
Ambassador
Sanitation Management
Employee
Benefits
Reimagined

Welcome to the Team!

Your 2023-2024 Benefit Options Guide

Enroll Online - It's Easy!

Enroll online through our convenient benefits enrollment portal. Everything you need is at your fingertips. Here you will find complete information about all the plans Ambassador offers, including benefit summaries, plan documents, COBRA, Medicare, Health Insurance Marketplace coverage options and premium assistant programs.

You will need a valid email in order to enroll in benefits. If you don't have a valid email, we will be glad to help set one up for you.

GO TO:

- www.teamambassador.com
- Click on the Benefits Tab
- Login to the Benefits Portal
- Enter your SSN as xxx-xx-xxxx
- Enter your DOB as xx/xx/xxxx
- Enroll or Decline Coverage
- Verify your personal information
- Submit your Enrollment
- Receive your confirmation

Be sure to go through all of the benefit election pages until you reach the Summary Page. Make sure you answer any questions and scroll to the bottom and hit the submit button.

If you submitted everything correctly, you will see a confirmation pop up. You will also receive a confirmation via email. If you do not receive a confirmation, then your elections may not have been submitted properly. At this point you need to contact us at Benefits@teamambassador.com. We will be glad to verify that your benefit elections went through!

Welcome to Ambassador and welcome to the 2023-2024 Benefit Options Guide. Ambassador continues to offer a comprehensive benefits package to support the health and well-being of you and your family by offering several comprehensive health plan options, a way to protect your income while your working, financial security in the event of your disability or death, and help you save for retirement.

NEW HIRE - Your Initial Enrollment Period

If you are a new employee and being offered benefits for the first time, congratulations! You have almost completed your 90 day waiting period and are now eligible to enroll.

- Deadline to Enroll - 25th day of the month
- Effective Date - the 1st day of month following your 90th day.
- You are required to enroll or decline coverage. All employees must login to the benefit enrollment system and either enroll or decline coverage.
- The next opportunity you will have to enroll will be during open enrollment held in November each year unless you have a qualifying event.

OPEN ENROLLMENT PERIOD

Open Enrollment - Following your initial enrollment period, you can only change your benefit elections during Ambassador's annual Open Enrollment held in November each year. Even if you don't want to make changes to your current elections, be sure to login into your account to make sure all of your personal information is up to date and see what's new!

- Open Enrollment Dates
  - Begins: November 1st
  - Ends: November 30th
- Enroll or make changes to your current benefits.
- Update your personal information.
- Make sure your beneficiary information is up to date.
- Your current benefit elections will automatically rollover into the new plan year. If your happy with your current elections, you don't have to do anything.
- Effective Date - the elections or changes you make during Open Enrollment become effective on January 1st.

Eligibility

Eligible Dependents & Coverage Types

Eligible Employees

All employees who meet the following criteria are eligible to participate:

- Full-time employees who have been employed 90 days.
- Part-time employees who have been employed 90 days and average at least 30 hours per week.
- Employees that have had a status change from part-time to full-time.

Eligible Dependents

- Legal Spouse - as a result of a marriage that is valid and recognized in the State in which you live.
- Children up to age 26 including:
  - Natural Child
  - Step Child
  - Legally Adopted Child
  - Child placed with you for adoption
  - Grandchild for whom you have legal custody
- Children over age 26, if disabled and dependent upon you for support.

Types of Coverage

- ***Employee Only*** - Single Coverage for the employee only.
- ***Employee & Spouse*** - Two Party Coverage for employee and spouse - does not include children.
- ***Employee & Child***(ren)- Includes the employee and legally dependent children. Does not include Spouse.
- ***Family*** - Includes a spouse and all legally dependent children.

Dependent (Spouse & Children) Eligibility and Verification Process

The Dependent Eligibility Verification process is completed on all new dependents enrolled in the plans. Employees will receive a letter or email from one of our third party administrators, requesting documentation to show dependents enrolled in a plan meet the dependent eligibility criteria. Examples of documentation include a certified birth certificate or a certified marriage certificate.

All documents are sent to our third party vendors which will verify each dependent. You will have approximately 30 days to respond to this request, so be prepared.

Please watch your mail and email for the appropriate request for documents. Failure to respond and provide requested documentation will result in a loss of coverage for your dependents.

Cigna Medical Plans at a Glance

Description	Cigna Open Access	Cigna H.S.A.
Level of Benefit (Medal Color)	Silver Major Medical Plan	
Network	Cigna Network	
Third Party Administrator	Cigna	
In-Network Deductible (Ind. / Fam.)	$5,000 / $10,000	
Out of Network Deductible (Ind. / Fam.)	$15,000 / $30,000	
Co-Insurance (Plan Pays / You Pay)	70% / 30%	
Annual Maximum	None	
Maximum Out-of-Pocket (Ind./Fam.)	$8,000 / $16,000	
Preventative Care Annual Physicals Well Woman Visits (Pap Smear, Mammogram) Routine Colonoscopies Routine Cancer Screenings New Born & Child Immunizations	Plan Pays 100%	
Physician Visits Primary Care Physician (PCP) Urgent Care / Walk-in Clinics Specialist	Unlimited office visits $50 Co-pay $50 Co-pay 30% after deductible	Unlimited office visits 30% after deductible 30% after deductible 30% after deductible
Emergency Services Emergency Room Ambulance Services	Non-Emergencies Not Covered 30% after deductible 30% after deductible	
Maternity Services	30% after deductible	
Diagnostic Test, Labs, MRI, X-ray	30% after deductible	
Chemo, Radiation & Renal Dialysis	30% after deductible	
Facility Services Inpatient Hospital Services Outpatient Hospital Services Skilled Nursing Facility	Unlimited Visits 30% after deductible 30% after deductible 30% after deductible - 60 days per person per year	
Medical Equipment and Home Health Svcs	30% after deductible - 60 visits per person per year	
Rehab, Physical Therapy Services Outpatient Physical, Occupational, etc.	20 visits per person per year 30% after deductible	
Mental Health & Substance Abuse Services Inpatient Hospital Outpatient Services Office Visits	13 visits per person per year 30% after deductible Plan Pays 100% Plan Pays 100%	
Prescriptions Services - Provider Pharmacy Deductible Annual Pharmacy Maximum Benefit Generics Branded Specialty Mail Order (90 day supply)	Express Scripts Subject to the plan deductible None, Some Maintenance Medications are Free 40% after deductible 40% after deductible 40% after deductible 40% after deductible	
Weekly Premium Employee Only Employee & Spouse Employee & Child(ren) Family	 $ 71.15 $142.30 $128.75 $209.33	 $ 68.57 $144.00 $130.29 $205.72

First Health Medical Plans at a Glance

Blue Ribbon	Basic	Mini Med
Gold Major Medical Plan	Bronze Major Medical Plan	Limited Liability Medical Plan
First Health Network		
Taylor Benefit Resources (TBR)		
$1,750 / $3,500	$3,500 / $10,500	$1,000 / $3,000
$3,500 / $7,000	Not Available	Not Available
75% / 25%	60% / 40%	60% / 40%
None	None	$25,000 Per Person Per Year
$7,500 / $15,000	$10,000 / $20,000	$10,000/ $20,000
Plan Pays 100%		
Unlimited office visits $50.00 copay $75.00 copay $100.00 copay	3 office visits per year $50.00 copay $75.00 copay $100.00 copay	3 office visits per year $50.00 copay $75.00 copay 40% after deductible
Non Emergencies Not Covered 25% after deductible 25% after deductible	Non-Emergencies Not Covered 1 visit per person per year 40% after deductible	
25% after deductible	40% after deductible	Not Covered
25% after deductible	40% after deductible	40% after deductible
25% after deductible	Not Covered	Not Covered
Unlimited Visits 25% after deductible 25% after deductible 25% after deductible	1 visit per person per year 40% after deductible 40% after deductible 40% after deductible	1 visit per person per year 40% after deductible 40% after deductible Not Covered
25% after deductible	Not Covered	Not Covered
30 visits per person per year 25% after deductible	Not Covered	Not Covered
13 visits per person per year 25% after deductible 25% after deductible $75.00 copay	13 office visits per year Not Covered Not Covered $75.00 copay	Not Covered
WelldyneRx None $10,000 annual max on specialty drugs $10 Co-pay 25% after deductible 25% after deductible Free - Plan Pays 100%	WelldyneRx None $5,000 per person per year $10 Co-pay 40% after deductible 40% after deductible Free-Plan Pays 100%	WelldyneRx None $2,500 per person per year $10 Co-pay 40% after deductible Not Covered Free-Plan Pays 100%
$ 64.25 $129.72 $120.74 $167.36	$ 39.13 $ 78.27 $ 74.35 $ 97.83	$ 21.52 $ 43.05 $ 40.89 $ 53.81

Options....*find a plan that is as unique as you!*

Choosing the medical plan that is right for you can be complicated. Knowing just a few things before you compare plans can make it simpler.

