Employee Benefits Guide

PLAN YEAR:

July 1, 2022 - June 30, 2023

Table of Contents

All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.

DISCLAIMER

This guide is a brief summary of benefits offered to your group and does not constitute a policy.

Your employer may amend the benefits program at any time. Your Summary Plan Description (SPD) will contain the actual detailed provisions of your benefits. The SPD will be available at mymarkiii.com.

If there are any discrepancies between the information in this guide and the SPD, the language in the SPD will always prevail.

Important Points

- ✓ Your plan year runs from July 1, 2022 to June 30, 2023. This means your benefit elections will take effect July 1, 2022 unless otherwise noted.

- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.

- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event as outlined by the IRS.

- ✓ It is **MANDATORY** that every employee updates their beneficiary for The Standard. If you have any questions, please consult with a Mark III Benefits Counselor.

- ✓ Over the past few years, the Long-Term Disability product offered has seen a significant increase in claims, which in turn has caused the price to increase. **Since disability is so important and a much-needed benefit for employees, your employer has decided to make an adjustment to the LTD plan design to continue to offer this coverage at an affordable rate.** The new plan design will now have step-rates. This means the price is based off your age and will increase as you get older. This change will go into effect on 7/1/2022. Please consult with a Mark III Benefits Counselor during open enrollment to review your current plan and new deduction amount.

- ✓ **Texas Life Whole Life will be coming off payroll**. To continue your Texas Life Whole Life coverage with direct bill or to cancel, contact Texas Life at 1-800-283-9233. For more information, consult with a Mark III Benefits Counselor during your scheduled open enrollment.

- ✓ **MassMutual Whole Life has been added as part of your benefits package**. This does not replace your current Texas Life Whole Life coverage if you wish to keep it. For more information, consult with a Mark III Benefits Counselor during your scheduled open enrollment.

- ✓ This benefits guide is equipped with mobile-friendly barcodes commonly referred to as QR Codes. Use your smartphone to scan the QR codes to view your benefit summaries.

- ✓ All policy information can be found on your employee benefits portal at https://mymarkiii.com/hertfordcountync/.

- ✓ Are you a New Hire at Hertford County and need help enrolling or have a benefits question? Dial the number below to speak with your trusted Mark III Benefits Representative.

  - Michelle Love, Benefits Representative
  - Email: michelle@markiiieb.com
  - Phone: (919) 200-3845

Qualifying Life Events

Open Enrollment selections are generally locked for the plan year, but certain exceptions called Qualifying Life Events (QLEs) can grant you a special enrollment period in which to make midyear changes. You are permitted to change benefit elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Post-Tax benefits can be changed during the plan year without a QLE. Please contact your Group Contact for information on cancelling post-tax benefits.

Examples of QLEs

The following events will open a special ***30-day*** enrollment period from the date of the event, allowing you to make changes to your coverage. Documentations may be required.

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Welcome to Your Benefits!

Mark III Employee Benefits is here to help guide you through the benefits offered by your employer. This guide is simply a brief summary of benefits offered and does not constitute a policy.

Pre-Tax Benefit Information

A "**pre-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or until you have a qualifying change in your status (i.e. birth of a child, divorce, separation, reduction in hours, etc.). If your premiums are deducted on a pre-tax basis, any benefits received under the plan could be treated as taxable income.

- ✓ BlueCross BlueShield Medical
- ✓ Ameritas Dental
- ✓ Superior Vision
- ✓ MetLife Group Cancer
- ✓ Aflac Group Accident
- ✓ Aflac Group Hospital Indemnity

Post-Tax Benefit Information

A "**post-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. You **WILL NOT** be able to make any changes once the enrollment period is over unless you experience a qualified even outlined by the IRS (i.e. birth of a child, divorce, separation, reduction in hours, etc.).

- ✓ Aflac Group Critical Illness w/out Cancer
- ✓ Aflac Group Critical Illness w/ Cancer
- ✓ AUL Short-Term Disability
- ✓ AUL Long-Term Disability
- ✓ The Standard Term Life
- ✓ MassMutual Whole Life

How to Enroll at Open Enrollment

Call Center Enrollment

Dial the number below to speak with a trusted Mark III Benefits Counselor. They will explain the benefits offered and help get you enrolled.

It is **STRONGLY** encouraged to schedule an appointment time to meet with a Benefits Counselor. Visit the link below to schedule an appointment.

Call Center: 1 (833) 864-1644 *(M – F, 8:00 a.m. – 5:00 p.m. EST)*
Schedule Appointment: https://mymarkiii.com/hertfordcountync/enrollment/

Self-Service Enrollment

You have the option to self-enroll in your benefits through the online enrollment platform. Visit the link below and follow the onscreen instructions on how to self-enroll.

To Self-Enroll Visit: https://mymarkiii.com/hertfordcountync/enrollment/

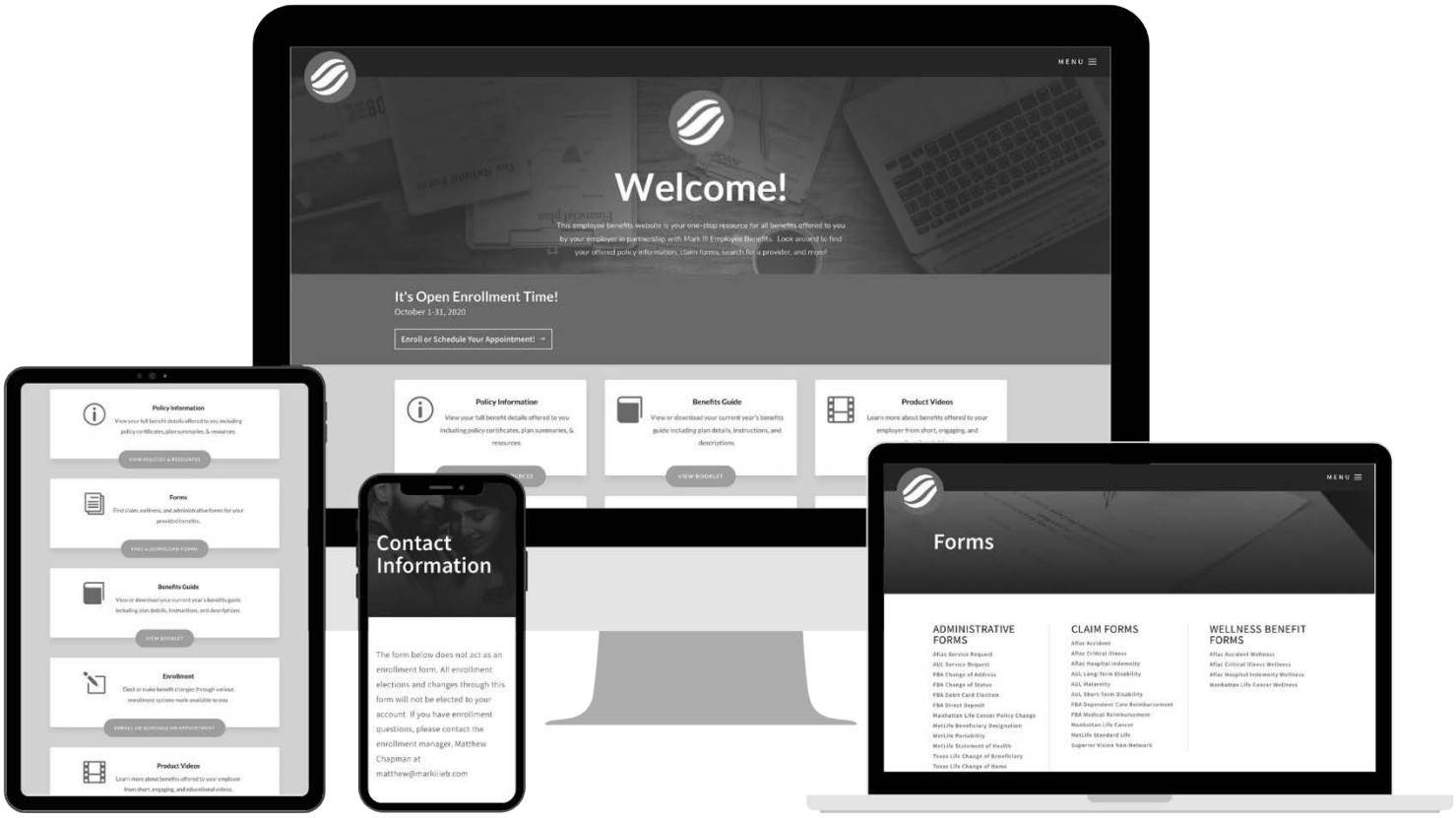
Employee Portal

Use your smartphone to scan the QR code for quick access to your employee portal page. Review your benefits guide online, download claim forms, access the online enrollment platform, and much more!

