(s) per calendar year	$250	$500
Coma Benefit			
Coma	1 time(s) per accident; Unlimited time(s) per calendar year	$7,500	$10,000
Laceration Benefit			
Without repair by stiches	1 time per accident; 3 time(s) per calendar year	$50	$75
Repaired by stiches but less than 2 inches long		$75	$125
Repaired by stiches and 2-6 inches long		$200	$350
Repaired by stiches and over 6 inches long		$400	$700
Broken Tooth Benefit			
Crown	1 time(s) per accident; Unlimited time(s) per calendar year (applies to all procedures)	$200	$300
Extraction	1 time(s) per accident; Unlimited time(s) per calendar year (applies to all procedures)	$100	$150
Filling	1 time(s) per accident; Unlimited time(s) per calendar year (applies to all procedures)	$25	$50
Eye Injury Benefit			
Eye Injury	1 time(s) per accident; Unlimited time(s) per calendar year	$300	$400

		LOW PLAN	HIGH PLAN
BENEFIT	BENEFIT LIMITS	ALL COVERED	ALL

Accident Insurance

		PERSONS	COVERED PERSONS
MEDICAL TREATMENT AND SERVICES BENEFITS CATEGORY			
Ground Ambulance Benefit			
Ground Ambulance	1 time(s) per accident; Unlimited time(s) per calendar year	$300	$400
Air Ambulance Benefit			
Air Ambulance	1 time(s) per accident; Unlimited time(s) per calendar year	$1,000	$1,250
Emergency Care Benefit			
Emergency Room	1 time per accident (combined with Non-Emergency Initial Care Benefit). Payable within 48 hours after the accident.	$150	$200
Physician's Office		$75	$100
Urgent Care		$75	$100
Non-Emergency Initial Care Benefit			
Non-Emergency Initial Care	1 time per accident (combined with Emergency Care Benefit)	$75	$100
Medical Testing Benefit			
Medical Testing (X-rays, MRI/MR, Ultrasound, NCV, CT/CAT, EEG)	2 time(s) per accident; Unlimited time(s) per calendar year	$150	$200
Physician Follow-Up Benefit			
Physician Follow-Up Visit	2 time(s) per accident; 6 time(s) per calendar year	$75	$100
Transportation Benefit			
Transportation	1 time(s) per accident; 2 time(s) per calendar year	$300	$400
Therapy Services Benefit			
Acupuncture	10 time(s) per accident; Unlimited time(s) per calendar year	$35	$50
Chiropractic Therapy		$35	$50
Cognitive Behavioral Therapy		$35	$50
Occupational Therapy		$35	$50
Physical Therapy		$35	$50
Respiratory therapy		$35	$50
Speech Therapy		$35	$50
Vocational Therapy		$35	$50
Pain Benefit			
Pain Management (for Epidural Anesthesia)	1 time(s) per accident; Unlimited time(s) per calendar year	$75	$100

Accident Insurance

Prosthetic Device Benefit			
One Device Only	1 time(s) per accident; Unlimited time(s) per calendar year	$750	$1,000
More than One Device		$1,500	$2,000
Medical Appliance Benefit			
Brace		$75	$150
Cane		$75	$150
Crutches		$75	$150
Walker - expected use < 1yr		$150	$200
Walker - expected use >=1 yr		$300	$400
Walking Boot		$75	$150
Wheel chair or motorized scooter - expected use < 1yr		$200	$300
Wheel chair or motorized scooter - expected use >=1yr		$750	$1,000
Other medical device used for Mobility		$75	$150
Medical Appliance Benefit Limit (for all appliances combined per accident)		$750	$1,000
Modification Benefit			
Modification	1 time(s) per accident; Unlimited time(s) per calendar year	$1,000	$1,500
Blood/ Plasma/ Platelets Benefit			
Blood/Plasma/Platelets	1 time(s) per accident; Unlimited time(s) per calendar year	$400	$500
Surgery Benefits			
Surgical Repair – Cranial	1 time(s) per accident; Unlimited time(s) per calendar year	$1,500	$2,000
Surgical Repair – Hernia		$150	$200
Surgical Repair – Ruptured Disc		$750	$1,500
Surgical Repair – Skin Graft (% of Burn Benefit)		50%	50%
Surgical Repair – Torn Cartilage in Knee		$750	$1,500
Surgical Repair – Torn tendon/ligament/rotator cuff - one		$750	$1,000
Surgical Repair – Torn tendon/ligament/rotator cuff - two or more		$1,500	$2,000
Surgical Repair – Thoracic Cavity or Abdominal Pelvic Cavity		$1,500	$2,000
Exploratory Surgery (for any Surgery Benefit procedure)		$150	$200
Other Outpatient Surgery Benefit			