The "Medal" Categories: There are 3 categories of health insurance plans: Bronze, Silver and Gold. These categories show how you and your plan share costs. Plan categories have nothing to do with the quality of care.

Your Total Health Care Costs: You will pay a premium through your payroll deductions. Even if you don't use the medical services, you still incur this expense every pay period. Then you pay out-of-pocket costs, including a deductible, when you get care. It's important to think about all the costs when shopping for a plan.

Premium + Deductible + Out-of-Pocket Costs = Total Health Care Costs

Factor in how many times you go to the doctor each year and the total cost of your prescriptions each month. If you don't have any underlying health conditions, or take medications on a routine basis.... you may not need to purchase a Silver or Gold rated plan. The Bronze level plan maybe all you need right now. However, if you are over the age of 50, have a specific underlying medical condition, such as diabetes, or take expensive medications every month, you would want to consider a Silver or Gold rated health plan.

One important thing to know....**all plans cover preventive services at no cost to you**. No matter which plan you choose, you can go for your annual physicals, well-woman visits, including a routine mammogram, routine colonoscopies, routine cancer screenings, and immunizations. Make sure you take advantage of these type of services. They cost you nothing out of pocket!

You can find the complete Summary of Benefits and Official Plan Documents on our website under the Benefits Tab: www.teamambassador.com

Plan Network Types: All the plans that Ambassador offers are PPO's - Preferred Provider Organizations. This means that you can still go to any doctor you choose, but you will save money by using a doctor that is in your network. Check and see if your providers accept Cigna or First Health Network before you choose a plan.

A Limited Liability Medical Plan - The Mini Med

The Limited Liability Plan is a medical plan with much lower and more restricted benefits than a major medical plan with much lower premiums. It offers all the essential coverage that you need in a medical plan such as; doctor's visits, prescriptions, emergency services and hospitalization up to a certain point. Once this plan pays a total benefit costs of $25,000 for the year, you have exhausted all of your annual benefit. This means that you don't have anymore coverage until the next calendar year. It pays 100% of all preventative services, up to 3 office visits per year, emergency room and hospitalization up to $25,000 per year, and $5,000 in prescriptions a year. If you are healthy with no underlying medical condition, and don't take expensive medications on a monthly basis, this may be a good plan for you and your family. But note, this is a short term plan and not designed to cover a catastrophic event such as a heart attack, cancer, or a major accident that would require surgery or rehabilitation.

The Basic Medical Plan

The Basic Medical Plan offers similar coverage to the Mini Med, but it is considered a major medical plan and does not have an annual coverage limit for essential health care services. The Basic Plan covers 100% of all preventative services, up to 3 office visits per year, emergency services, hospitalization with no annual limit, and up to $5,000 in covered prescriptions per year. However, this plan does not cover some catastrophic events such as cancer, rehabilitation, physical therapy, or substance abuse services. The coverage level is in the name: **BASIC**. This is a great basic medical plan. It's everything you need and nothing that you don't.

The Blue Ribbon Medical Plan

The Blue Ribbon Medical Plan is an A-Rated Gold Level major medical plan offering comprehensive, robust health coverage. It pays 100% of all preventative services and 75% of all other heath services. There are no restrictive limits inside the Plan. However, there is a $10,000 pharmacy limit on Specialty medications. This plan also comes with a Platinum Level price as it is the most expensive plan that Ambassador offers. If you have an underlying medical condition, or if you know you will have major medical expenses coming up, then this is the plan for you. You will sleep better at night knowing you are covered from A-Z!

Cigna - Open Access Co-Pay Plan

The Cigna Open Access Plan makes it easy to get quality, in-network care with access to a large, national network of providers. Plus, you have the option to choose a primary care provider to coordinate your care and you don't need specialist referrals. This plan pays 100% of all preventive services, $50 copay to see your primary care provider and 75% of all other heath care services. The plan pays for 60% of all covered medications and 100% of some monthly maintenance medications. The Cigna plans also come with features such as access to virtual care, telemedicine, 24/7 online pharmacy, and managed care programs. Track your claims and locate providers online at www.mycigna.com.

Cigna - Health Savings Account (H.S.A.)

An H.S.A. is offered with a Qualified High Deductible Health Plan (HDHP). In addition to your premium, you can make tax free contributions into your health savings account that can be used to pay out of pocket medical expenses and premiums in the future. You can set your own qualified savings account up or use one offered through Ambassador. This plan pays 70% of all heath care cost after you meet your deductible. While this plan is a great way to save for future medical expenses it is important to note that other than preventative services, ***this plan does not pay for any health care expenses until you meet your deductible***. This plan will replace the current Ambassador H.S.A. through TBR.

Check Your Networks & List of Covered Prescriptions

Before you choose a plan, go online and make sure your doctor and current medications are covered. Once you make your election, you cannot change it until the next Open Enrollment.

www.firsthealth.com for the Mini Med, Basic & Blue Ribbon Plans	**www.mycigna.com for the Cigna Open Access & Cigna H.S.A. Plans**

Ambassador Voluntary Benefits

Dental - Low Plan Sun Life Dental Access to Nationwide dental network. Go to any dentist you choose, however by using an in-network provider, you will receive significant discounts on all services. www.sunlife.com/sunlifedental-network ***Dental premium deductions will vary based on your assignment and pay cycle.***	Annual Deductible	$50 Per Person
	Annual Max Benefit	$1,000 Per Person
	Preventive Care Routine Oral Exams 2 cleanings Per Year X-rays 1 Bitewing Series Per Year 1 Full Mount X-ray Per Year	 Plan Pays 100% Up to $1,000 Maximum Benefit Per Person Per Year
	Basic Dental Care Fillings Oral Surgery Extractions Repair Bridges & Dentures	Deductible then the Plan pays 80% Up to $1,000 Maximum Benefit Per Person Per Year
	Major Dental Care Diagnostic Services Exams & X-rays Root Canals, Crowns Bridges & Dentures	12 Month Waiting Period Deductible then the Plan pays 50% up to the Maximum Benefit Per Person Per Year
	Level of Benefit Employee Only Employee & Spouse Employee & Children Family	**Weekly Premium** $ 8.77 $ 17.31 $ 16.15 $ 21.92
Dental - High Plan ***Dental premium deductions will vary based on your assignment and pay cycle.***	Includes all the services above with the addition of Orthodontics. $2,000 Annual Benefit $2,000 Lifetime Orthodontic Benefit Per Person Covers Children and Adults	
	Level of Benefit Employee Only Employee & Spouse Employee & Children Family	**Weekly Premium** $ 12.69 $ 24.23 $ 21.92 $ 30.00
Vision Plan **Vision Service Plan (VSP)** **www.vsp.com**	Annual Deductible	$10 for Exams & Lenses
	Annual Maximum Benefit	None
	Preventative Annual Eye Exam Retinal Screening	 Plan Pays 100% Plan Pays 100%
	Lenses & Frames Single, Bifocal & Trifocal Lenses Frames	 $25 copay $150 Allowance & 20% over Allow

Ambassador Voluntary Benefits

Vision Continued....

Vision premium deductions may vary based on your assignment and pay cycle.

Contact Lenses	
Fitting & Follow up	$65 Co-pay
Contacts - Elective	$165 Annual Allowance
Contacts - Medically Needed	$165 Annual Allowance

Level of Benefit	Weekly Premium
Employee Only	$ 2.08
Employee & Spouse	$ 4.15
Employee & Children	$ 3.46
Family	$ 5.77

Accident Plan
Sun Life

Accident premium deductions may vary based on your assignment and pay cycle

On or Off the Job accident coverage
Benefits paid directly to the employee
Used to off-set out of pocket expenses that medical does not cover such as travel costs for services and time missed from work.
Includes accidental death and dismemberment coverage

Level of Benefit	Weekly Premium
Employee Only	$ 5.97
Employee & Spouse	$ 9.45
Employee & Children	$10.37
Family	$13.86

Cancer & Critical Illness Plan
Sun Life

Premium deductions may vary based on your assignment and pay cycle.

Benefits are paid directly to the employee
Includes lump sum payment for initial diagnosis.
Covers cancer, heart attack, stroke, aneurysm, coma, coronary bypass, blindness, kidney failure and organ transplant.