Scan me!

Employee Benefits Portal

Find details about all of your benefits, download forms, submit claims, ask questions, and more at https://mymarkiii.com/hertfordcountync/.



- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

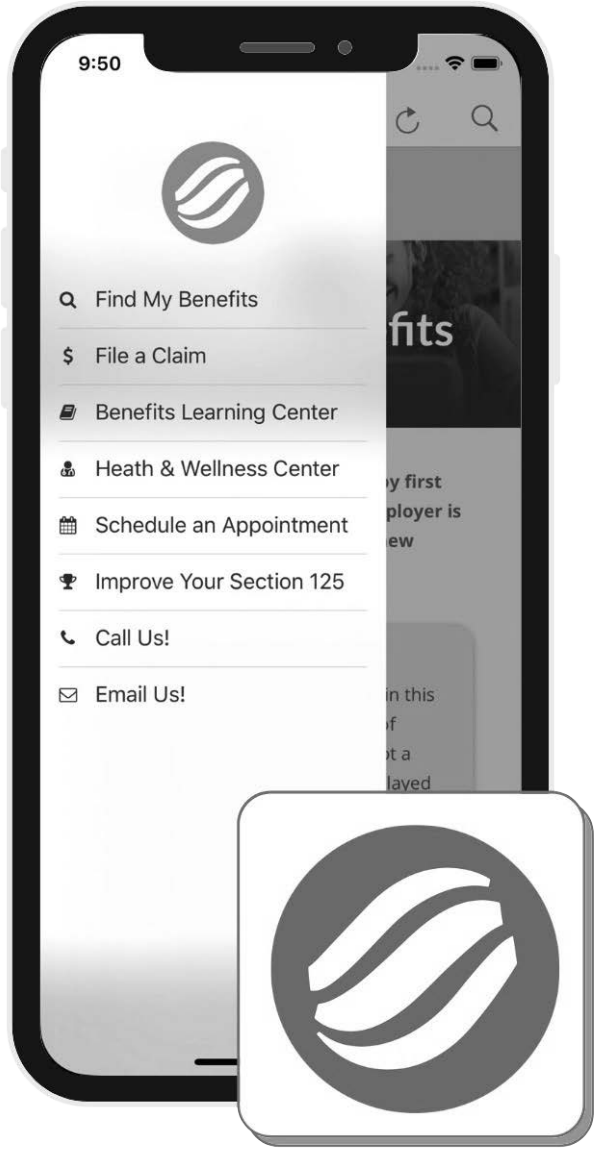
Scan me!

Available 24/7* from any internet enabled device for your convenience.

**As with all technology, due to technical difficulties beyond our control there may be small windows of time the benefits website is down. In the case of outage, plan information can always be requested from your HR office or Mark III Employee Benefits.*

MyMark III Mobile App

Find details about all of your benefits, download forms, submit claims, ask questions, and more on the MyMark III Mobile App!



- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

Scan Me!

Your Trusted Benefits Partners at your fingertips!

Download on the App Store

GET IT ON Google Play

Filing a Claim

Ameritas Dental

Visit https://www.Ameritas.com to file an electronic claim or you can download a claim form and submit to: P.O. Box 82520 | Lincoln, NE 68501-2520

Superior Vision

Visit https://mymarkiii.com/hertfordcountync/forms/ to download your claim form. Mail or fax a copy of the itemized invoice or receipt imprinted with the provider's name and address along with the form to the contact information below.

- Fax your claim to 916-852-2277 or
- Mail to Superior Vision Services, Inc. | Attn: Claims Processing | P.O. Box 967 | Rancho Cordova, CA 95741

MetLife Group Cancer

Visit https://mymarkiii.com/hertfordcountync/forms/ to download your claim form. MetLife Wellness Benefits can also be called in to a Bay Bridge claim's examiner at (800) 845-7519. Please have the following information available:

1. Claimant Name
2. Date of Service
3. Name of Service/Screening
4. Provider Name & Phone Number

Group Aflac

Visit https://www.aflacgroupinsurance.com and click on **Customer Service** and then **File a Claim**. Choose your claim form and follow the instructions. Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information.

AUL Disability

Visit https://mymarkiii.com/hertfordcountync/forms/ to download your claim form. There are four options for submitting your disability claim:

1. Call the disability claim team at 1-855-517-6365. You should have all information available before calling the disability claim team
2. Email to Disability.claims@oneamerica.com
3. Fax to 1-844-287-9499
4. Mail to American United Life Insurance Company, P.O. Box 7003, Indianapolis, IN 46207

Wellness Benefit Amounts

- ✓ MetLife Group Cancer - **$100**
- ✓ Aflac Group Accident - **$60**
- ✓ Aflac Group Hospital Indemnity - **$50**
- ✓ Aflac Group Critical Illness *(Employee/Spouse Only)* - **$100**

Employee Portal

Use your smartphone to scan the QR code below for quick access to your employee portal page. Review your benefits guide online, download claim forms, schedule an appointment, and much more!

Scan me!

HEALTHY LIVING

Core Benefit options to keep you and your family healthy.

Medical Plan Benefit Summary

BlueCross BlueShield of North Carolina

Benefit	*In-Network*	*Out-of-Network*
Deductible	$2,500 Individual | $5,000 Family	$5,000 Individual | $10,000 Family
Out-of-Pocket Limit	$5,500 Individual | $11,000 Family	$11,000 Individual | $22,000 Family
Primary Care Visit	$25 Copay	50% Coinsurance
Specialist Visit	$50 Copay	50% Coinsurance
Preventative Care/Screenings	No Charge	30% Coinsurance
Diagnostic Text (X-Ray, Blood Work)	30% Coinsurance	50% Coinsurance
Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance
Facility Fee	30% Coinsurance	50% Coinsurance
Physician/Surgeon Fees	30% Coinsurance	50% Coinsurance
Emergency Room Care	$500 Copay	$500 Copay
Emergency Medical Transportation	30% Coinsurance	30% Coinsurance
Urgent Care	$50 Copay	$50 Copay
Drug Tier	*In-Network*	*Out-of-Network*
Tier 1	$4 Copay	$4 Copay
Tier 2	$25 Copay	$25 Copay
Tier 3	$35 Copay	$35 Copay
Tier 4	$75 Copay	$75 Copay
Tier 5	25% Coinsurance	25% Coinsurance

Blue 20/20 Exam Only Plan	*In-Network Member Cost*	*Out-of-Network Reimbursement*
Exam w/ Dilation as Necessary	$25	Up to $39
Frequency (Exam)	Once every 12 Months	
Rates	Employee $1.13 Employee + Spouse $2.14 Employee + Child $1.67 Employee + Children $2.82 Employee + Family $3.32	

Blue 20/20

There's more unlimited discounts honored only at in-network providers!

- ✓ 40% off complete pair of prescription eyeglasses and prescription sunglasses
- ✓ 20% off non-prescription sunglasses
- ✓ 20% off a partial pair of eyeglasses (frames only or lenses only)
- ✓ 20% off accessories like lens cleaning solution, contact lens solution and readers
- ✓ 15% off conventional contact lenses
- ✓ 15% off the retail price of 5% off the promotional price of Lasik Vision Correction

EyeMed · Independent Provider Network · Pearle Vision · Sears Optical · LensCrafters · Target Optical · JCPenney | optical

This document is a highlight of plan benefits provided by BlueCross BlueShield of North Carolina as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For a complete list of covered procedures, please see your benefits administrator.

Medical Premiums

BlueCross BlueShield of North Carolina

BCBSNC Medical Rates with Blue 20/20 Vision Included				
Tier of Coverage	**Total Premium**	**Employer Contribution**	**Employee Contribution Monthly Rate (12 Pay)**	**Employee Contribution Semi-Monthly (24 Pay)**
Employee Only	$714.45	$714.45	$0.00	$0.00
Employee/Spouse	$1,366.70	$714.45	$667.92	$333.96
Employee/Child	$975.38	$714.45	$272.26	$136.13
Employee/Children	$1,339.86	$714.45	$641.49	$320.75
Employee/Family	$1,827.25	$714.45	$1,134.21	$567.11

Telehealth Benefits/MDLIVE

Sunburn at the beach? Stomach bug on Thanksgiving? In a rural area with no doctors nearby? Think you've got the flu but don't feel up to driving to your doctor's office? These are just a few of the reasons people use telehealth. And you can too! Your Blue Cross and Blue Shield of North Carolina (Blue Cross NC) health plan includes telehealth services from MDLIVE. It's a good option for minor health problems when you can't see your regular doctor. Plus, it's often more convenient and cost-effective than urgent care.

Scan the QR Code below or visit https://mymarkiii.com/hertfordcountync/policy-information/ to view the Telehealth/MDLIVE information and how you can get started today!