Accident Insurance

Other Outpatient Surgery Benefit	1 time(s) per accident; Unlimited time(s) per calendar year	$300	$400

BENEFIT	BENEFIT LIMITS	LOW PLAN ALL COVERED PERSONS	HIGH PLAN ALL COVERED PERSONS
ACCIDENT – HOSPITAL BENEFITS CATEGORY			
Hospital Admission Benefit			
Admission	1 time per accident; Unlimited times per calendar year	$1,000	$2,000
ICU Supplemental Admission (paid in addition to Admission)		$1,000	$2,000
Hospital Confinement Benefit			
Confinement	30 days per accident. Payable after the first day of admission. ICU Supplemental Confinement will pay an additional benefit for 30 of those days.	$150	$300
ICU Supplemental Confinement (paid in addition to Confinement)		$150	$300
Inpatient Rehabilitation Benefit			
Inpatient Rehabilitation	15 days per accident; 30 days per calendar year	$150	$200

BENEFIT	BENEFIT LIMITS	LOW PLAN ALL COVERED PERSONS	HIGH PLAN ALL COVERED PERSONS
OTHER BENEFITS CATEGORY			
Health Screening Benefit	1 time(s) per calendar year	$50	$50
Lodging Benefit	15 day(s) per calendar year	$100	$200

Organized Sports Activity Injury Benefit Rider
This coverage includes an Organized Sports Activity Benefit Rider. The rider increases the amount payable under the Certificate for certain benefits by 25% for injuries resulting from an accident that occurred while participating as a player in an organized sports activity. The rider sets forth terms, conditions and limitations, including the covered persons to whom the rider applies.

Notes Regarding Certain Benefits:

- Accidental Death Benefits Category: The benefit amount will be reduced by the amount of any Accidental Dismemberment/Functional Loss/Paralysis Benefits and Modification Benefit paid for Injuries sustained by the Covered Person in the same Accident for which the Accidental Death Benefit is being paid.
- Accidental Death Common Carrier Benefit: "Common Carrier": refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details.
- Lodging Benefit: The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from the insured's primary residence.

Please contact MetLife for detailed definitions and state variations of covered benefits.

Accident Insurance

Kathy's daughter, Molly, was riding her bike to school. On her way there she fell to the ground, was knocked unconscious, and was taken to the local emergency room (ER) by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[3]	Benefit Amount
Ambulance (ground)	**$400**
Emergency Care	**$200**
Physician Follow-Up ($100 x 2)	**$200**
Medical Testing	**$200**
Concussion	**$500**
Broken Tooth (repaired by crown)	**$300**
Benefits paid by MetLife Group Accident Insurance	**$1,800**

Benefit amount is based on a sample MetLife plan design. Actual plan design and benefits may vary.

Questions & Answers

Q. Who is eligible to enroll for this accident coverage?

A. You are eligible to enroll yourself and your eligible family members![4] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my accident coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[5] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

A. Please call MetLife directly at Monday through Friday from 8:00 a.m. to 8 p.m., EST and talk with a benefits consultant.

Insurance Rates

MetLife offers group rates and payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Accident Insurance	Monthly Cost to You	
Coverage Options	**Low Plan**	**High Plan**
Employee	$10.26	$16.26
Employee & Spouse	$18.44	$28.32
Employee & Child(ren)	$20.14	$33.16
Employee & Spouse/Child(ren)	$28.32	$45.22

[1] Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[2] Availability of benefits varies by state. See your Disclosure Statement or Outline of Coverage/Disclosure Document for state variations.
[3] Benefits and amounts are based on sample MetLife plan design. Plan design and plan benefits may vary.

Accident Insurance

[4] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Children may be covered to age 26. There are benefit reductions that may begin at age 65.

[5] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

WOW!

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

- You own it
- You can take it with you when you change jobs or retire
- You pay for it through convenient payroll deductions: no checks to write or links to click
- You can cover your spouse, children and grandchildren, too[1]
- You can get a living benefit if you become terminally ill[2]
- It's Affordable
- You can qualify by answering just 3 questions - no exam or needles

1. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
2. Conditions apply.