Maximum Annual Benefits:	
Employee	$20,000
Spouse	$10,000
Child	$ 5,000

Premium is Based on Employee's Age
Weekly Rates

Age	EE	EE& Spouse	EE & Child	Family
0-29	3.05	4.06	3.55	4.57
30-34	4.71	6.28	8.23	7.06
35-39	6.09	8.12	7.11	9.14
40-44	9.55	12.74	11.15	14.33
45-49	10.38	13.85	12.12	15.58
50-54	23.95	31.94	27.95	35.93
55-59	32.54	43.38	37.96	48.81
60-64	45.83	61.11	53.47	68.75
65-69	66.18	88.25	77.22	99.28
70+	87.92	117.23	102.58	131.88

Ambassador Voluntary Benefits

Group Life Plans
Sun Life

Guarantee issue up to $200,000 for Employee Coverage
Up to $50,000 for Spouse Coverage
$10,000 for Child Coverage
Portable/convertible to individual policy
Accelerated Death Benefit
Waiver of Premium
Five Year Age Banded Rates

Premium deductions may vary depending on your assignment and pay cycle.

Employee Life
Weekly Rates

Age	$10,000	$25,000	$50,000	$100,000	$150,000	$200,000
18-29	.35	.87	1.73	3.46	5.19	6.92
30-34	.39	.98	1.96	3.92	5.88	7.85
35-39	.48	1.21	2.42	4.85	7.27	9.69
40-44	.60	1.50	3.00	6.00	9.00	12.00
45-49	.72	1.79	3.58	7.15	10.73	14.31
50-54	1.18	2.94	5.88	11.77	17.65	23.54
55-59	1.68	4.21	8.42	16.85	25.27	33.69
60-64	2.49	6.23	12.46	24.92	37.38	49.85
65-69	4.13	10.33	20.65	41.31	61.96	82.62
70+	7.22	18.06	36.12	72.23	108.35	144.46

Spouse Life
Weekly Rates

Age	$10,000	$25,000	$50,000
18-29	.35	.87	1.73
30-34	.39	.98	1.96
35-39	.48	1.21	2.42
40-44	.60	1.50	3.00
45-49	.72	1.79	3.58
50-54	1.18	2.94	5.88
55-59	1.68	4.21	8.42
60-64	2.49	6.23	12.46
65-69	4.13	10.33	20.65
70+	7.22	18.06	36.12

Child Life
Weekly Rate

Ages 6 Months - 26 Years $10,000 in Coverage	$1.00 Per Week Per Covered Child

Ambassador Voluntary Benefits

Short Term Disability Salary Continuation Benefit

Ambassador offers salary continuation to all eligible employees working at least 30 hours per week. This coverage is a program and is NOT an insurance plan. You pay $7.95 per week to participate.

If you become sick and unable to work due to a medical condition, with an illness that causes you to miss work for more than 2 weeks, then the company will pay you 60% of your weekly salary, up to a max benefit of $675 per week, for up to 12 weeks.

- Covers off the job illness and accidents.
- Pays 60% of Salary up to a max benefit of $2,500 per mo. for 3 months
- Pre-existing conditions apply
- Physician Statement required.
- 14 day elimination period.
- Waiver of Premium.

$6.95 Per Week - Regardless of Your Age

Pre-Existing Conditions

Pre-existing conditions apply. This means that if you were diagnosed with an Illness, planned procedure or pregnancy with-in 12 months of the effective date of coverage, benefits may not be payable.

COVID-19 Clause

The two week elimination period is waived if you are out of work due to testing positive with COVID-19 or out of work to care for a family member that has tested positive. You may also be eligible for benefits if you are required by your employer to quarantine due to direct COVID-19 exposure in the work place, or to care for a minor child under the age of 12 who is out of school due to quarantine or school closure.

401(k) Retirement Plan Transamerica

Begin your journey and enroll. The first step in your journey to retirement is enrolling in your employer-sponsored retirement savings plan. Simply request a 401(k) enrollment kit.

You can manage your investments and account online by visiting www.TA-Retirement.com.

The website provides up to date information, helpful tips, and interactive tools to help you discover, build and manage your account, including a complete set of investment fact sheets.

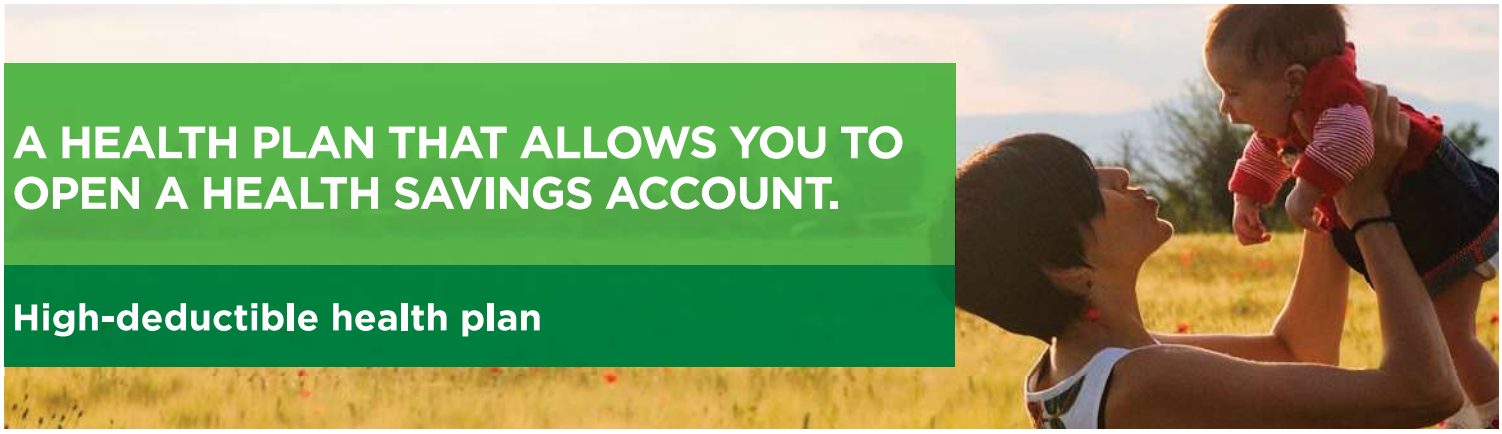
- Employees are eligible to enroll after you have completed 12 months of continuous service.
- Rollover's - You can rollover your 401(k) balance from your previous employer
- Contribute a certain percent % each pay period or a flat amount
- 24-7 online access to manage your account and investments
- No service fee or account fee
- Employee Contributions are vested immediately
- Employer Match - 50% of the first 6%.
- You must request and submit a paper application

Contribution Limits

Under Age 55	Contribute up to $20,500 per year
Over Age 55	Contribute up to $27,000 per year

To Request an Application

To see if you are eligible to participate or to request an application please contact: ***Benefits@teamambassador.com.*** Upon request, a 401(k) enrollment and investment kit will be mailed or emailed to you. Instructions on how to complete the application and where to send your enrollment form is included in the Enrollment Kit.



A HEALTH PLAN THAT ALLOWS YOU TO OPEN A HEALTH SAVINGS ACCOUNT.

High-deductible health plan

Your employer offers a high-deductible health plan (HDHP) through Cigna that allows you eligibility to open a health savings account (HSA) with a financial institution.[1]

The HSA lets you save and accumulate money and use the savings to pay for qualified medical expenses now or in the future. If you change health plans or employers, that money goes with you.

Features of the HDHP

- Preventive care covered at 100% when you visit a network health care provider.[2] Not all plans cover out-of-network preventive care so check your plan materials for details
- Pay coinsurance/copay for all other covered services after you meet the self-only or family deductible
- Pay deductible and coinsurance/copay using your personal funds or from your HSA
- Out-of-pocket (OOP) expenses are limited to a maximum amount, which is outlined in your plan's benefit summary

Features of an HSA

- You and your employer can contribute tax-free money to your account[3]
- Savings can be used, tax free, to pay for qualified medical expenses, as identified by the IRS. Use of the savings toward other expenditures will result in penalties and/or taxes
- Your HSA administrator may offer investment options to help your account grow
- You may continue to deposit money in the HSA as long as you remain HSA eligible
- There's no "use it or lose it" rule – the money you save and earnings on your investments are yours to keep, and they remain in the account year to year

How your HDHP works

With an HDHP through Cigna, you can visit the doctor or hospital that's right for you.[4] And you don't need a referral to see a specialist. However, you'll pay less when you go to an in-network provider.