Register With Blue Connect

Register for BlueConnectNC.com, your personalized member services website. It is the guide to the tools and information you need to manage your health plan and health care. Blue Connect is personalized to you, to help you understand your own health care and treatment options. You can also find information about your coverage and claims. It's designed to make health care easier, giving you on-the-go access when, where and how you want it. Register today to set up your User ID and Password!

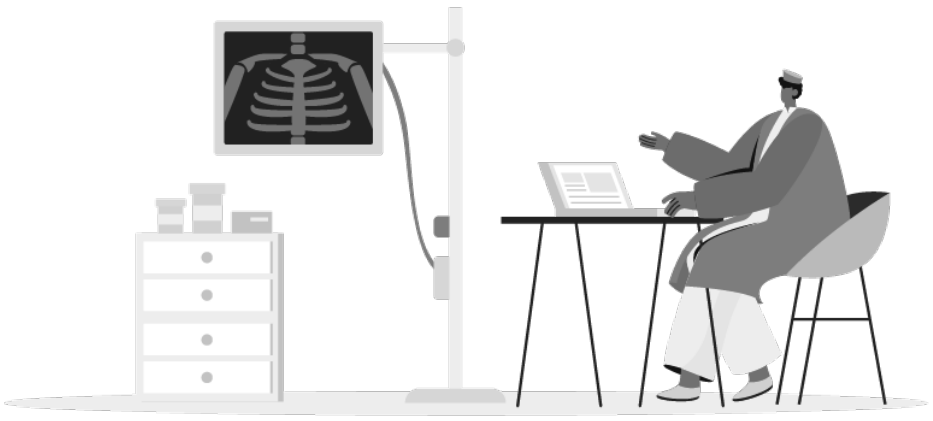
Scan the QR Code below or visit https://mymarkiii.com/hertfordcountync/policy-information/ to view the Blue Connect information and how you can get registered today!

Summary of Benefits & Coverage (SBC) Documents

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit www.bluecrossnc.com/booklets.

Scan the QR Code below to view your SBCs or visit https://mymarkiii.com/hertfordcountync/policy-information/.

Scan me!



Employee Assistance Program

COMPSYCH®
The GuidanceResources Company®

Contact Us...Anytime, Anywhere
No cost, confidential solutions to life's challenges.

Confidential Emotional Support
Our highly trained clinicians will listen to your concerns and quickly refer you to in-person counseling and other resources for:
- ✓ Anxiety, depression, stress
- ✓ Grief, loss and life adjustments
- ✓ Relationship/marital conflicts

Online Support
GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:
- ✓ Articles, podcasts, videos, slideshows
- ✓ On-demand trainings
- ✓ "Ask the Expert" personal responses to your questions

24/7 Support, Resources & Information
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Call: 800.272.7255
TDD: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

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Web ID: COM589

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

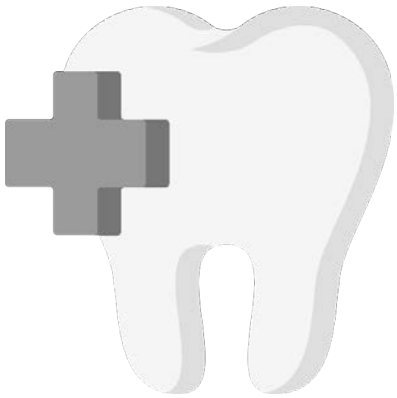
Dental Plan

Ameritas

Deductible

Deductible is waived for all preventive services. There is a $50 lifetime deductible on basic services that everyone has to satisfy upon their first claim under Basic services. Additionally, there is a $50 calendar year deductible for anyone having Major services. There is no family maximum on the $50 calendar year deductible and it therefore applies to all members upon their first Major services claim in a calendar year.

Type 1 – Preventive and Diagnostic



Type I benefits are payable at 100% co-insurance. ***No deductible applies.***

- Exams (Two per benefit period)
- Space Maintainers
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Bitewings (Two per benefit period)

Type 2 – Basic Procedures

Type II benefits are payable at 80% co-insurance. ***$50.00 lifetime deductible applies.***

- Sealants (Under age 17)
- Anesthesia
- Limited Exams
- Denture Repair
- Restorative Amalgam & Resin (excluding inlays & crowns)
- Oral Surgery – Simple & Complex Extractions
- Periodontics (Gum Disease)
- Endodontics (Root Canal)

Type 3 – Major Procedures

Type III benefits are payable at 50% co-insurance. ***$50.00 calendar year deductible applies.***

- Crown Repair
- Crowns (1 in 5 years per tooth)
- Prosthodontics – (fixed bridge; removable complete/partial dentures; 1 in 5 years)
- Onlays

Orthodontia - For Adults and Children

Paid at 50% co-insurance with a $1,000 lifetime maximum per person. ***No deductible applies***.

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

Annual Maximum Benefit

- Type 1 , 2, and Type 3 Procedures - $2,000* per calendar year per person.
- Orthodontia Procedures - $1,000 lifetime per person (carry over does not apply).

Ameritas Rewards

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year.

Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But, members can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Dental Rewards amount is added to the following year's maximum
Orthodontia Carryover	$100	Additional lifetime benefit amount will not exceed $100 the orthodontia allowance
Maximum Carryover rollover	unlimited	No maximum, there is no limit on the amount of dollars a member can accumulate

RX Savings

Our valued plan members and their covered dependents (even their pets) can save on prescription medications through any Walmart or Sam's Club pharmacy across the nation. This Rx discount is offered at no additional cost, and it is not insurance.

To receive the Walmart Rx discount, Ameritas plan members just need to show their original Ameritas ID card. The identifier is the Ameritas logo. It's that easy. Or members can visit us at ameritasgroup.com and sign into (or create) a secure member account where they can print off an online-only Rx discount savings ID card.

Eligible Employees

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

Eligible Dependents

Provides Coverage On:
• Your Spouse
• Children up to age 26 years of age

Dental Exclusions (Deferment Period)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Predetermination of Benefits

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

Certificate of Insurance

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

Late Entrant Provision

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.**

For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

Section 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

Limitations/Exclusions (This is not a complete List)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he /she is eligible for benefits under Workers' Compensation Act or similar laws.

Ameritas Dental Semi-Monthly Rates

Employee Only	$14.12
Employee + Spouse	$26.12
Employee + Child(ren)	$35.84
Employee + Family	$47.84

Ameritas

If you have any questions about the PPO or the plan, please call: Ameritas Group Claims Department at 1.800.487.5553
For Claims/Customer Service call Ameritas: 1.800.776.9446 | Website: www.ameritas.com

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For a complete list of covered procedures, please see your benefits administrator.

Vision Plan

SuperiorVision™

Copayment:

$10 Exam
$10 Materials[1]
$25 Contact Lens Fitting Fee (standard & specialty)

How to Use the Plan

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologist, optometrists, and opticians. The plan also contract with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "**Locate a Provider**" for an updated list. You will learn about "in-network" and "out-of-network" providers - it is an important distinction when receiving benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam in important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnose a variety of health issues - not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

Benefits	Frequency	In-Network	Non-Network
Comprehensive Exam (by an Ophthalmologist)	12 Months	Covered in Full	Up to $44.00
Comprehensive Exam (by a Optometrist)	12 Months	Covered in Full	Up to $39.00
Frames (Standard)	24 Months	$150.00 retail allowance	Up to $77.00
Contact Lens Fitting Standard[2] Specialty[2]	12 Months	 Covered in Full $50.00 retail allowance	 Not Covered Not Covered
Lenses (Standard) per pair Single Bifocal Trifocal Progressive lens upgrade	12 Months	 Covered in Full Covered in Full Covered in Full See description[3]	 Up to $34.00 Up to $48.00 Up to $64.00 Up to $64.00
Contact Lenses[4]	12 Months	$150 retail allowance	Up to $100.00

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements.

[1]Materials co-pay applies to lenses and frames only, not contact lenses
[2]See your benefits materials for definitions of standard and specialty contact lens fittings
[3]Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay.
[4]Contact lenses are in lieu of eyeglass lenses and frames benefit

Discounts on Covered Materials[1]	
Frames	20% off amount over allowance
Conventional Contacts	20% off amount over allowance
Disposable Contacts	10% off amount over allowance

These discounts apply to the glasses and contacts that are covered under the vision benefits.

Discounts on Non-Covered Exam & Materials[1]	
Exams, Frames, and prescription lenses	30% off retail
Contacts, miscellaneous options	20% off retail
Disposable	10% off retail
Retinal Imaging	$39 maximum member out-of-pocket

We offer discounts on unlimited materials after the initial benefit is utilized.