Flexible Premium Adjustable Life Insurance to age 121. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18. Some limitations apply. See the PureLife-plus brochure for details. Texas Life is licensed to do business in the District of Columbia and every state but New York.

19M004-C 1003 (exp0321)

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

Life Insurance Highlights
For the employee

PURELIFE-plus

Flexible Premium Life Insurance to Age 121
Policy Form PRFNG-NI-10

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually costs more and declines in death benefit.

The policy, PURELIFE-plus, is underwritten by Texas Life Insurance Company, and it has these outstanding features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite,[1] PURELIFE-plus gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.
- **Minimal Cash Value.** Designed to provide high death benefit, PURELIFE-plus does not compete with the cash accumulation in your employer-sponsored retirement plans.
- **Long Guarantees.** Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).
- **Refund of Premium.** Unique in the marketplace, PURELIFE-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months (24 months in Illinois), you will have the option to receive 92% (84% in Illinois) of the death benefit, minus a $150 ($100 in Florida) administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.)*

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, minor children and grandchildren.

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative for costs and complete details.

[1] Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2008

See the PURELIFE-plus brochure for details.

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

10M055-C 1040 (Expires 0612)

Not for use in WA.

Information about PURE**LIFE**-plus

Minimal Cash Values Buy this policy for its life insurance protection, not its cash value. The primary benefit is life insurance. Payment of the Table Premium produces a small cash value (Benchmark Cash Value).

Permanent Life Insurance Coverage Unlike group term life insurance, PureLife-plus is a personally owned, permanent individual life insurance policy to age 121 that can never be canceled or reduced as long as you pay the necessary premiums, even if your health changes.

Guaranteed Period Continuous, timely, and uninterrupted payment of the Table Premium guarantees coverage for the Guaranteed Period stated in the policy. Texas Life (We) cannot legally predict the premium required to continue coverage after the Guaranteed Period. It may be lower, the same, or higher than the Table Premium. However, if the premium to continue coverage is ever higher, We guarantee a limited right to a partial refund of premium.

Guaranteed Limited Right to Partial Refund of Premium If a premium higher than the Table Premium is ever required to continue coverage after the Guaranteed Period, you have the choice to: (a) pay the higher premium(s) required to continue coverage; or, (b) surrender the policy and receive a partial refund of premium equal to 120 times the minimum monthly premium due at issue (10 years worth of Table Premium). You are eligible for this refund if the actual cash value equals or exceeds the Benchmark Cash Value and you have taken no prior partial surrenders. Conditions apply.

Accelerated Death Benefit For no added premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider (Form ULABR-07).1 ("Terminal Condition" in PA.) If the insured becomes terminally ill (or has a terminal condition in PA or a qualifying event in a state with ICC in the policy form number) you may elect to claim an accelerated benefit while the insured is still alive in lieu of the insurance proceeds payable at death. In most states the single sum benefit is 92% (84% in IL) of the insurance proceeds. There is also an administrative fee of $150 ($100 in FL).This is not a long-term care benefit. Terminal Illness (or Condition) is an injury or sickness diagnosed and certified by a qualifying physician that, despite appropriate medical care, is reasonably expected to result in death within 12 months (24 months in IL). We can, at our expense, request the opinion of a physician We choose. A 90-day exclusion period applies unless the terminal illness results from accidental bodily injury (30 days in CT, IL, LA, MD, UT; 0 days in OR, PA, SC) Other conditions and limitations apply. Pay premiums faithfully. The rider terminates if the policy ever lapses for non-payment of premium, even if the policy is later reinstated. The right to accelerate benefits under this rider does not extend to any Child Term Life Insurance Rider. However, if the accelerated benefit is paid, the Child Rider becomes paid-up term insurance to each insured child's age 25. Payment of the Accelerated Death Benefit terminates the policy and all optional benefits/riders without further value.