Q. What is a qualified HDHP?

A. A qualified HDHP has an annual network deductible of at least:

	2021	2022
Self-only	$1,400	$1,400
Family	$2,800	$2,800

The annual network OOP expenses can't exceed:

OOP maximums

	2021	2022
Self-only	$7,000	$7,050
Family	$14,000	$14,100

OOP maximums must include deductibles, coinsurance/copays and other amounts you may pay for covered benefits, but don't include premiums/plan contributions. Preventive care is covered at 100% when you visit an in-network provider.[2]

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

827103 n Facets 06/21

Q. How are medical claims paid?

A. When you receive health care services, your provider submits a claim to Cigna. After we process the claim, the provider sends you a bill for the remaining amount. You can use your HSA funds to pay for the expenses, or you can pay the bill using personal funds and let the HSA grow.

Q. How do I pay for prescriptions?

A. It's simple; when you pick up your prescription from the pharmacy, you can pay using your HSA checks or debit card. At most network pharmacies, you'll pay the discounted cost of the drug, subject to your medical deductible. Your pharmacy will advise you on what you will need to pay.

Q. What if my provider wants me to pay at the time of service?

A. Ask your provider to first submit the claim to Cigna to ensure proper discounts are applied. If you must pay at the time of service, you can pay using HSA funds and then submit a claim to Cigna. If you happen to overpay, your provider will reimburse you. You must deposit any reimbursed money back into your HSA, otherwise you're subject to penalties and/or income taxes.

Q. How do I manage my health plan?

A. At **myCigna.com**, you'll find all the tools and resources you need to manage your plan. You can:

- Find an in-network provider
- View claims status
- Research online health and wellness information
- Compare hospital quality information and use the prescription drug price comparison tool
- Check costs for various treatments and procedures

How an HSA works

With an HSA, you contribute tax-free money to an account.[3] You can start using the money right away to pay for current qualified expenses or let the account grow over time to help cover future expenses.

Q. What can I use my HSA funds for?

A. You can use your HSA funds for qualified medical expenses, as determined by the IRS, that aren't covered by your health plan. Some examples include:

- Deductibles and coinsurance for medical and dental care
- Prescriptions
- Vision care, including eyeglasses and LASIK eye surgery
- Smoking cessation treatment and prescriptions
- Some insurance premiums, such as for long-term car COBRA and health care coverage premiums while yo receive unemployment compensation

Q. How do I pay for qualified medical expenses?

A. Contact your HSA administrator about how funds can be withdrawn to pay for certain medical expenses. Generally, a debit card and/or checkbook will be available.

Q. What if I change health plans?

A. All the money in your HSA is yours to keep. If you are no longer enrolled in a qualified HDHP you will not be able to make any more contributions to the account, but can use the money that has accumulated to pay for medical expenses. If you enrolled in an HSA midyear, and contributed the maximum annual amount, you may be subject to additional taxes and penalties if you don't maintain your HSA eligibility through the following tax year.

Components of coverage

HDHP

- Lower premiums/plan contributions compared with traditional health plans
- Coverage for preventive care[2]
- Choice of a doctor or hospital within your Cigna network[4]

HSA[5]

- Tax-deductible deposits and tax free growth[3]
- Use savings to pay for qualified medical expenses, tax free[3]
- Money is yours to keep, even if you switch employers or health plans
- Investment options (if offered by your HSA administrator)
- Withdrawals after age 65 without penalty (taxes will apply)

Q. Am I eligible to open and contribute to an HSA?

A. Yes, as long as you:

- Are enrolled in a qualified HDHP
- Are not covered by any other medical plan, except what is permitted by the IRS – examples of permitted coverage include dental, vision and long-term care
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on another individual's tax return
- Are not enrolled in a general-purpose health flexible spending account (FSA) (and neither is your spouse)

Q. How much can I contribute?

A. Your total annual contribution, plus contributions from any other sources, including any employer contributions, can't exceed:

	2021	2022
Self-only	$3,600	$3,650
Family	$7,200	$7,300

If you're age 55 or older, you can make an additional catch-up contribution of up to $1,000. If you enroll in an HSA midyear, you can contribute the maximum annual amount; however, you may be subject to additional taxes and penalties if you don't maintain HSA eligibility through the following tax year.

Q. When can I make contributions?

A. Contact your HSA administrator for the options available to you. Typically, contributions may be made any time of the year in one lump sum or in payments throughout the year. If you do make your contribution in one lump sum and are no longer enrolled in an HDHP, you need to withdraw any excess to avoid penalties.

Q. What if I exceed the maximum contribution amount?

A. Excess contributions are subject to income taxes and an additional penalty tax. Regardless of the contribution source, you're responsible for making sure you don't exceed the maximum amount allowed by the IRS.

Q. Are rollover contributions allowed?

A. Yes, in some cases. Rollover contributions from medical savings accounts and other HSAs are allowed and don't count toward the yearly maximum contribution. Rollovers from an IRA, a health reimbursement account (HRA) or a health FSA may be permitted in certain circumstances. Check with your HSA administrator on options available.

Q. Can my employer contribute to my HSA? If so, how much?

A. Yes – that's what's great about an HSA. Typically, at open enrollment your employer will let you know if and how much they'll contribute. You can then decide how much you want to contribute, as long as you don't exceed the maximum amount allowed by the IRS. What your employer contributes will be reported on your W-2 form, but it's not considered taxable income.[3]

Q. What happens to my HSA when I die? Does my employer keep the funds?

A. No, your employer doesn't keep the funds. The HSA will automatically transfer to the beneficiary you elect. If that person is your surviving spouse, they will not be subject to applicable taxes. If the HSA is transferred to a designated beneficiary other than your spouse, the funds are considered taxable income.

See irs.gov, IRS Publications 502 and 969, for additional information about qualified medical expense and helpful information about HSAs.

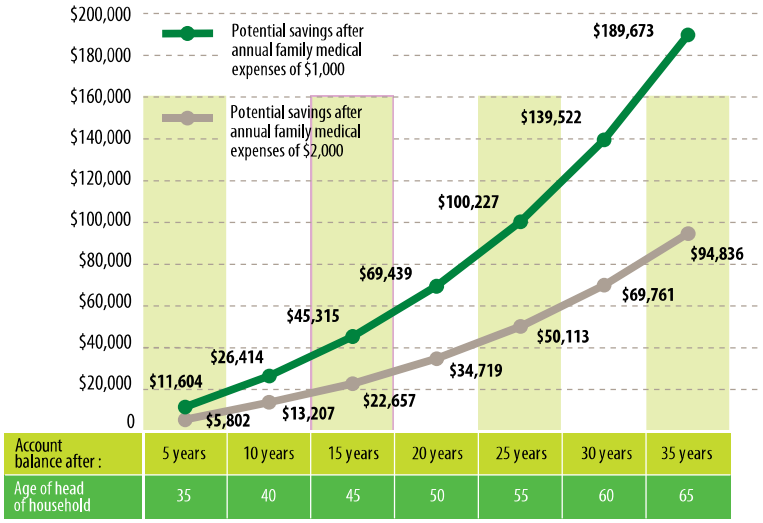
Consider the savings of an HSA

An HSA lets you take advantage of tax savings, helps you build a cash reserve for medical expenses and allows you to take an active role in your health care decisions. The more involved you are, the more dollars remain in your HSA.

With an HSA comes the opportunity to build savings over time, tax free.[3] The following example illustrates how a family eventually can save more than $189,000.

This example assumes:

- An HSA for family coverage
- Head of household begins contributing at age 30
- A $3,000 annual deductible
- A $3,000 annual contribution
- A 5% rate of return



Over 35 years, a family with average annual medical expenses of $1,000 can potentially save up to $189,673. For illustrative purposes only. Individual results will vary and are not guaranteed.

