



EMPLOYEE BENEFITS HANDBOOK

July 1, 2026 – June
30, 2027

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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, 2026 to June 30, 2027. This means your benefit elections will take effect July 1, 2026 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 outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending and Dependent Care accounts each year! It will not automatically renew.
- ✓ **Wellness Benefits:** Certain plans have Wellness Benefits for covered screening tests. This means you can get money back for having a qualified screening test and then filing a wellness claim for the qualified screening test. Look for the wellness benefit to better you and your family!
- ✓ 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/personcountync/>.



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.” 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. Documentation is 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 unless you have a qualifying life event (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.

- ✓ Cigna Medical
- ✓ FBA Flexible Spending Accounts
- ✓ Humana Dental
- ✓ Superior Vision by MetLife
- ✓ MetLife Group Cancer
- ✓ Aflac Accident
- ✓ Aflac 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 life event outlined by the IRS (i.e. birth of a child, divorce, separation, reduction in hours, etc.).

- ✓ Aflac Critical Illness
- ✓ OneAmerica (AUL) Short-Term Disability
- ✓ OneAmerica (AUL) Long-Term Disability
- ✓ The Standard Term Life
- ✓ MassMutual Whole Life

How to Enroll at Open Enrollment

Onsite Enrollment

Our trusted Mark III Benefits Counselors will be available to meet with employees onsite to explain the benefits offered and to help get you enrolled.

Self-Service Enrollment

You have the option to self-enroll in your benefits through the online enrollment platform. Visit the link below to self-enroll.