Child Term Life Insurance Rider In lieu of an individual policy on each child, if the primary insured is age 59 or less you may apply for a Child Term Life Insurance Rider for $10,000. It insures the primary insured's children and step-children who are ages 15 days through age 18 at the time of application. Children thereafter born to or adopted by the primary insured are covered 15 days after birth. Coverage continues to age 25. Coverage terminates at the primary insured's age 65. Coverage on a step-child ceases upon the primary insured's divorce from the step-child's natural or adoptive parent. If the primary insured dies, coverage is paid-up to the earlier of the insured child's age 25 or the Contract Anniversary Date on which the primary insured's Attained Age would have been 65. (ULCL-CIR-07)

Important Notice The insurance proceeds, cash values, and loan values will all be reduced to zero and will no longer be payable if Texas Life pays the Accelerated Death Benefit. The benefit under this rider is intended to qualify for favorable income tax treatment under the Internal Revenue Code of 1986. If the benefit qualifies for such favorable tax treatment, it will be excludable from your income and not subject to federal income taxation. Receipt of the benefit may affect your, your spouse's or your family's eligibility for Medicaid, Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. Tax and public benefit laws relating to acceleration of life insurance benefits are complex. You should consult a qualified tax or legal advisor or social services agency to determine how receipt of such payment will affect you and your family. Neither Texas Life nor its agents are authorized to give tax or legal advice.

Interim Insurance Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through automatic deduction; (2) the deduction authorization is signed; and, (3) the proposed insured is insurable at standard rates under our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date we decline the application; (c) the date We notify the applicant that s/he is ineligible for interim insurance; or, (d) the 180th day after the application date. In Kansas, clauses (3) and (d) do not apply, and clauses (b) and (c) apply only when we refund all premiums.

This is a summary only. Policy provisions prevail. This information is not a contract or an offer to contract.
Policy Form PRFNG-NI-10

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative for costs and complete details.

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age Issue	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-1			9.25							81
2-4			9.50							80
5-8			9.75							79
9-10			10.00							79
11-16			10.25							77
17-20			10.25	15.05	18.25	26.25	34.25	42.25	50.25	75
21-22			10.50	15.45	18.75	27.00	35.25	43.50	51.75	74
23			10.75	15.85	19.25	27.75	36.25	44.75	53.25	75
24-25			11.00	16.25	19.75	28.50	37.25	46.00	54.75	74
26			11.50	17.05	20.75	30.00	39.25	48.50	57.75	75
27-28			11.75	17.45	21.25	30.75	40.25	49.75	59.25	74
29			12.00	17.85	21.75	31.50	41.25	51.00	60.75	74
30-31			12.25	18.25	22.25	32.25	42.25	52.25	62.25	73
32			13.00	19.45	23.75	34.50	45.25	56.00	66.75	74
33			13.50	20.25	24.75	36.00	47.25	58.50	69.75	74
34			14.25	21.45	26.25	38.25	50.25	62.25	74.25	75
35		10.05	15.25	23.05	28.25	41.25	54.25	67.25	80.25	76
36		10.35	15.75	23.85	29.25	42.75	56.25	69.75	83.25	76
37		10.80	16.50	25.05	30.75	45.00	59.25	73.50	87.75	77
38		11.25	17.25	26.25	32.25	47.25	62.25	77.25	92.25	77
39		12.00	18.50	28.25	34.75	51.00	67.25	83.50	99.75	78
40	9.25	12.75	19.75	30.25	37.25	54.75	72.25	89.75	107.25	79
41	9.95	13.80	21.50	33.05	40.75	60.00	79.25	98.50	117.75	80
42	10.75	15.00	23.50	36.25	44.75	66.00	87.25	108.50	129.75	81
43	11.45	16.05	25.25	39.05	48.25	71.25	94.25	117.25	140.25	82
44	12.15	17.10	27.00	41.85	51.75	76.50	101.25	126.00	150.75	83
45	12.85	18.15	28.75	44.65	55.25	81.75	108.25	134.75	161.25	83
46	13.65	19.35	30.75	47.85	59.25	87.75	116.25	144.75	173.25	84
47	14.35	20.40	32.50	50.65	62.75	93.00	123.25	153.50	183.75	84
48	15.05	21.45	34.25	53.45	66.25	98.25	130.25	162.25	194.25	85
49	15.95	22.80	36.50	57.05	70.75	105.00	139.25	173.50	207.75	85
50	16.95	24.30	39.00	61.05	75.75	112.50				86
51	18.15	26.10	42.00	65.85	81.75	121.50				87
52	19.45	28.05	45.25	71.05	88.25	131.25				88
53	20.45	29.55	47.75	75.05	93.25	138.75				88
54	21.45	31.05	50.25	79.05	98.25	146.25				88
55	22.55	32.70	53.00	83.45	103.75	154.50				89
56	23.55	34.20	55.50	87.45	108.75	162.00				89
57	24.75	36.00	58.50	92.25	114.75	171.00				89
58	25.85	37.65	61.25	96.65	120.25	179.25				89
59	27.05	39.45	64.25	101.45	126.25	188.25				89
60	28.55	41.70	68.00	107.45	133.75	199.50				90
61	29.85	43.65	71.25	112.65	140.25	209.25				90
62	31.45	46.05	75.25	119.05	148.25	221.25				90
63	33.05	48.45	79.25	125.45	156.25	233.25				90
64	34.75	51.00	83.50	132.25	164.75	246.00				90
65	36.65	53.85	88.25	139.85	174.25	260.25				90
66	38.75									90
67	41.05									91
68	43.55									91
69	46.05									91
70	48.65									91