To get started with an HSA, follow these simple steps

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
Enroll in a qualified HDHP	**Establish your HSA**	**Contribute to your HSA**	**Start paying for qualified expenses**	**Watch your account grow**
First, complete the medical enrollment form, online or on paper, for the HDHP through Cigna (this is a qualified HDHP that makes you eligible to open an HSA).	If your employer hasn't arranged for an HSA administrator, you can open an account with any HSA administrator of your choice.	Money can be contributed through payroll deductions (if available through your employer) or by sending deposits directly to your HSA administrator.	Pay for expenses using your HSA funds (payment options will vary by HSA administrator) or pay using your personal funds and let your HSA funds grow!	Your account earns interest and you may have investment options available through your HSA administrator.[6]

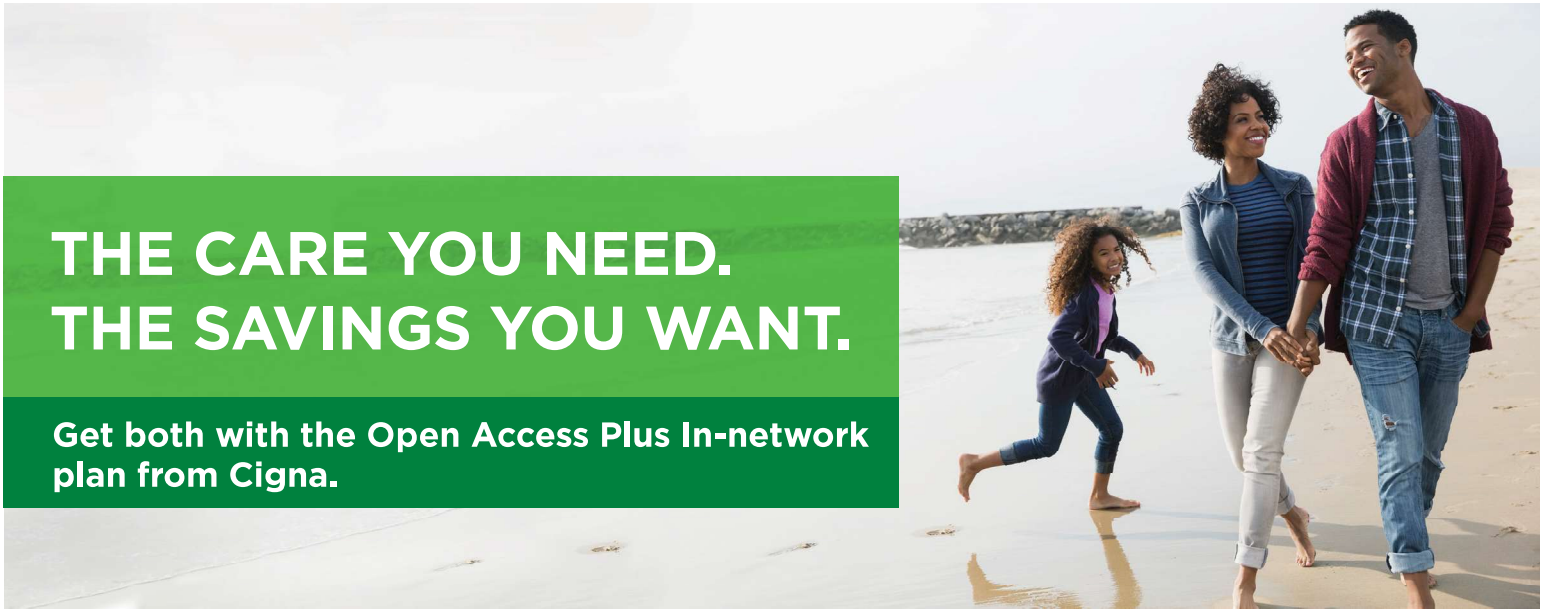
Contact your HSA administrator for specific rules regarding establishment of your HSA.

Visit Cigna.com/expenses for a full list of eligible expenses.

Our Customer Service Advocates are available 24/7/365. Call 866.494.2111 or the number on the back of your ID card.

1. A financial institution that you choose must be a qualified HSA trustee or custodian.
2. Not all preventive care services are covered. For example, immunizations for travel are generally not covered. Review your plan materials for more information, including a list of covered and non-covered services.
3. HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. A few states do not allow pretax treatment of contributions or earnings. Contact your personal tax advisor for details.
4. Some plans may not include coverage outside of the plan network. Review your plan documents for details.
5. Either your employer may arrange an HSA administrator or you may open an account with an HSA administrator of your choice. The HSA provider and/or trustee/custodian is responsible for its HSA services, transactions and related activities. Cigna and your employer are not responsible for HSA services, administration or operation.
6. Investments are subject to market fluctuation, investment risk, and possible loss of principal. You are encouraged to discuss these strategies with a professional financial planner and tax advisor.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.



THE CARE YOU NEED. THE SAVINGS YOU WANT.

Get both with the Open Access Plus In-network plan from Cigna.

Offering flexible access to thousands of providers – plus programs and services to support your whole health needs – the Open Access Plus In-network (OAPIN) plan is designed to make it easier for you to get the quality care you need and the savings you want.

Here's how it works.

- **In-network coverage**
  When you visit a health care provider who is in the Cigna OAPIN network, you receive in-network coverage and will have lower out-of-pocket costs. That's because our in-network health care providers have agreed to charge lower fees, and your plan will pay for covered services. If you choose to visit a provider outside of the network, you will not have coverage under your plan, except in emergencies.
- **No-referral specialist care**
  A primary care provider (PCP) is recommended, but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network provider. If you choose to visit a provider outside of the network, you will not have coverage under your plan.
- **Care coordination**
  Our robust medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.
- **Hospital stays**
  In an emergency, you have coverage. However, requests for nonemergency hospital stays (other than maternity stays) and some types of outpatient care must have prior authorization or be preauthorized. This lets Cigna determine if the services are covered by your plan. Your Cigna OAPIN network provider will arrange for prior authorization.
- **Out-of-pocket costs**
  Depending on your plan, you may have to pay an annual amount (deductible) before your plan begins to pay for covered health care costs. You may also need to pay a copay and/or coinsurance (a portion of the covered charge) for covered services. Then, your plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100% for the rest of your plan year.

  If you receive out-of-network care, out-of-network providers and facilities will bill you directly. Those additional costs do not contribute to your deductible or out-of-pocket limits (except for emergency care).

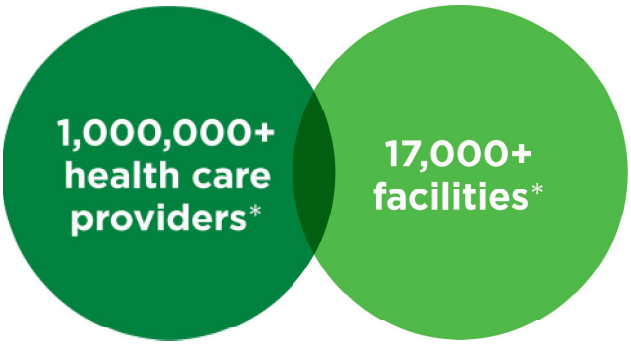
Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company.

939713 a 01/21

Where you live, work or travel



Added convenience and support

- **Virtual Care**
  Connect 24/7 with board-certified providers and pediatricians for minor medical conditions. You can also schedule online appointments for licensed counselors or psychiatrists for behavioral or mental health conditions. You and your covered family members can get care from anywhere via video or phone.**
- **Cigna Health Information Line**
  With the Cigna Health Information Line, clinicians are just a phone call away – 24/7, and at no extra cost. They can help you understand health issues you might be experiencing, and help you to make informed decisions – whether it's reviewing home treatment options, following up on a provider's appointment, or choosing and finding the right care in the right setting.
- **Live, 24/7/365 customer service**
  Customer service representatives are here for you where and when you need us – over the phone, via chat at **myCigna.com** or on the myCigna® App.

On **myCigna.com** and the myCigna App, you have easy access to personalized tools to help you take control of your health and your health care spending. From your computer or mobile device, you can:

- Manage and track claims
- See cost estimates for medical procedures
- Compare quality information for providers and hospitals
- Track your account balances and deductibles
- Use the easy health and wellness tools
- Print a temporary ID card

Want to check if your provider is in the Cigna OAPIN network before you enroll?

Just go to Cigna.com and click on "Find a Provider, Dentist or Facility" and then click on "Plans through your employer or school" to search the provider directory.

Cigna®

* Based on Cigna internal provider data for OAPIN service area as of 2/2020. Subject to change.

** Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents.

YOUR PHARMACY BENEFITS

Get the most from your plan's coverage

Your pharmacy benefits provide you with access to many Cigna programs and services that can help you manage your health and prescription medication needs.

- **One ID card for both your pharmacy and medical needs**
- 24/7 live, personalized customer support
- Easy access to medications
- One customer-focused team – medical, behavioral and pharmacy – working together to keep you healthy
- One-on-one guidance to help you choose – and use – your health care wisely

Your drug list.

The Cigna Prescription Drug List is a list of generic and brand name prescription medications your plan covers. All medications on the drug list are approved by the U.S. Food and Drug Administration (FDA). Log in to the **myCigna**® app or website, or check your plan materials, to learn more about the medications your specific plan covers.