Lens Type*	Member out-of-pocket[1]
Scratch coat	$15
Ultraviolet coat	$12
Tints, solid	$15
Tints, gradients	$18
Polycarbonate	$40
Blue light filtering	$15
Digital single vision	$30
Progressives lenses • Standard|Premium|Ultra|Unlimited	$55|$110|$150|$225
Anti-Reflective coating • Standard|Premium|Ultra|Unlimited	$50|$70|$85|$120
Polarized lenses	$75
Plastic photochromic lenses	$80
High index (1.67|1.74)	$80|$120

*The above table highlights some of the most popular lens types and is not a complete listing. This table outlines member out-of-pocket costs[1] and are not available for premium/upgraded options unless otherwise noted.

Laser Vision Correction (LASIK)[1]

A National LASIK Network of laser vision correction providers, featuring QualSight, offers Superior Vision members a discount on services. These discounts should be verified prior to service.

Hearing Discounts[1]

A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Superior Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

[1]Not all providers participate in Superior Vision Discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all Superior Vision providers/all locations.

Superior Vision Rates

Insured	Semi-Monthly Rates
Employee Only	$4.85
Employee + Spouse	$9.60
Employee + Child(ren)	$9.41
Employee + Family	$14.30

SuperiorVision™

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for you vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.

STAY WELL

Voluntary Benefit options that enhance you and your family's well being.

Cancer Plan

MetLife

BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Plan Features

- ✓ Donor Benefits
- ✓ Wellness Benefits
- ✓ Many Benefits have No Lifetime Maximum
- ✓ Covers certain Lodging & Transportation
- ✓ Portable (take it with you)
- ✓ In & Out of hospital benefits
- ✓ Pays regardless of other coverage

Benefit	*Benefit Option*
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, Hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	Low Plan: $2,500 High Plan: $5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or .50¢ per mile if a personal vehicle is used
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging .50¢ per mile if a personal vehicle is used
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	a. $200 b. Actual billed charges for round trip coach fare; or personal automobile expense of .50¢ per mile c. Actual billed charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay incurred expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	Up to 25% of surgical benefit paid. $100 max per covered person for skin cancer
Ambulatory Surgical Center. We will pay the incurred expenses at an Ambulatory Surgical Center. No Lifetime Maximum	$250 per day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year

Benefit	*Benefit Option*
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	Low Plan: Incurred Expenses up to $2,500 per month High Plan: Incurred Expenses up to $5,000 per month
Miscellaneous Diagnostic Services. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime max of $10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to $4,000 per month
Colony Stimulating Factors. We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Incurred Expenses up to $500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if an Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges . This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non- Local Transportation Benefits of the policy.	Actual billed charges limited to a lifetime max up to $750 for evaluation. Actual billed charges limited to a lifetime max up to $350 for transportation & lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to $1,500 lifetime max per amputation
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	$35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	$300 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	$50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	$100 per day
New or Experimental Treatment. We will pay the actual billed charges by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	$50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day
Hairpiece. We will pay the actual billed charges per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual billed charges up to a lifetime max of $150
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 per day

Other Specified Diseases Covered:

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

Payment of Benefits

Benefits are payable for a Covered Person's Positive Diagnosis of a Cancer or Specified Disease that begins after the Certificate Effective Date and while this Certificate has remained in force.

Pre-Existing Condition Limitation

No benefits will be provided during the first 12 months of the policy for cancer diagnosed before the 30th day after the effective date shown in the policy schedule. During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person. **Pre-Existing Condition** means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions & Other Limitations

The policy pays benefits only for diagnoses resulting from Cancer of Specified Diseases, as defined in the Policy. It does not cover:

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by: a) Specified Disease or Specified Disease treatment; or b) Cancer or Cancer treatment, or unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approve by a Physician; or
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Termination of Coverage

A Covered Person's insurance under the Policy will automatically terminate on the earliest of the following dates:

1. the date that the Policy terminates.
2. the date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the date the Policy is amended to terminate the eligibility of the Employee class.
4. any premium due date, if premium remains unpaid by the end of the grace period.
5. the premium due date coinciding with or next following the date the Covered Person ceases to be a member of an eligible class.
6. the date the Policyholder no longer meets participation requirements.

Portability

On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates. The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

a) the Named Insured; or
b) any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
c) any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
d) a newborn child (as described in the Eligibility Section).

Child (Children) means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

In consideration of additional premium, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits
Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit
You may choose the benefit of $325 (Low Plan) or $625 (High Plan) per day. It is reduced by one-half at age 75.

Double Benefits
We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the named insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU
We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU, if you are admitted on an emergency basis, and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit
We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step Down Unit.

Exceptions and Other Limitations

Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable: if you go into an ICU before the Certificate Effective Date; if you go into an ICU for intentionally self-inflicted injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law in the jurisdiction where the accident or cause of loss occurred.

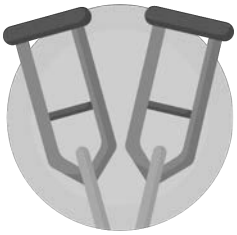
Group Cancer Rate Quote

Semi-Monthly Rates		
Coverage Tier	**Option 1 - Low**	**Option 2 - High**
Individual	$11.69	$15.45
Individual + Spouse	$23.80	$31.44
Individual + Child(ren)	$16.60	$21.68
Family	$28.72	$37.67

Variable Benefit Elections		
Benefit	**Option 1 - Low**	**Option 2 - High**
Hospital Confinement	$100	$100
Surgical	$3,000	$3,000
Radiation/Chemotherapy	$2,500 per month	$5,000 per month
First Diagnosis	$2,500	$5,000
Colony Stimulating Factors	$500 per month	$500 per month
Wellness	$100	$100
Intensive Care Rider	$325	$625

MetLife

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company. This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected. Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact: Bay Bridge Administrators P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519



Group Accident Plan

Plan Features

- Benefits are payable regardless of any other insurance programs.
- Coverage is guaranteed-issue, provided the applicant is eligible for coverage.
- The plan features benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits are available for spouse and/or dependent children.
- There's no limit on the number of claims an insured can file.
- Premiums are paid by convenient payroll deduction.
- Immediate effective date – Coverage will be effective the date the employee signs the application.
- 24-Hour Coverage.

Eligibility (Issue Ages)

- Employee at least age 18
- Spouse at least age 18
- Children under age 26

The employee may purchase Accident Insurance coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

Coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Accident Benefits – High Option

Complete Fractures		Closed Reduction Benefits
	Employee	**Spouse/Child(ren)**
Hip/Thigh	$4,500	$4,000
Vertebrae	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (depressed)	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand/Wrist	$2,250	$2,000
Foot/Ankle/Knee Cap	$2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (mandible)	$1,800	$1,600
Skull (simple)	$1,575	$1,400
Upper Arm/Upper Jaw	$1,575	$1,400
Facial Bones (except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320

If the fracture requires open reduction, we will pay 200% of the amount shown. A **fracture** is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown. **Multiple fractures** refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture. However, we will pay no more than 200% of the benefit amount for the fractured bone which has the highest dollar amount. **Chip fracture** refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown for the affected bone. The maximum amount payable for the Fracture Benefit per covered accident is 200% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations		
	Employee Closed Reduction	Spouse/Child(ren) Closed Reduction
Hip	$4,000	$3,000
Knee (not kneecap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

If the dislocation requires open reduction, we will pay 200% of the amount shown. **Dislocation** refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan. **Multiple dislocations** refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 200% of the benefit amount for the dislocated joint that has the higher dollar amount. **Partial dislocation** is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint. The maximum amount payable for the Dislocation Benefit per covered accident is 200% of the benefit amount for the dislocated joint that has the higher dollar amount. If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 200% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident:

- The insured is injured,
- The injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations	
Up to 2” long	$50
2”-6” long	$200
More than 6” long	$400
Lacerations not requiring stiches	$25

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration. If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment & surgery within 90 days)	$250
Removal of foreign body from eye (requiring no surgery)	$50
Tendons/Ligaments* (treatment within 60 days, surgical repair within 90 days) • Single • Multiple If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	 $400 $600
Ruptured Disc (treatment within 60 days, surgical repair within one year) • Injury occurs during first certificate year • Injury occurs after first certificate year	 $100 $400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year) • Injury occurs during first certificate year • Injury occurs after first certificate year	 $100 $400

Burns (treatment within 14 days, first degree burns not covered)	
Second Degree	
• Less than 10% of body surface covered	$100
• At least 10%, but not more than 25% of body surface covered	$200
• At least 25%, but not more than 35% of body surface covered	$500
• More than 35% of body surface covered	$1,000
Third Degree	
• Less than 10% of body surface covered	$1,000
• At least 10%, but not more than 25% of body surface covered	$5,000
• At least 25%, but not more than 35% of body surface covered	$10,000
• More than 35% of body surface covered	$20,000
Concussion (A concussion or Mild Traumatic Brain Injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: Concussion and MTBI are used interchangeably. The concussion must be diagnosed by a doctor.)	$200
Coma (state of profound unconsciousness lasting 30 days or more)	$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	$1,000
Exploratory Surgery (without repair. i.e. arthroscopy)	$250
Emergency Dental Work (injury to sound, natural teeth)	
• Repaired with crown	$150
• Resulting in extractions	$50

Medical Fees (for each accident)	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for X-rays or doctor services. For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident. We will pay the Medical Fees Benefit:

- For treatment received due to injuries from a covered accident **and**
- For each covered accident up to one year after the accident date.