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
Issue	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-1										81
2-4										80
5-8										79
9-10										79
11-16										77
17-20			15.25	23.05	28.25	41.25	54.25	67.25	80.25	71
21-22			16.00	24.25	29.75	43.50	57.25	71.00	84.75	71
23			16.75	25.45	31.25	45.75	60.25	74.75	89.25	72
24-25			17.25	26.25	32.25	47.25	62.25	77.25	92.25	71
26			17.75	27.05	33.25	48.75	64.25	79.75	95.25	72
27-28			18.25	27.85	34.25	50.25	66.25	82.25	98.25	71
29			18.50	28.25	34.75	51.00	67.25	83.50	99.75	71
30-31			21.00	32.25	39.75	58.50	77.25	96.00	114.75	72
32			21.75	33.45	41.25	60.75	80.25	99.75	119.25	72
33			22.00	33.85	41.75	61.50	81.25	101.00	120.75	72
34			22.25	34.25	42.25	62.25	82.25	102.25	122.25	71
35		15.30	24.00	37.05	45.75	67.50	89.25	111.00	132.75	72
36		15.75	24.75	38.25	47.25	69.75	92.25	114.75	137.25	72
37		16.80	26.50	41.05	50.75	75.00	99.25	123.50	147.75	73
38		17.25	27.25	42.25	52.25	77.25	102.25	127.25	152.25	73
39		18.45	29.25	45.45	56.25	83.25	110.25	137.25	164.25	74
40	14.15	20.10	32.00	49.85	61.75	91.50	121.25	151.00	180.75	76
41	15.05	21.45	34.25	53.45	66.25	98.25	130.25	162.25	194.25	77
42	16.15	23.10	37.00	57.85	71.75	106.50	141.25	176.00	210.75	78
43	17.55	25.20	40.50	63.45	78.75	117.00	155.25	193.50	231.75	80
44	18.25	26.25	42.25	66.25	82.25	122.25	162.25	202.25	242.25	80
45	19.25	27.75	44.75	70.25	87.25	129.75	172.25	214.75	257.25	81
46	20.05	28.95	46.75	73.45	91.25	135.75	180.25	224.75	269.25	81
47	21.05	30.45	49.25	77.45	96.25	143.25	190.25	237.25	284.25	82
48	21.95	31.80	51.50	81.05	100.75	150.00	199.25	248.50	297.75	82
49	23.25	33.75	54.75	86.25	107.25	159.75	212.25	264.75	317.25	83
50	24.35	35.40	57.50	90.65	112.75	168.00				83
51	25.45	37.05	60.25	95.05	118.25	176.25				83
52	27.05	39.45	64.25	101.45	126.25	188.25				84
53	28.45	41.55	67.75	107.05	133.25	198.75				85
54	29.75	43.50	71.00	112.25	139.75	208.50				85
55	31.15	45.60	74.50	117.85	146.75	219.00				85
56	32.75	48.00	78.50	124.25	154.75	231.00				85
57	34.35	50.40	82.50	130.65	162.75	243.00				86
58	36.05	52.95	86.75	137.45	171.25	255.75				86
59	37.75	55.50	91.00	144.25	179.75	268.50				86
60	39.55	58.20	95.50	151.45	188.75	282.00				86
61	41.85	61.65	101.25	160.65	200.25	299.25				86
62	44.05	64.95	106.75	169.45	211.25	315.75				87
63	46.25	68.25	112.25	178.25	222.25	332.25				87
64	48.45	71.55	117.75	187.05	233.25	348.75				87
65	50.85	75.15	123.75	196.65	245.25	366.75				87
66	53.45									88
67	56.25									88
68	59.15									88
69	62.25									88
70	65.55									89

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

Universal Availability Notice

Tatum Municipal Schools 403(b)

PLAN HIGHLIGHTS

Visit NBSbenefits.com/403b for additional information

Congratulations! You are eligible to participate in the 403(b) retirement plan provided by the **Tatum Municipal Schools** 403(b). Contributing to a 403(b) plan will give you peace of mind through financial security during your retirement. A 403(b) plan allows you to contribute a portion of your compensation as a pre-tax or post-tax (Roth) contribution (if allowed by your Employer) in order to save for retirement. Participation in the 403(b) plan is completely voluntary. If you are already contributing to the 403(b) plan, now is a perfect time to increase your contributions.