Some medications on your drug list have extra requirements before your plan will cover them.[1] This helps to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation.

- **Prior Authorization**
  Certain medications need approval from Cigna before your plan will cover them. These medications have a **(PA)** next to them on your drug list.
- **Quantity Limits**
  For some medications, your plan only covers up to a certain amount over a certain length of time. For example, 30 mg a day for 30 days. These medications have a **(QL)** next to them on your drug list.
- **Step Therapy**
  Certain high-cost medications are part of the Step Therapy program. These medications have a **(ST)** next to them on your drug list. Step Therapy encourages the use of lower-cost medications (typically generics and preferred brands) that can be used to treat the same condition. These conditions include, but are not limited to, depression, high blood pressure, high cholesterol, skin conditions and sleep disorders. Your plan doesn't cover the higher-cost Step Therapy medication until you try one or more alternatives first (unless you receive approval from Cigna).

The Cigna 90 Now program makes it easier to fill the medications you take every day.

Your plan includes a program called Cigna 90 Now℠. Cigna 90 Now makes it easier for you to fill your maintenance medications. These are the medications you take every day to treat an ongoing health condition like diabetes, high blood pressure, high cholesterol or asthma. Here's how the Cigna 90 Now program works.

- **If you choose to fill a 30-day supply,** you can use any retail pharmacy in your plan's network. You have the option of switching to a 90-day supply at any time.
- **If you choose to fill a 90-day supply,**[2] you can use select in-network retail pharmacies that are approved to fill 90-day prescriptions. You can also use home delivery (if your plan allows).[3]

Together, all the way.®

Cigna®

835912 h 11/19

Your pharmacy network.

There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. And some stores are open 24-hours.

- All retail pharmacies in your plan's network can fill 30-day prescriptions, and select pharmacies can fill 90-day prescriptions.
- Go to **Cigna.com/Rx90network**, or log in to the **myCigna** app or website, to find an in-network retail pharmacy near you.
- You can also use home delivery, if your plan allows.[3]

Cigna's pharmacists can help you stay on track with your medications.

Taking your medication regularly is important to your overall health. If you stop taking it or skip a dose, you may have side effects or other health issues. Our pharmacists are here to answer any questions you have. They offer confidential support and will talk with you about prescription medication interactions and side effects. They can also help you find ways to lower your medication costs. To talk with a pharmacist, call **800.835.8981**. They're available Monday-Friday, 7:00 am-7:00 pm CST.

Choose home delivery. Get medications delivered to your door, and more.

If you take a medication every day to treat an ongoing health condition like diabetes, high blood pressure, high cholesterol or asthma, home delivery may be a convenient option for you.[3] They offer:

- **Convenience.** Get free standard delivery to your home or work address within the United States.
- **Easy refills.** Fill up to a 90-day supply of your medication at one time, so you fill less often.
- **Free refill reminders.** Get refill reminders to help make sure you don't miss a dose.
- **Easy order tracking.** Track your orders and request refills using the myCigna app or website.
- **24/7 access to licensed pharmacists.** Talk with a pharmacist anytime, day or night.

For more information or to get started using home delivery, call **800.835.3784**.

Accredo can help you manage your complex medical condition.

Managing a complex medical condition like Hepatitis C, Multiple Sclerosis and Rheumatoid Arthritis isn't easy. As part of your Cigna-administered pharmacy benefits, you have access to Accredo, a Cigna specialty pharmacy.[3] Accredo's team of specialty-trained pharmacists and nurses will provide you with the personalized care and support you need to manage your complex medical condition. They'll help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

Services included at no extra cost:

- 24/7 access to hundreds of specialty-trained pharmacists and nurses experienced in complex conditions that require specialty medications.
- Access to a wide-range of personalized care services. This includes counseling and training on how to administer your medication.
- Refill your prescriptions by text.[4]
- Get your medication delivered to your home (or location of your choice).[5]
- Get real-time updates once they ship your order.
- A dedicated team that coordinates copay assistance and other options if you need help paying for your medication.

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm and Saturdays, 7:00 am–4:00 pm CST. **Please be sure to call Accredo about two weeks before your next refill so they have time to get a new prescription from your doctor's office.** You can also talk with a pharmacist at any time, 24/7. To learn more about Accredo, you can go to **Cigna.com/specialty**.

Use the myCigna app or website.

24/7 access to all you need to know about your plan's coverage.

- Find out how much your medication costs, and view lower-cost alternatives (if available)[6]
- See which medications your plan covers
- Find an in-network pharmacy
- See your pharmacy claims and coverage details
- Manage your home delivery prescription orders.[3]

FAQs

Q Why do certain medications need approval before my plan will cover them?

A The review process helps to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q How do I know if I'm taking a medication that needs approval?

A Log in to the **myCigna** app or website, or check your plan materials, to learn more about how your plan covers your medications. If your medication has a (PA) or (ST) next to it, your medication needs approval before your plan will cover it. If it has a (QL) next to it, you may need approval depending on the amount you're filling.

Q How do I get approval for my medication?

A Ask your doctor's office to contact Cigna so we can start the coverage review process. They know how the review process works and will take care of everything for you.

Q What happens if I try to fill a prescription that needs approval – but I don't get approval ahead of time?

A When your pharmacist tries to fill your prescription, he or she will see that the medication needs prior approval. Because you didn't get approval ahead of time, your pharmacist won't be able to fill it.

Q What happens if I try to fill a prescription that has a quantity limit?

A Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office will need to contact Cigna to request approval for coverage.

Q My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?

A To receive in-network coverage under your plan, you'll need to switch to a pharmacy in your plan's network. If your plan offers out-of-network coverage, you'll pay out-of-network costs to fill a prescription there.

Q Can I fill a 90-day prescription at any pharmacy in my plan's network?

A No – you can only fill 90-day prescriptions at select pharmacies in your plan's network. Go to **Cigna.com/Rx90network**, or log in to the **myCigna** app or website, to find a pharmacy in your plan's network that's approved to fill 90-day prescriptions.

Q What kinds of medications are best filled in a 90-day supply?

A Maintenance medications. These are the medications you take every day to treat an ongoing health condition like diabetes, high blood pressure, high cholesterol or asthma.

Q Do I need my doctor's approval to switch to a 90-day prescription?

A Yes – you'll need to get a new prescription from your doctor's office for a 90-day supply.

Q Why should I consider filling a 90-day supply?

A A 90-day supply helps make life easier. You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, you're less likely to miss a dose.[7]

Q Will I save money if I fill my medication in a 90-day supply?

A It depends on your plan and the medication you're taking. Log in to the **myCigna** app or website and click on "Price a Medication" to see how much a 90-day supply will cost you.[6]

Q What do I have to do to use home delivery?

A Call your doctor's office and ask for a 90-day prescription. Then, send it to our home delivery pharmacy. Here are two ways to do this:

1. **Electronically:** For fastest service, ask your doctor's office to send your prescription electronically. Then call **800.835.3784** with your Cigna ID number and shipping and billing information.
2. **By phone:** Call **800.835.3784**. Have your medication name, doctor's name and payment information ready. Our home delivery pharmacy will contact your doctor's office to get a new prescription.

Q Is there an extra cost to use home delivery?

A No – it's part of your plan's pharmacy benefits. And there's also no extra cost for standard delivery.

Q Can I have my maintenance medications delivered to me overnight?

A Yes. There's an extra cost to overnight or rush delivery of your order, but standard shipping is always free. Also, your order won't be processed any faster. Overnight service only gets your order delivered to you faster.

FAQs

Q How can I place an order for specialty medications?

A Here are three easy ways to place an order:

1. Log in to **myCigna** and click on the Prescriptions tab, then select "Manage Prescriptions." We'll automatically connect you to your Accredo online account.
2. Call Accredo at **877.826.7657**, Monday–Friday 7:00 am–10:00 pm and on Saturdays, 7:00 am–4:00 pm CST.
3. Go to **Accredo.com** and log in to your online account.

Call us 24/7

- CUSTOMER SERVICE: **Call the number on your Cigna ID card**
- HOME DELIVERY: **800.835.3784**
- ACCREDO: **877.826.7657**

Cigna®

1. These coverage requirements may not apply to your specific plan. Some plans don't have prior authorization, quantity limits or Step Therapy. Log in to the myCigna app or website, or check your plan materials, to find out if your plan includes these specific coverage requirements.
2. Certain medications may only be packaged in less than a 90-day supply. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
3. Not all plans offer home delivery and Accredo as a covered pharmacy option. Please log in to the myCigna app or website, or check your plan materials, to learn more about the pharmacies in your plan's network.
4. The ability to refill prescriptions by text is only available for certain medications. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, simply reply to their welcome text to get started. Standard text messaging rates apply.
5. As allowable by law.
6. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
7. Internal Cigna analysis performed Jan 2019, utilizing 2018 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

Voluntary Short Term Disability

Anyone who needs a paycheck needs to protect it.