Emergency Room Treatment	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room **and**
- Receives initial treatment within 14 days after the covered accident.

This benefit is payable only once per 24-hour period and only once per covered accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit	
Employee or Spouse	$75
Child(ren)	$45

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, **and**
- Is held in a hospital for observation for at least 24 hours, **and**
- Receives initial treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-Up Treatment	$25

We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 14 days of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy	$25

We will pay the amount shown for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 14 days of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-up Treatment benefit is paid.

Air Ambulance	$500
Ambulance	$100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

Transportation (within 90 days)	
Train or Plane	$300
Bus	$150

If hospital treatment or diagnostic study is recommended by your physician and is not available in the insured's city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood/Plasma	$100

If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	$500

If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids—including false teeth—are not covered.

Appliance	$100

We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

Family Lodging Benefit (per night)	$100

If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness	$60

This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams
- Blood screenings
- Eye examinations
- Immunizations
- Flexible sigmoidoscopies
- Ultrasounds
- Mammograms
- Pap smears
- PSA tests

Hospital Admission	$1,000

We will pay the amount shown, when because of a covered accident, the insured:

- Is injured,
- Requires hospital confinement, **and**
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day)	$200

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day)	$400

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same injury is 30 days. This benefit is payable in addition to the Hospital Confinement Benefit.

Accidental Death & Dismemberment (within 90 days)			
	Employee	**Spouse**	**Children**
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Finger(s) of Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

- Loss of a hand – The hand is cut off at or above the wrist joint; **or**
- Loss of a foot – The foot is cut off at or above the ankle; **or**
- Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**
- Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:
- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**
- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Limitations & Exclusions

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:
- **War** - participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service. This does not include terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness. This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.
- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- **Illegal Acts** – participating or attempting to participate in an illegal activity or working at an illegal job.
- **Sports** – participating in any organized sport—professional or semiprofessional.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Aflac Group Accident Rates

24 Hour Plan	Semi-Monthly Rates
Employee	$8.10
Employee & Spouse	$11.58
Employee & Dependent Children	$15.45
Family	$18.93

Wellness Benefit included in rates.

Group Hospital Indemnity Plan

Plan Description

The Group Supplemental Hospital Indemnity Insurance Plan provides benefits for inpatient and outpatient services as a result of covered accidents and sicknesses.

Plan Features

- Benefits available for spouse and/or dependent children.
- Premiums are paid by convenient payroll deduction.
- Admission and per day Hospital Confinement Benefits included.
- The plan is portable with certain stipulations
- Pays regardless of any other insurance programs.
- Covers both injuries and sicknesses.
- Surgery and Anesthesia Benefits included.

Eligibility

Issue Ages
Employee 18-64
Spouse 18-64
Children under age 26

Spouse & Dependent Children Coverage Available

The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate. If the employee is eligible then the employee's spouse and dependent children are eligible to participate.

Guaranteed-Issue

During the initial enrollment, coverage is guaranteed-issue, which means you may not have to answer health questions to be eligible for coverage. Subsequent to the initial enrollment, evidence of insurability may be required.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Benefits

Hospital Confinement (per day)	
Plan I - Low	$100
Plan II - High	$150

We will pay the amount shown when an insured is confined to a hospital as a resident bed patient as the result of an injury or because of a covered sickness. To receive this benefit for injuries received in an injury, the insured must be confined to a hospital within six months of the date of the covered accident. The maximum period for which a covered person can collect benefits for hospital confinements resulting from covered sickness or from injuries received in the same covered accident is 180 days. This benefit is payable for only one hospital confinement at a time—even if the confinement is a result of more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.

Hospital Admission (per confinement)	
Plan I - Low	$500
Plan II - High	$1,500

We will pay the amount shown when an insured is admitted to a hospital and confined as a resident bed patient because of an injury or because of a covered sickness. To receive this benefit for injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident. We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment. We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again. This benefit option will be based on the insured's current major medical plan's deductible to assist the insured in meeting the out-of-pocket liability.

Residents of Massachusetts are not eligible for Hospital Admission Benefit amounts in excess of $500

Anesthesia Benefits	
Plan I - Low	Up to $188
Plan II - High	Up to $375

When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.

Surgical Benefit (per procedure)	
Plan I - Low	Up to $750
Plan II - High	Up to $1,500

If an insured has surgery performed by a physician due to an injury or because of a covered sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a hospital (on an inpatient or outpatient basis), in an ambulatory surgical center, or in a physician's office. If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations (the operation that is nearest in severity and complexity). If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit—the largest—will be provided.

Wellness (per calendar year)	
Plan I & II – Low & High	$50

We will pay the amount shown when an insured visits a doctor and he is neither injured nor sick. This benefit is payable once per calendar year per insured.

Limitations & Exclusions

Pre-Existing Condition Limitation: A pre-existing condition means, within the 12-month period prior to the insured's effective date, conditions for which medical advice or treatment was received or recommended. We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured's effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition—whichever is less. A claim for benefits for loss starting after 12 months from the effective date of the insured's certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition. Pregnancy will not be covered if conception was before the Effective Date of the Insured Person's Certificate. Pregnancy will be covered as any other sickness when date of conception is after the Insured Person's Effective Date of coverage. Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines. If the certificate is issued as a replacement for a certificate previously issued under this plan, then the pre-existing condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining pre-existing condition limitation period of the prior certificate continues to apply to the prior level of benefits.

Exclusions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above). We will not pay benefits for loss contributed to by, caused by, or resulting from:

1. War – Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.
2. Suicide – Committing or attempting to commit suicide, while sane or insane.
3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.
4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.
6. Aviation – Operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft, including those, which are not motor–driven.
7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts – Participating or attempting to participate in an illegal activity or working at an illegal job.
9. Sports – Participating in any organized sport: professional or semi–professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

Aflac Group Hospital Indemnity Rates

Plan I - Low	Semi-Monthly Rates
Employee	$7.85
Employee + Spouse	$15.52
Employee + Child(ren)	$10.75
Family	$18.42

Plan II - High	Semi-Monthly Rates
Employee	$15.48
Employee + Spouse	$30.59
Employee + Child(ren)	$21.46
Family	$36.56

Group Critical Illness Plan

without Cancer

Aflac

Lump Sum Single Payment Policy/First Occurrence
Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $30,000 for spouses
- Dependent children are covered at 50% of the primary insured's amount at no additional charge
- Guaranteed-Issue coverage is available for employee and spouse
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Includes an Additional Benefits Rider with benefits for the following: Coma, Paralysis, Severe Burn, Loss of Sight, Loss of Hearing, Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed- Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available:
Up to **$20,000** for employees and up to **$10,000** for spouses with no participation requirement.

For employee amounts over **$20,000** and spouse amounts over **$10,000**:
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18-69
- Spouse 18-69
- Children under age 26

Benefit-eligible employees, working at least **30 hours** or more weekly, with at least **0 days** of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is also eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **100%** of the employee amount, not to exceed the $30,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $30,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Children-only coverage is not available.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Group Critical Illness Benefits

First Occurrence Benefit - After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Critical Illnesses Covered Under Plan	Percentage of Face Amount/Benefit
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End-Stage)	100%
Stroke	100%
Coronary Artery Bypass Surgery +	25%

Additional Occurrence Benefit - We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

Reoccurrence Benefit - We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months.

+Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.

Health Screening Benefit - $100

After the Waiting Period, an Insured may receive a maximum of **$100** for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

- Stress test on a bicycle or treadmill
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- Thermography
- Colonoscopy

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe Burns	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1	
Coronary Artery Bypass Surgery	100%
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

Exceptions and Reductions

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description. Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the Effective Date. No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation and Exceptions

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the Effective Date resulted in the insured receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the Effective Date.

Additional Benefit Rider Exceptions

All limitations and exclusions that apply to the Critical Illness plan also apply to the rider. The Waiting Period and Pre-existing condition limitation apply from the date the rider is effective. No benefits will be paid for loss which occurred prior to the effective date of the rider. Benefits are not payable for loss if these conditions result from another Critical Illness. The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months. The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the rider is in force; and the cause of the illness is not excluded by name or specific description.