What is a 403(b) Plan?

A 403(b) plan, also known as a Tax-Sheltered Annuity (TSA), is a tax-deferred retirement plan provided for employees of certain tax-exempt, governmental organizations or public education institutions.

What are the benefits of contributing to a 403(b) Plan?

LOWER TAXES
The 403(b) contributions you make can be on a pre-tax basis. This means that the money used to invest in the 403(b) plan is not taxed until the funds are withdrawn. For example, if your federal marginal income tax rate is 25%, and you contribute $100 a month to a 403(b) plan, you have reduced your federal income taxes by nearly $25. In effect, your $100 contribution costs you only $75. The tax savings grow with the size of your 403(b) contribution.

TAX-DEFERRED GROWTH
In your 403(b) plan, interest and earnings grow tax-deferred. This means that your interest will grow tax-free until the time of your withdrawal. The compounding interest on your 403(b) plan allows your account to grow more quickly than money saved in a taxable account where interest and earnings are taxed each year.

TAKING THE INITIATIVE
Contributing to a 403(b) retirement plan helps you take control of your future retirement needs. Other sources of retirement income, including state pension plans and Social Security, often do not adequately replace a person's salary upon retirement. A 403(b) plan can be a great way to supplement your income at retirement.

POSSIBLE TAX CREDITS
Pre-tax contributions may put you in a lower tax bracket reducing your overall tax rate.

DISTRIBUTIONS FROM THE PLAN
Either you or your beneficiary will be able to withdraw your vested balance when one of the following occurs:

1. Retirement
2. Termination of Employment
3. Attainment of Age 59 ½
4. Total Disability
5. Death

The vendors may require additional paperwork.

LOANS
You may borrow up to 50% of your vested balance up to $50,000 (whichever is less). Contact your current vendor about their specific loan provisions.

REQUIRED MINIMUM DISTRIBUTIONS (RMD)
Distributions are required at age 73. Exceptions may apply.

HIGHER LIMITS
Annual contribution limits are much higher than those of an IRA.

How much can you contribute to a 403(b) Plan?

You may elect to save:

- 100% of your income up to $23,000 (2024)
- Extra $7,500 if age 50+

HOW TO ENROLL IN THE PLAN

Your employer has provided investment option(s) for you. A list of approved vendor(s) and the Salary Reduction Agreement ("SRA") can be found by visiting the National Benefit Services website at http://www.nbsbenefits.com/non-erisa-403b-forms/ or by contacting NBS (contact information below).

Once you have chosen an approved vendor, please open a 403(b) account directly with them. To begin investing, send the completed SRA form to NBS who will work with your employer to begin contributions.

INVESTMENT CHOICES
Annuity contracts made available through insurance companies or custodial accounts through a retirement account custodian are allowed in 403(b) plans. You will need to contact the vendor for a comprehensive listing and information regarding the available investment options.

EXCHANGES
As a participant in the 403(b) plan, you have the option to move funds, or "exchange" tax-free between different vendors within the same plan.

ROLLOVERS
You also have the option of rolling retirement funds from previous employers to your current employer's plan, thus simplifying retirement management.

ROTH
You may also choose to invest part of your income on an after-tax (Roth) basis. Roth contributions are taxed at the time of the investment though contributions *and* earnings grow tax-free until withdrawn. Qualified distributions will allow you to withdraw your money tax-free.

HARDSHIP DISTRIBUTIONS
An in-service hardship distribution may be allowed if you satisfy certain criteria. Contact NBS for more information about the requirements.