A paycheck is a terrible thing to lose. Virtually everyone needs one every month to pay for things like food, shelter, health care, transportation—necessities of life. No paycheck, and suddenly the cash flow reverses, from feeding the nest egg to draining it to pay for ordinary (and sometimes extraordinary) expenses. Ambassador offers salary continuation benefits to all full-time employees working at least 30 hours per week or more. STD covers the first 60% of your paycheck up to a maximum benefit of $2,500 per month.

Voluntary Group Disability Insurance

- Employees that work at least 30 hours per week are eligible to purchase short term disability.
- Covers 60% of your base salary up to a maximum benefits of $2,500 per month
- 7-Day elimination period
- Payable for up to 13 weeks
- Maternity covered as an illness
- COVID is considered a covered illness . The 7 day elimination period is waived if you are out of work due to testing positive with COVID or out of work to care for a family member that has tested positive. You may also be eligible for benefits if you are required by your employer to quarantine due to direct COVID exposure in the work place, or to care for a minor child under the age of 12 who is out of school due to quarantine or school closure.
- You are required to exhaust any accrued PTO, vacation time or accumulated sick leave before benefits are payable.
- Pre-existing conditions apply. This means that if you were diagnosed with an illness, planned medical procedure or pregnancy with-in 12 months of the effective date, benefits may not be payable.
- You are responsible for notifying the Benefits Department to apply for benefits when you are out due to an illness. The Benefits Department will not automatically be notified when you are out of work on LOA/FMLA.

Contact Information

Questions Regarding:	Plan ID	Point of Contact	Phone	Email
401(k) Enrollment & Information	Plan ID 932107-0000	Kelly Cone-Martinez	229-226-2909 Ext 114	Kelly.Cone@teamambassador.com
401K Investment & Account Mgt	Plan ID 932107-0000	TransAmerica	800-401-8726	www.TA.Retirement.com
Accident Claims	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Benefit Consulting		Ron Arline	229-228-4903	ron@madisonstreetagency.net
Cancelation of Coverage		Carol Dixon	229-977-2468	Benefits@teamambassador.com
Cancer & Crittical Illness Claims	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Certificate of Coverage				
Cigna	Group 634436	Cigna	866-494-2111	www.mycigna.com
Taylor Benefit Resources (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Claims Status				
Cigna	Group No. 0634436	Cigna	866-494-2111	www.mycigna.com
Taylor Benefit Resources (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Dental & Vision	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
COBRA				
Cigna	Group No. 0634436	Carol Dixon	229-977-2468	Benefits@teamambassador.com
Taylor Benefit Resources (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Dental & Vision	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Coverage Questions				
First Health Plans (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Cigna	Group No. 0634436	Cigna	866-494-2111	www.mycigna.com
All Sun Life Products	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Coverage Verification				
First Health Plans (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Cigna	Group No. 0634436	Cigna	866-494-2111	www.mycigna.com
Dental & Vision	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Enroll or Decline Coverage		Carol Dixon	229-977-2468	Benefits@teamambassador.com
Insurance Cards				
First Health Plans (TBR)	Group No. 1004	TBR	229-225-9943	info@tbrtpa.com
Cigna	Group No. 0634436	Cigna	866-494-2111	www.mycigna.com
Dental & Vision	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
Insurance Consulting		Ron Arline	229-228-4903	ron@madisonstreetagency.net
Life Insurance Claims	Policy No. 956084	Sun Life	800-247-6875	sunlife.com/us
List of Covered Medications				
First Health Plans (TBR)	Group No. 1004	WelldyneRX	888-479-2000	www.welldynerx.com
Cigna	Group No. 0634436	Express Scripts	800-351-9170	www.mycigna.com
Locate In-Network Provider				
First Health Plans (TBR)	Group No. 1004	First Health Network	800-937-6824	www.firsthealth.com
Cigna	Group No. 0634436	Cigna Network	866-494-2111	www.mycigna.com
Dental	Policy No. 956084	Sun Life Dental Network	800-442-7742	sunlife.com/sunlifedentalnetwork.com
Vision	Policy No. 956084	VSP Network	800-877-7195	vsp.com / Choice Network
Mail Order Prescriptions				
First Health Plans (TBR)	Group No. 1004	WelldyneRX	888-479-2000	www.welldynerx.com
Cigna	Group No. 0634436	Express Scripts	800-351-9170	www.cigna.com
Medicare Supplement Plans		Ron Arline	229-228-4903	ron@madisonstreetagency.net
Network Questions				
First Health Plans (TBR)	Group No. 1004	First Health Network	800-937-6824	www.firsthealth.com
Cigna	Group No. 0634436	Cigna Network	866-494-2111	www.cigna.com
Dental	Policy No. 956084	Sun Life Dental Network	800-442-7742	sunlife.com/sunlifedentalnetwork.com
Vision	Policy No. 956084	VSP Network	800-877-7195	vsp.com / Choice Network
Pharmacy Consultations Pharmacy Questions				
First Health Plans (TBR)	Group 1004	WelldyneRX	888-479-2000	www.welldynerx.com
Cigna	Group 0634436	Express Scripts	800-351-9170	www.cigna.com
Plan Summary & Plan Documents		Ambassador Webesite		www.teamambassador.com
Short Term Disability		Carol Dixon	229-977-2468	Benefits@teamambassador.com
Website Issues		Carol Dixon	229-977-2468	Benefits@teamambassador.com

Dental Plan 1- Lower Plan

What's covered (basic plan)

Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$1,000 per person	$1,000 per person

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any calendar year
- Routine dental cleanings – 2 in any calendar year
- Fluoride treatment – 1 in any 6 month period. *Only for children under age* 19
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age 19*
- Space maintainers – *only for children under age 19*
- Bitewing x-rays – 1 in any calendar year
- Intraoral complete series x-rays – 1 in any 36 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 2 in any calendar year
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns– *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive or basic services
- 12 months for major services

Dental Plan 1- Lower Plan

Frequently asked questions (basic plan)

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists[3].

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[4] and dependent children. An eligible child is defined as a child to age 26.[5]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app—*Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $500.

1. American Academy of Periodontology https://www.perio.org/consumer/gum-disease-and-other-diseases (accessed 07/21).
2. American Academy of Periodontology https://www.perio.org/newsroom/periodontal-disease-fact-sheet (accessed 07/21).
3. Zelis Network Analytics data as of January 2022 and based on unique dentist count. Sun Life's dental networks include its affiliate, Dental Health Alliance, L.L.C.® (DHA), and dentists under access arrangements with other dental networks. Nationwide counts are state level totals.
4. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
5. Please see your employer for more specific information.
6. Classification of services varies by plan design.
7. Total number of combined prophylaxis cleaning and periodontal maintenance procedures cannot exceed 4 in a 12 month period.

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

Dental Plan 2- Higher Plan

What's covered (enhanced plan)

Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$2,000 per person	$2,000 per person
Type IV Ortho Service	$2,000 lifetime child and adult	$2,000 lifetime child and adult

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any calendar year
- Routine dental cleanings – 2 in any calendar year
- Fluoride treatment – 1 in any 6 month period. *Only for children under age* 19
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age 19*
- Space maintainers – *only for children under age 19*
- Bitewing x-rays – 1 in any calendar year
- Intraoral complete series x-rays – 1 in any 36 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 2 in any calendar year
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns– *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period

Type IV Ortho Services, including:

- No orthodontic treatment age limitation

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive or basic services
- 12 months for major services
- 12 months for orthodontic services

Dental Plan 2- Higher Plan

Frequently asked questions (enhanced plan)

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists[3].

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[4] and dependent children. An eligible child is defined as a child to age 26.[5]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app—*Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $500.

1. American Academy of Periodontology https://www.perio.org/consumer/gum-disease-and-other-diseases (accessed 07/21).
2. American Academy of Periodontology https://www.perio.org/newsroom/periodontal-disease-fact-sheet (accessed 07/21).
3. Zelis Network Analytics data as of January 2022 and based on unique dentist count. Sun Life's dental networks include its affiliate, Dental Health Alliance, L.L.C.® (DHA), and dentists under access arrangements with other dental networks. Nationwide counts are state level totals.
4. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
5. Please see your employer for more specific information.
6. Classification of services varies by plan design.
7. Total number of combined prophylaxis cleaning and periodontal maintenance procedures cannot exceed 4 in a 12 month period.