Heart Event Rider Exceptions

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount. The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium. Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness. Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

Pre-existing Conditions Exception

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from an insured's effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date. Any benefits for coronary artery bypass surgery denied under the coverage due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

Exceptions

No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for loss which occurred prior to the effective date of coverage. Diagnosis must be made, and treatment received in the United States. **Treatment** means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

Aflac Group Critical Illness w/out Cancer – Semi-Monthly Rates

NON-TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.72	$3.68	$4.65	$5.61	$6.58	$7.54	$8.51	$9.47	$10.44	$11.40
30-39	$3.34	$4.94	$6.53	$8.13	$9.72	$11.31	$12.91	$14.50	$16.10	$17.69
40-49	$5.00	$8.26	$11.51	$14.76	$18.02	$21.27	$24.52	$27.78	$31.03	$34.28
50-59	$7.28	$12.81	$18.34	$23.87	$29.40	$34.93	$40.46	$45.99	$51.52	$57.05
60 - 69	$12.05	$22.35	$32.65	$42.95	$53.25	$63.55	$73.85	$84.15	$94.45	$104.75

NON-TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*
18-29	$2.72	$3.68	$4.65	$5.61	$6.58	$7.54
30-39	$3.34	$4.94	$6.53	$8.13	$9.72	$11.31
40-49	$5.00	$8.26	$11.51	$14.76	$18.02	$21.27
50-59	$7.28	$12.81	$18.34	$23.87	$29.40	$34.93
60 - 69	$12.05	$22.35	$32.65	$42.95	$53.25	$63.55

TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$3.22	$4.70	$6.17	$7.65	$9.12	$10.59	$12.07	$13.54	$15.02	$16.49
30-39	$4.28	$6.82	$9.35	$11.88	$14.41	$16.95	$19.48	$22.01	$24.55	$27.08
40-49	$8.21	$14.68	$21.14	$27.60	$34.06	$40.53	$46.99	$53.45	$59.91	$66.38
50-59	$12.68	$23.61	$34.54	$45.48	$56.41	$67.34	$78.27	$89.20	$100.13	$111.06
60 - 69	$21.45	$41.15	$60.85	$80.55	$100.25	$119.95	$139.65	$159.36	$179.06	$198.76

TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*
18-29	$3.22	$4.70	$6.17	$7.65	$9.12	$10.59
30-39	$4.28	$6.82	$9.35	$11.88	$14.41	$16.95
40-49	$8.21	$14.68	$21.14	$27.60	$34.06	$40.53
50-59	$12.68	$23.61	$34.54	$45.48	$56.41	$67.34
60 - 69	$21.45	$41.15	$60.85	$80.55	$100.25	$119.95

Continental American Insurance Company
Columbia, South Carolina
Toll Free: 800.433.3036
Website: aflacgroupinsurance.com

Group Critical Illness Plan

with Cancer

Aflac

Lump Sum Single Payment Policy/First Occurrence

Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $30,000 for spouses
- Dependent children are covered at 50% of the primary insured's amount at no additional charge
- Guaranteed-Issue coverage is available for employee and spouse
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Includes an Additional Benefits Rider with benefits for the following: Coma, Paralysis, Severe Burn, Loss of Sight, Loss of Hearing, Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed- Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available:
Up to **$20,000** for employees and up to **$10,000** for spouses with no participation requirement.

For employee amounts over **$20,000** and spouse amounts over **$10,000**:
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18-69
- Spouse 18-69
- Children under age 26

Benefit-eligible employees, working at least **30 hours** or more weekly, with at least **0 days** of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is also eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **100%** of the employee amount, not to exceed the $30,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $30,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Children-only coverage is not available.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Group Critical Illness Benefits

First Occurrence Benefit - After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is inforce, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

Critical Illnesses Covered Under Plan	Percentage of Face Amount/Benefit
Cancer (Internal or Invasive)*	100%
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End-Stage)	100%
Stroke	100%
Carcinoma in Situ +*	25%
Coronary Artery Bypass Surgery +	25%

Additional Occurrence Benefit - We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

Reoccurrence Benefit - We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the Insured has gone treatment free for 12 months.

+ Payment of the partial benefit for Carcinoma in Situ will reduce by 25% the benefit for internal Cancer. Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.
**For employees who have chosen the without cancer plan option, these cancer benefits do not apply.*

Health Screening Benefit - $100

After the Waiting Period, an Insured may receive a maximum of **$100** for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

- Stress test on a bicycle or treadmill
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- Thermography
- Colonoscopy

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe Burns	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1	
Coronary Artery Bypass Surgery	100%
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

Exceptions and Reductions

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description. Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the Effective Date. No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation and Exceptions

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the Effective Date resulted in the insured receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the Effective Date.

Additional Benefit Rider Exceptions

All limitations and exclusions that apply to the Critical Illness plan also apply to the rider. The Waiting Period and Pre-existing condition limitation apply from the date the rider is effective. No benefits will be paid for loss which occurred prior to the effective date of the rider. Benefits are not payable for loss if these conditions result from another Critical Illness. The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months. The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the rider is in force; and the cause of the illness is not excluded by name or specific description.

Heart Event Rider Exceptions

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount. The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium. Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness. Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

Pre-existing Conditions Exception

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from an insured's effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date. Any benefits for coronary artery bypass surgery denied under the coverage due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

Exceptions

No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for loss which occurred prior to the effective date of coverage. Diagnosis must be made, and treatment received in the United States. **Treatment** means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

Aflac Group Critical Illness w/ Cancer - Rates

NON-TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$3.19	$4.63	$6.07	$7.51	$8.95	$10.39	$11.83	$13.27	$14.71	$16.15
30-39	$4.07	$6.39	$8.71	$11.03	$13.34	$15.66	$17.98	$20.30	$22.62	$24.94
40-49	$6.65	$11.56	$16.46	$21.36	$26.27	$31.17	$36.07	$40.98	$45.88	$50.78
50-59	$10.45	$19.16	$27.86	$36.57	$45.27	$53.98	$62.68	$71.39	$80.09	$88.80
60 - 69	$17.85	$33.95	$50.05	$66.15	$82.25	$98.35	$114.45	$130.55	$146.65	$162.75

NON-TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*
18-29	$3.19	$4.63	$6.07	$7.51	$8.95	$10.39
30-39	$4.07	$6.39	$8.71	$11.03	$13.34	$15.66
40-49	$6.65	$11.56	$16.46	$21.36	$26.27	$31.17
50-59	$10.45	$19.16	$27.86	$36.57	$45.27	$53.98
60 - 69	$17.85	$33.95	$50.05	$66.15	$82.25	$98.35

TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$4.02	$6.30	$8.57	$10.85	$13.12	$15.39	$17.67	$19.94	$22.22	$24.49
30-39	$5.66	$9.57	$13.47	$17.38	$21.29	$25.20	$29.11	$33.01	$36.92	$40.83
40-49	$11.89	$22.03	$32.16	$42.30	$52.44	$62.58	$72.71	$82.85	$92.99	$103.13
50-59	$18.93	$36.11	$53.29	$70.48	$87.66	$104.84	$122.02	$139.20	$156.38	$173.56
60 - 69	$33.53	$65.30	$97.08	$128.85	$160.63	$192.40	$224.18	$255.96	$287.73	$319.51

TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*
18-29	$4.02	$6.30	$8.57	$10.85	$13.12	$15.39
30-39	$5.66	$9.57	$13.47	$17.38	$21.29	$25.20
40-49	$11.89	$22.03	$32.16	$42.30	$52.44	$62.58
50-59	$18.93	$36.11	$53.29	$70.48	$87.66	$104.84
60 - 69	$33.53	$65.30	$97.08	$128.85	$160.63	$192.40

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions. If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Aflac Group Insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company, Columbia, South Carolina.

AGC2000137 R1 EXP (03/23)

Short-Term Disability Plan

ONEAMERICA®

Class Description
All Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

Disability
You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly benefit is $500.

Elimination Period
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Benefit Duration
This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks.

Basis of Coverage
24 Hour Coverage, on or off the job.

Maternity Coverage
Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date.

Recurrent Disability
If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318. The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment
Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1,000 monthly benefit without medical questions. Employees may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

Exclusions and Limitations
This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group, the group policy will prevail.

AUL Short-Term Disability Semi-Monthly Rates

Benefit Duration
13 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$5.18
$600	$6.22
$700	$7.25
$800	$8.29
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.47
$1,400	$14.50
$1,500	$15.54
$1,600	$16.56
$1,700	$17.60
$1,800	$18.64
$1,900	$19.67
$2,000	$20.71

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Customer Service: 800-553-5318 | Disability Claims: 855-517-6365 | Fax: 844-287-9499
Disability Claims Email: Disability.Claims@oneamerica.com | www.employeebenefits.aul.com

Long-Term Disability Plan

OneAmerica®

LTD Class Description
All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Long-Term Disability.