NBS Retirement Service Center
PO Box 219006

Kansas City, MO, 64121-9006

Contact NBS if you have questions about the retirement plan

nbs national benefit services

Tatum Municipal Schools

Plan Contact Person:
Christi Mullins
306 West 3rd Street
Tatum, NM 88267
1.575.398.4455

457(b) Plan Highlights

Tatum Municipal Schools

Visit NBSbenefits.com/457b for additional information

Congratulations! You are eligible to participate in the 457 retirement plan provided by the **Tatum Municipal Schools 457(b).** Contributing to a 457 plan will give you peace of mind through financial security during your retirement. A 457 plan allows you to contribute a portion of your compensation as a pre-tax or post-tax (Roth) contribution (if allowed by your Employer) in order to save for retirement. Participation in the 457 plan is completely voluntary. If you are already contributing to the 457 plan, now is a perfect time to increase your contributions.

What is a 457 Plan?

A 457 plan is a tax-deferred compensation plan provided for employees of certain tax-exempt, governmental organizations or public education institutions.

What are the benefits of contributing to a 457 Plan?

LOWER TAXES
The 457 contributions you make can be on a pre-tax basis. This means that the money used to invest in the 457 plan is not taxed until the funds are withdrawn. For example, if your federal marginal income tax rate is 25%, and you contribute $100 a month to a 457 plan, you have reduced your federal income taxes by nearly $25. In effect, your $100 contribution costs you only $75. The tax savings grow with the size of your 457 contribution.

TAX-DEFERRED GROWTH
In your 457 plan, interest and earnings grow tax-deferred. This means that your interest will grow tax-free until the time of your withdrawal. The compounding interest on your 457 plan allows your account to grow more quickly than money saved in a taxable account where interest and earnings are taxed each year.

TAKING THE INITIATIVE
Contributing to a 457 plan helps you take control of your future retirement needs. Other sources of retirement income, including state pension plans and Social Security, often do not adequately replace a person's salary upon retirement. A 457 plan can be a great way to supplement your income at retirement.

POSSIBLE TAX CREDITS
Pre-tax contributions may put you in a lower tax bracket reducing your overall tax rate.

TRANSFERS
As a participant in the 457 plan, you have the option to move funds, or "transfer" tax-free between different vendors within the same plan.

ROLLOVERS
You also have the option of rolling retirement funds from previous employers to your current employer's plan thus simplifying retirement management.

DISTRIBUTIONS FROM THE PLAN
You or your beneficiary will be able to withdraw your vested balance when one of the following occurs:

1. Retirement
2. Termination of Employment
3. Attainment of Age 59 1/2
4. Total Disability
5. Death

The vendors may require additional paperwork.

HIGHER LIMITS
Annual contribution limits are much higher than those of an IRA.

How much can you contribute to a 457 Plan?

You may elect to save:

- 100% of your income up to $23,000.00 in 2024
- Extra $7500 if age 50+
- Limits are completely separate from those made to 403(b) or 401(k) accounts

REQUIRED MINIMUM DISTRIBUTIONS (RMD)
Distributions are required at age 73. Exceptions may apply.

HOW TO ENROLL IN THE PLAN
Your employer has provided investment option(s) for you. A list of approved vendor(s) and the Salary Reduction Agreement ("SRA") can be found by visiting the National Benefit Services website at http://www.nbsbenefits.com/non-erisa-403b-forms/
or by contacting NBS (contact information below).

Once you have chosen an approved vendor, please open a 457 account directly with them. To begin investing, send the completed SRA form to NBS who will work with your employer to begin contributions.

INVESTMENT CHOICES
Annuity contracts made available through insurance companies or custodial accounts through a retirement account custodian are allowed in 457 plans. You will need to contact the vendor for a comprehensive listing and information regarding the available investment options.

UNFORESEEABLE EMERGENCY
An in-service unforeseeable emergency distribution may be allowed if you satisfy certain criteria. Contact NBS for more information about the requirements.

ROTH
You may also choose to invest part of your income on an after-tax (Roth) basis. Roth contributions are taxed at the time of the investment though contributions *and* earnings grow tax-free until withdrawn. Qualified distributions will allow you to withdraw your money tax-free.

LOANS
You may borrow up to 50% of your vested balance up to $50,000 (whichever is less). Contact your current vendor about their specific loan provisions.

NBS Retirement Service Center
430 W 7th Street, Suite 219006

Kansas City, MO, 64105-1407

Contact NBS if you have questions about the retirement plan

Tatum Municipal Schools

Plan Contact Person:
Christi Mullins
306 West 3rd Street
Tatum, NM 88267
1.575.398.4455

a Combined Benefits Group, Inc *company*

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