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

Accident Plan

What's covered

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here.

DISLOCATIONS	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$8,000	$4,000
Knee, ankle, or bones of the foot	$4,000	$1,000
Elbow, wrist, Shoulder, Collarbone, bones of the hand or Lower jaw	$2,000	$1,000
Finger(s) or toe(s)	$400	$200
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$6,000	$3,000
Skull-depressed	$10,000	$5,000
Skull-simple	$5,000	$2,500
Vertebral processes, Bones of the face, Nose, Upper jaw, upper arm, Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$1,500	$750
Leg, Vertebrae or Sternum	$3,000	$1,500
Pelvis	$3,200	$1,600
Rib, Finger, Toe or Coccyx	$600	$300
Multiple ribs	$2,000	$1,000
ADDITIONAL INJURIES		
Eye Injury - surgical repair		$250
Eye Injury - object remove		$250
Gunshot wound		$500
Paralysis—paraplegia		$25,000
Paralysis—quadriplegia		$50,000
Coma		$10,000
Concussion		$100
BURNS	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$400	$1,000
41-65 square centimeters	$800	$2,000
66-160 square centimeters	$1,200	$6,000
161-225 square centimeters	$1,600	$14,000
More than 225 square centimeters	$2,000	$20,000
Skin graft	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor		$35
Single laceration under 5 cm with sutures		$65
5-15 cm with sutures (total of all lacerations)		$250
Greater than 15 cm with sutures (total of all lacerations)		$500

Accident Plan

MEDICAL SERVICES	
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$400
Diagnostic Exam - X-ray (1 time per covered accident)	$100
Accident Emergency Treatment, non-emergency room (once per covered accident)	$150
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$100
Physical Therapy (per visit up to 10 visits per covered accident)	$50
Medical Devices	$500
Epidural Pain Management (up to 2 times per covered accident)	$150
Prescription drug	$50
Prosthesis (one)	$500
Prosthesis (two)	$1,000
Blood, Plasma, or Platelet Transfusion	$200
HOSPITAL	
Hospital Admission (once per benefit year)	$1,500
Hospital Confinement (per day up to 365 days per covered accident)	$300
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$2,500
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)	$500
Ambulance (Ground)	$200
Ambulance (Air)	$2,000
Emergency Room Admission	$200
Family Lodging (per day up to 30 days per benefit year)	$200
Transportation (100 or more miles up to 3 times per covered accident)	$600
Rehabilitation Unit (per day up to 30 days per covered accident)	$100
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$750
Open Surgery	$2,500
Exploratory Surgery or Debridement	$500
Tendon/Ligament/Rotator Cuff Tear	$1,250
Torn Knee Cartilage	$1,250
Ruptured/Herniated Disc	$1,250
EMERGENCY DENTAL	
Emergency Dental extraction	$65
Emergency Dental crown	$200
WELLNESS	
Wellness Screening Benefit (once per benefit year)	$50

LIFE AND DISMEMBERMENT LOSSES*	
Accidental Death	$50,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$200,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$25,000
Loss of one hand, foot, leg, or arm	$15,000
Loss of sight of one eye or loss of one eye	$15,000
Two or more fingers or toes	$3,000
One finger or one toe	$1,500
Loss of hearing of one ear or loss of one ear	$5,000

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 100% of the employee benefit amount for dismemberment. Dependent children benefits are 50% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

Cancer & Critical Illness Plan

What's covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Angioplasty[R] (Pays 5%)	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Major Organ Failure[R]
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%)	
Other Conditions	Complete Blindness Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Paralysis	Complete Loss of Hearing Loss of Speech Advanced Alzheimer's Disease (Pays 25%)
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 6 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Cancer & Critical Illness Plan

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 critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. In order to receive benefits for more than one critical illness, there must be at least 6 consecutive months between each diagnosis date. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

How is my benefit taxed?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

CRITICAL ILLNESS FAST FACT

*Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.***

**"What Are Your Odds of a Heart Attack?" health.com, June 2018.

Critical Illness insurance is a limited benefit policy. The certificate has exclusions, limitations and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

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

Voluntary Life Insurance

Sun Life

MORE PROTECTION FOR YOUR LOVED ONES.
The people you love and support could face financial challenges without you. Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

HELPS YOU CLOSE ANY COVERAGE GAPS.
You may have life insurance today, either on your own or through your employer. Now is a good time to ask yourself if you need more coverage.

AMBASSADOR PERSONNEL, INC.

All Eligible Employees

POLICY #: 956084

BENEFITS (You can purchase this coverage at a group rate.)	
For you*	You can choose **$10,000, $25,000, $50,000, $100,000, $150,000 or $200,000**. No medical questions asked **up to the Guaranteed Issue amount of $200,000**. Benefits are reduced at age 70 and may reduce again in subsequent years as noted in your Certificate.
For your spouse*	If you elect coverage for yourself, you can choose **$5,000, $10,000, $25,000 or $50,000**. No medical questions asked **up to the Guaranteed Issue amount of $50,000**. The amount you select for your spouse cannot exceed 100% of your coverage amount. Coverage ends when you turn age 70.
For your child(ren)*	If you elect coverage for yourself, you can choose **$1,000 to $10,000**—in $1,000 increments. No medical questions asked. The amount you select for your child(ren) cannot exceed 100% of your coverage amount. Benefits may reduce as noted in your Certificate. Child(ren) must primarily depend on the employee for 50% or more of their support. A full benefit is payable for a dependent child who is 6 months to 19 or to 23 years old if a full-time student. A reduced benefit of $500 is payable for a child from 14 days to 6 months. (No benefit is payable for a child from birth to 14 days).

This coverage includes Accidental Death and Dismemberment insurance.

Voluntary Life

Frequently asked questions

What is my AD&D benefit?
We will pay your beneficiaries an Accidental Death insurance amount that matches your Voluntary Life, if you die from a covered accident. Additional benefits are available for accidental injuries (i.e., dismemberment) such as loss of limbs, fingers or sight. Refer to your Certificate for a full list of covered accidental injuries. This plan includes AD&D coverage for your dependents.

Do I need to answer any health questions to enroll?
Yes, if you request an initial amount higher than the Guaranteed Issue amount or if you want to increase coverage in excess of one increment annually. 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.

Can I increase my coverage at a later date?
Yes. You may increase your coverage by one increment amount annually, without having to answer health questions, even if the increase means that your coverage exceeds the Guaranteed Issue amount. Your benefits administrator can advise you on how to increase coverage annually. The maximum benefit amount still applies

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Can I access my life insurance if I become terminally ill?
You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is called an "Accelerated Benefit" and there are some important things to know about it, including that it is not long-term-care insurance, it may be taxable and it may affect your eligibility for public assistance programs. It will also reduce the total amount of the life insurance payment we pay to your beneficiary(ies).

What happens if I become Totally Disabled?
If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.

How does my beneficiary file a death claim?
Your beneficiary(ies) and your employer will complete the appropriate claims forms and submit them to us. We will notify your beneficiaries when the decision is made and if we have any questions. If approved, beneficiaries may elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

1. LIMRA, Facts about Life 2018.

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ambassador Personnel, Benefit Department, P.O. Box 2057, Thomasville, GA 31799 / Benefits@teamambassador.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Ambassador Personnel, Inc.	27-4676978
5. Employer address	**6. Employer phone number**
P.O. Box 2057	229-226-2909

7. City	8. State	9. ZIP code
Thomasville	GA	31799

10. Who can we contact about employee health coverage at this job?	Carol Dixon – Benefit Department
11. Phone number (if different from above)	12. Email address Benefits@teamambassador.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:
    Regular full–time or part–time employees residing or working in the United States who are scheduled to work a minimum of 30 hours per week that have been with the company for at least 90 days.

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal Spouse whose employer does not offer a medical insurance.

    Children up to Age 26 (natural born, step children, or legally adopted)

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

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

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

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

[x] **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? The first day of the month following the employee's 90th day.

[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

[x] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ $16.85

b. How often? [x] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? No Changes

[ ] Employer won't offer health coverage

[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

* An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to: Ambassador Personnel, Inc. at P.O. Box 2057, Thomasville, GA 31799.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

All Correspondences relating to the contents of this Notice should be directed as follows:
Ambassador Personnel, Inc.
P.O. Box 2057
Thomasville, Georgia 31799
Phone Number: 844-292-9904
Benefits@teamambassador.com
www.teamambassador.com

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.