LTD Monthly Benefit
You can choose to **insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000 in $500 increments. The minimum benefit is $500.**

LTD Elimination Period
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

LTD Benefit Duration
This is the period of time that benefits will be payable for long-term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

Age When Total Disability Begins	Maximum Period Benefits are Payable
Prior to Age 61	5 Years
61	Lesser of SSFRA or 5 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and Over	12 Months

LTD Total Disability Definition
An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefits have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

Special Conditions
Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

Mental & Nervous / Drug & Alcohol
Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

Other Income Offsets
AUL will not reduce your LTD disability benefit with other disability income benefits that you might be receiving from AUL or external sources such as Social Security or other disability or income benefits you may receive, or be eligible to receive.

Waiver of Premium
AUL will waive the premium payments for your coverage while you are disabled and will continue to be waived during the elimination period and the benefit eligibility period.

Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Continuity of Coverage will apply if the employee was insured under the employers' prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

The Portability Privilege is not available to any Person that retires (when the person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly benefit without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

Exclusions and Limitations

This plan will not cover any disability resulting from certain events or conditions such as but not limited to war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. Additional exclusions and limitations may apply.

AUL Long-Term Disability Semi-Monthly Rates

Monthly Benefit Amount	Age 0 - 29	Age 30 - 39	Age 40 - 49	Age 50 - 59	Age 60 +
$500	$1.88	$3.13	$4.08	$11.00	$16.50
$1,000	$3.75	$6.25	$8.15	$22.00	$33.00
$1,500	$5.63	$9.38	$12.23	$33.00	$49.50
$2,000	$7.50	$12.50	$16.30	$44.00	$66.00

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This information is provided as a Benefit Outline. It is not part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverages under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

Basic Term Life Plan

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's, or his or her dependent's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Hertford County, except for the cost of your dependent's insurance, which is paid by you through payroll deduction. Enrollment materials needed to elect coverage will be provided.

Eligibility

- **Definition of a Member**: You are a member if you are an active employee of Hertford County and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
- **Eligibility Waiting Period**: If you are already a member on the date the group policy is effective, you are eligible on that date. If you become a member after the group policy effective date, you are eligible on the first of the month that follows or coincides with 30 consecutive days as a member.

Benefits

- **Basic Life Coverage Amount**: Your Basic Life coverage amount is $10,000.
- **Basic AD&D Coverage Amount**: For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
- **Life Age Reductions**: Basic Life and AD&D insurance coverage amount reduces to 50% at age 70.
- **Basic Dependents Life Coverage Amount**: The Basic Dependents Life coverage amount for your eligible spouse is $1,000. Your spouse is the person to whom you are legally married. The Basic Dependents Life coverage amount for each of your eligible children is $1,000. Child means your child from live birth through age 25.

Other Basic Life Features & Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium
- Repatriation Benefit

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Line of Duty Benefit
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D and Basic Dependents Life insurance policy sponsored by Hertford County. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Hertford County may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact your human resources representative.

Additional Term Life Plan

This coverage is designed to help provide financial support and stability to your family should you pass away. You can also cover your eligible spouse and child(ren). Life insurance is an easy, responsible way to help protect your family from financial hardship during a difficult time — and into the future.

About This Coverage

- Competitive group rates.
- The convenience of payroll deduction.
- Benefits if you become terminally ill or die.

If you take no action you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

How Much Can I Apply For?

- **For You:** $10,000 - $300,000 in increments of $10,000.
- **For Your Spouse:** $10,000 - $300,000 in increments of $10,000.
- **For Your Child(ren):** $5,000 - $10,000 in increments of $5,000.

Guarantee Issue Maximum During Initial Enrollment

- **For You:** Up to $100,000
- **For Your Spouse:** Up to $30,000

**Your combined Basic and Additional Life amounts cannot exceed 6 times your annual earnings. Spouse amount cannot exceed 100% of your Additional Life coverage.*

Annual Enrollment: If you are currently enrolled in Additional Life insurance for an amount less than $100,000, you may elect to increase your coverage by $10,000 or $20,000, but not to exceed the guarantee issue amount of $100,000, without having to answer health questions (does not apply to spouse and/or child coverage). If you are not currently enrolled in Additional Life insurance, you may elect $10,000 or $20,000 of coverage without having to answer health questions. ***Spouses and children not currently enrolled in Additional Life must submit a Statement of Health when applying for coverage.***

Additional Features

- **Accelerated Benefit:** If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How Much Life Insurance Do You Need?

After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Medical bills
- Daily expenses
- Burial expenses
- Your children's education

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs.**

How Much Your Coverage Costs

Your Basic Life insurance is paid for by Hertford County. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount. Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ × _____ = _____ → _____

Enter the amount of coverage you are requesting (see Benefit amounts in The About This Coverage section).		Enter your rate from the rate table.		This amount is an estimate of how much you would pay each month.		To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your spouse's age and your spouse's rate. If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.30 for $1,000, no matter how many children you're covering.

Age (as of last July 1)	Your Rate (per $1,000 of Total Coverage)	Your Spouse's Rate (per $1,000 of Total Coverage)
<30	$0.086	$0.086
30 - 34	$0.130	$0.130
35 - 39	$0.172	$0.172
40 - 44	$0.28	$0.28
45 - 49	$0.452	$0.452
50 - 54	$0.732	$0.732
55 - 59	$1.248	$1.248
60 - 64	$1.786	$1.786
65 - 69	$2.882	$2.882
70 - 74	$4.73	$4.73
75+	$7.87	$7.87

Additional Life Semi-Monthly Premiums

Coverage Amount	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*	70-74*	75+*
$10,000	0.43	0.65	0.86	1.40	2.26	3.66	6.24	8.93	9.37	11.83	19.68
$20,000	0.86	1.30	1.72	2.80	4.52	7.32	12.48	17.86	18.73	23.65	39.35
$30,000	1.29	1.95	2.58	4.20	6.78	10.98	18.72	26.79	28.10	35.48	59.03
$40,000	1.72	2.60	3.44	5.60	9.04	14.64	24.96	35.72	37.47	47.30	78.70
$50,000	2.15	3.25	4.30	7.00	11.30	18.30	31.20	44.65	46.83	59.13	98.38
$60,000	2.58	3.90	5.16	8.40	13.56	21.96	37.44	53.58	56.20	70.95	118.05
$70,000	3.01	4.55	6.02	9.80	15.82	25.62	43.68	62.51	65.57	82.78	137.73
$80,000	3.44	5.20	6.88	11.20	18.08	29.28	49.92	71.44	74.93	94.60	157.40
$90,000	3.87	5.85	7.74	12.60	20.34	32.94	56.16	80.37	84.30	106.43	177.08
$100,000	4.30	6.50	8.60	14.00	22.60	36.60	62.40	89.30	93.67	118.25	196.75
$110,000	4.73	7.15	9.46	15.40	24.86	40.26	68.64	98.23	103.03	130.08	216.43
$120,000	5.16	7.80	10.32	16.80	27.12	43.92	74.88	107.16	112.40	141.90	236.10
$130,000	5.59	8.45	11.18	18.20	29.38	47.58	81.12	116.09	121.76	153.73	255.78
$140,000	6.02	9.10	12.04	19.60	31.64	51.24	87.36	125.02	131.13	165.55	275.45
$150,000	6.45	9.75	12.90	21.00	33.90	54.90	93.60	133.95	140.50	177.38	295.13
$160,000	6.88	10.40	13.76	22.40	36.16	58.56	99.84	142.88	149.86	189.20	314.80
$170,000	7.31	11.05	14.62	23.80	38.42	62.22	106.08	151.81	159.23	201.03	334.48
$180,000	7.74	11.70	15.48	25.20	40.68	65.88	112.32	160.74	168.60	212.85	354.15
$190,000	8.17	12.35	16.34	26.60	42.94	69.54	118.56	169.67	177.96	224.68	373.83
$200,000	8.60	13.00	17.20	28.00	45.20	73.20	124.80	178.60	187.33	236.50	393.50
$210,000	9.03	13.65	18.06	29.40	47.46	76.86	131.04	187.53	196.70	248.33	413.18
$220,000	9.46	14.30	18.92	30.80	49.72	80.52	137.28	196.46	206.06	260.15	432.85
$230,000	9.89	14.95	19.78	32.20	51.98	84.18	143.52	205.39	215.43	271.98	452.53
$240,000	10.32	15.60	20.64	33.60	54.24	87.84	149.76	214.32	224.80	283.80	472.20
$250,000	10.75	16.25	21.50	35.00	56.50	91.50	156.00	223.25	234.16	295.63	491.88
$260,000	11.18	16.90	22.36	36.40	58.76	95.16	162.24	232.18	243.53	307.45	511.55
$270,000	11.61	17.55	23.22	37.80	61.02	98.82	168.48	241.11	252.90	319.28	531.23
$280,000	12.04	18.20	24.08	39.20	63.28	102.48	174.72	250.04	262.26	331.10	550.90
$290,000	12.47	18.85	24.94	40.60	65.54	106.14	180.96	258.97	271.63	342.93	570.58
$300,000	12.90	19.50	25.80	42.00	67.80	109.80	187.20	267.90	281.00	354.75	590.25

**Coverage amounts for ages 65 and over reduce due to age reduction (see Life Insurance Age Reductions section.)*
Premiums for Employee coverage are determined by the employees age. Premiums for Spouse coverage are determined by the spouses age.

Child Life Semi-Monthly Premiums

Coverage Amount	Premium
$5,000	$0.75
$10,000	$1.50

Important Details

Eligibility Requirements

To be eligible for coverage, you must be: An active employee of Hertford County regularly working at least 30 hours per week **OR** an elected official of Hertford County; Insured for Basic Life insurance through The Standard to qualify for Additional Life insurance. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible. If you buy Additional Life insurance for yourself, you may also buy additional coverage for your eligible children and/or spouse. This is called Dependents Life insurance. You can choose to cover your spouse, meaning a person to whom you are legally married. Child means your child from live birth through age 25. Your child cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

Medical Underwriting Approval

Required for: All late applications (applying 31 days after becoming eligible); Requests for coverage increases; Reinstatements; Eligible but not insured under the prior life insurance plan. Visit **http://www.standard.com/mybenefits/mhs_ho.html** to submit a medical history statement online.

Coverage Effective Date

To become insured, you must: Meet the eligibility requirements listed in the previous sections; Serve an eligibility waiting period*; Receive medical underwriting approval (if applicable); Apply for coverage and agree to pay premium, and; Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective. If you are not actively at work on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage. **Defined as date you become a member*

Life Insurance Age Reductions

Under this plan, you and your spouse coverage amount reduces to 65 percent at age 65, to 50 percent at age 70. Your spouse's coverage will not be reduced because of your age unless your insurance is subject to termination under the Waiver or Premium provision.

Waiver of Premium

Your premiums may be waived if you: Become totally disabled while insured under this plan; Are under age 60, and; Complete a waiting period of 180 days. If these conditions are met, your Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Exclusions

Subject to state variations, you and your dependents are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

When Your Insurance Ends

Your insurance ends automatically when any of the following occur: The date the last period ends for which a premium was paid; The date your employment terminates; The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances); The date the group policy, or your employer's coverage under the group policy, terminates; For each elective insurance coverage, the date that coverage terminates under the group policy. In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent. For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204
www.standard.com

Whole Life Plan

MassMutual

Group Whole Life Insurance at a Glance

Our group whole life insurance provides smart, convenient protection that also helps you achieve your financial goals.

Consider The Advantages:

MassMutual@work Group Whole Life Insurance provides coverage at a set premium, builds cash value over time you can borrow from[1] and pays a death benefit to your loved ones. Group Whole Life Insurance may be easier and more affordable than you think.

Provides Guarantees

- ✓ Guaranteed death benefit
- ✓ Guaranteed level premiums
- ✓ Guaranteed cash-value accumulation
- ✓ ***Guaranteed Issue (GI) amounts of $150,000 for employees and $25,000 for child/grandchildren. No GI for spouse.***

Dividend Eligible[2]

MassMutual@work whole life certificate owners are eligible to receive dividends. During enrollment, you'll have the opportunity to select the dividend option that fits you best. Options include:

- Cash
- Dividend accumulations
- Paid-up additional insurance

Portable, Lifelong Coverage

You own the certificate along with the accumulated cash values and you can take it with you even if you leave the company. Additionally, if you leave the company and take your certificate with you, you can change your dividend option and choose to have your dividend payments reduce your premiums.

Tax Advantages

Whole life insurance policies offer a combination of valuable tax advantages, including:

- Generally income-tax-free death benefit
- Tax-deferred cash-value growth

Waiver of Premium

In the event that the certificate owner becomes totally disabled from any occupation as described in the rider, the premium for the base certificate and the riders will be waived for the duration of the insured's disability, following a continuous six-month waiting period. Benefits payable to attained age 67 (may vary by state). This rider is selected at the group level and available only at time of issue. This rider is available at an additional cost. Employees can elect to cancel the rider at any time; once cancelled it cannot be reinstated.

Accelerated Death Benefit Provisions

As the certificate owner, you can receive an advance, or acceleration, of a portion of the death benefit under the certificate, if the insured is diagnosed with a terminal illness or if the insured has a chronic illness.

- **Terminal Illness**: The Accelerated Death Benefit for Terminal Illness is payable when the insured meets the definition of Terminally Ill, generally diagnosed with an illness that will result in death within 12 months (24 months in some states.)
- **Chronic Illness**: The Accelerated Death Benefit for Chronic Care is payable when the insured meets the definition of Chronically Ill, meaning has a medical condition which requires continuous confinement in an eligible institution (e.g., licensed 24-hour nursing facility) and the insured is expected to remain there for the rest of their life.

These accelerated death benefits are not long term care insurance and may be used for any purpose. In many cases, these benefits allow access to more funds than would be available through a certificate loan or certificate cash surrender value. There from the Chronic Care Benefit. A tax advisor should be consulted regarding a request for accelerated benefits.

These benefits are not long term care insurance and may be used for any purpose. In many cases, these benefits allow access to more funds than would be available through a certificate loan or certificate cash surrender value. There is a fee taken from the Chronic Care Benefit. Consult with your tax advisor regarding a request for accelerated benefits.

Please be sure to review all of the features of your coverage.

Whole Life Premiums

Use your smartphone to scan the QR code to view your whole life premiums.
All policy information can also be found by visiting https://mymarkiii.com/hertfordcountync/policy-information/.

Scan me!

[1] Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.
[2] Dividends are not guaranteed. The certificate is eligible to receive dividends beginning on the second anniversary.

Continuation of Benefits

If you Leave Employment

Group Aflac

If you are no longer employed and would like to keep your current Aflac Group policies in place, you may be able to port your plans. Please visit http://www.aflacgroupinsurance.com/, under Customer Service > Service Requests > Continuation of Coverage. Follow the steps to port your Aflac Group plans. For more information, contact **Aflac at 1-800-433-3036.**

Medical, Dental and/or Vision Plan

Under the group medical, dental, and vision plans you and your covered dependents are eligible to continue coverage through COBRA. For COBRA information, call **FBA at 1-800-437-3539.**

AUL Short-Term and/or Long-Term Disability

Once an employee is on the AUL disability plan(s) for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 31 days from your date of termination to apply for portability. For more information, contact **AUL at 1-800-553-5318.**

MassMutual Whole Life

When you leave employment, you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **MassMutual at 1-800-272-2216.**

MetLife Group Cancer

You may continue your MetLife Group Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information, contact **Bay Bridge Administrators (TPA) at 1-888-252-3607**

The Standard Term Life

When you leave employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact **The Standard at 1-800-378-4668.**

**If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.*

Contact Information

Aflac | Policy #21683
P.O. Box 84075 | Columbus, GA 31993
Phone: 1-800-433-3036
Email: cscmail@Aflac.com
Aflacgroupinsurance.com

American United Life (AUL) | Policy #614097
P.O. Box 368 | Indianapolis, IN 46206-0368
Claims Toll-Free Number: 1-855-517-6365
Customer Service: 1-800-553-5318
www.oneamerica.com

Ameritas Dental | Policy #10-13072
Customer Service: 1-800-487-5553
www.ameritas.com

Blue Cross Blue Shield of NC
Customer Service: 1-888-206-4697
www.bcbsnc.com

MassMutual
Phone: 1-800-272-2216
www.massmutual.com

MetLife | Bay Bridge Administrators, LLC. | #1015
P.O. Box 161690 | Austin, TX 78716
Phone: 1-800-845-7519
Fax: 512-275-9350
www.bbadmin.com

The Standard Insurance Company | Policy #164339-A
Phone: 1-800-378-4668
www.standard.com

Superior Vision | Policy #28252
Customer Service: 1-800-507-3800
Fax - 916-852-2277
Claims Administration
P.O. Box 967 | Rancho Cordova, CA 95741
www.superiorvision.com

Texas Life Insurance Company (Old Plan) | Policy #SS0C0K
P.O. Box 830 | Waco, TX 76703-0830
Phone: 1-800-283-9233
www.texaslife.com

View additional benefits information
or download forms at: mymarkiii.com

Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits

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