To Self-Enroll Visit: <https://mymarkiii.com/personcountync/enrollment/>

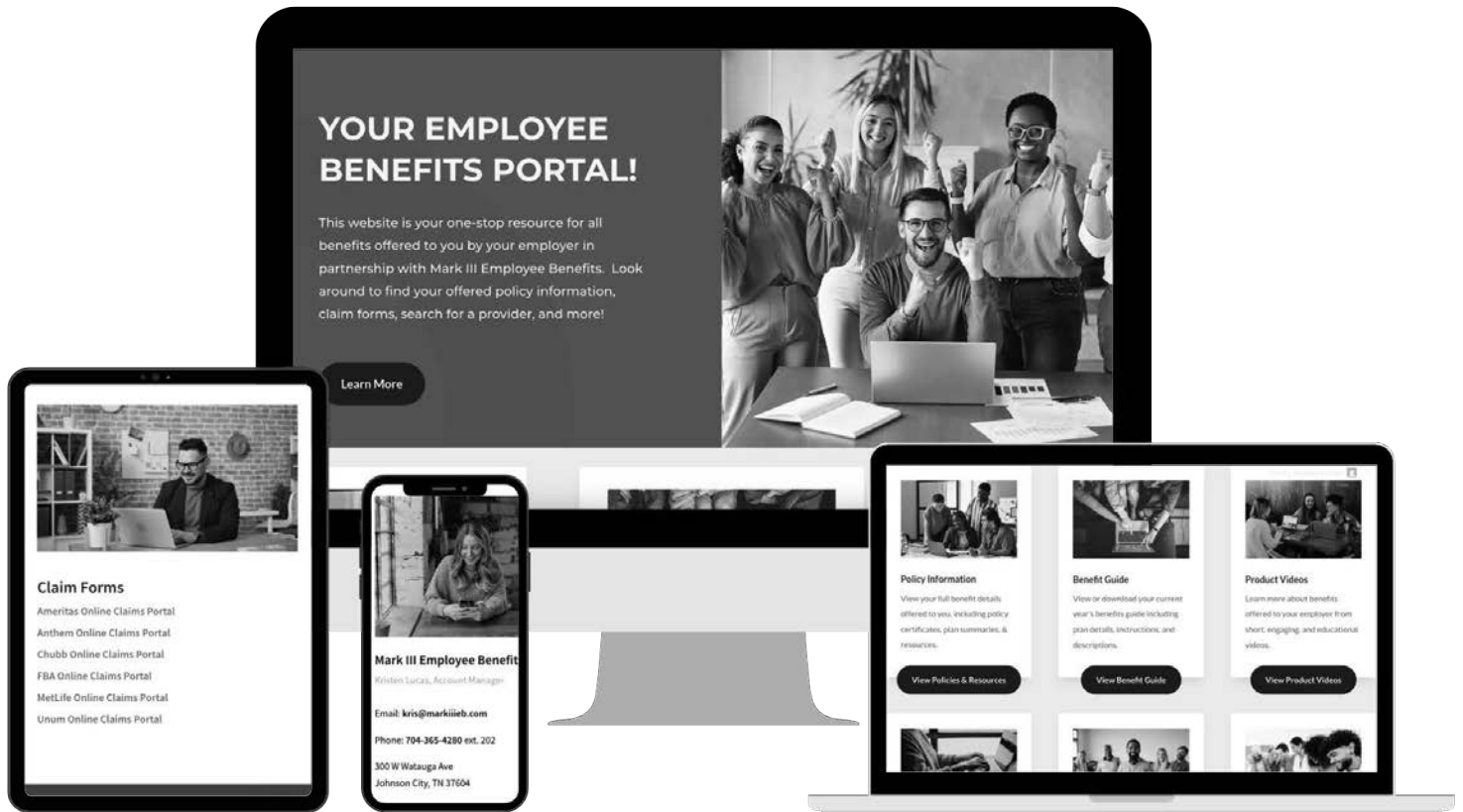
Employee Benefits Portal

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



Employee Benefits Portal

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



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

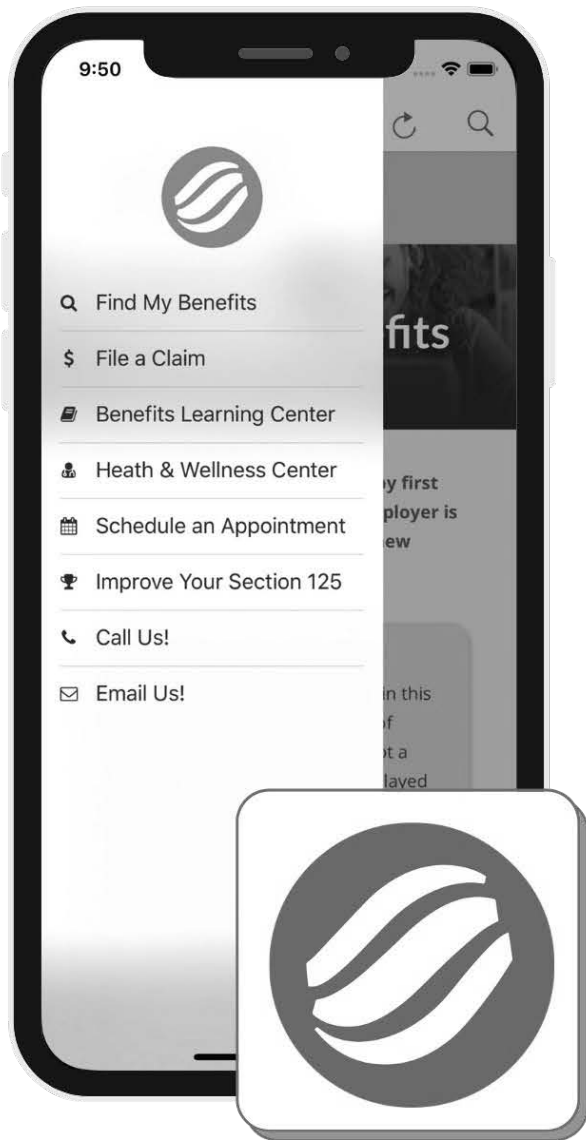


Available 24/7* from any internet enabled device for your convenience.

**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

Search for “MyMark III” to access benefit information on the go!

Available on:



*Your Trusted Benefits
Partners at your fingertips!*



Filing a Claim

Humana Dental

Visit <https://mymarkiii.com/personcountync/forms/> to download your claim form or file online at <https://www.humana.com/provider/medical-resources/>. 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 located on your claim form.

Superior Vision by MetLife

Visit <https://mymarkiii.com/personcountync/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 located on your claim form.

MetLife Cancer

Visit <https://mymarkiii.com/acpsva/forms/> to access your claim form. You may also utilize the online claims portal by visiting https://portal.bbadmin.com/users/sign_in.

- Please have the following information available: Claimant Name, Date of Service, Name of Service/Screening, Provider Name, and Phone Number.
- Wellness Benefits can also be called into a Bay Bridge claim's examiner at (800) 845-7519.

Group Aflac

Visit <https://mymarkiii.com/personcountync/forms/> to download your claim form or file online at <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/personcountync/forms/> to download your claim form. Mail, fax, or email a copy of the itemized invoice or receipt imprinted with the provider's name and address along with the form to the contact information located on your claim form.

Employee Benefits Portal

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

Visit: <https://mymarkiii.com/personcountync/>





Wellness Benefits

What is a Wellness Benefit?

Certain plans have a wellness feature built into your benefit options. This benefit gives **money back to you** for having a qualified screening test and then filing a claim for the screening test performed.

Qualified Screening Tests*

- ✓ Hemocult stool analysis
- ✓ Breast ultrasound
- ✓ Mammography
- ✓ CA 125 (blood test for ovarian cancer)
- ✓ CA 15-3 (blood test for breast cancer)
- ✓ CEA (blood test for colon cancer)
- ✓ Colonoscopy
- ✓ Pap smears
- ✓ Blood Screenings
- ✓ PSA (blood test for prostate cancer)
- ✓ Stress test (bicycle or treadmill)
- ✓ Electrocardiogram (EKG)
- ✓ Coronavirus Testing



**The list of screening tests above is for illustrative purposes. Please see your plan provisions and limitations for a full list of qualified screening test.*

Get Paid by Staying Proactive!

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

Download Your Wellness Claim(s)

Visit your employee benefits portal to download your wellness benefit claim form(s).

Employee Benefits Portal: <https://mymarkiii.com/personcountync/>



Scan me!



HEALTHY LIVING

*Core Benefit options to keep
you and your family healthy.*



Medical Plan Summary



Cigna PPO/OAP Plan Summary

Benefit	In-Network	Out-of-Network
Deductible	\$2,000 Individual \$4,000 Family	\$4,000 Individual \$8,000 Family
Out-of-Pocket Limit	\$4,000 Individual \$8,000 Family	\$8,000 Individual \$16,000 Family
Primary Care Visit	\$30 Copay/Visit Deductible does not apply	50% Coinsurance
Specialist Visit	\$60 Copay/Visit Deductible does not apply	50% Coinsurance
Preventative Care/Screenings	No Charge Deductible does not apply	50% Coinsurance
Diagnostic Text (X-Ray, Blood Work)	20% Coinsurance X-Ray No Charge Blood Work	50% Coinsurance
Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance
Facility Fee (e.g., hospital room)	\$250 Copay/Admission, 20% Coinsurance	\$500 Deductible/Admission, 50% Coinsurance
Physician/Surgeon Fees	20% Coinsurance	50% Coinsurance
Emergency Room Care	20% Coinsurance	20% Coinsurance
Emergency Medical Transportation	20% Coinsurance	20% Coinsurance
Urgent Care	\$60 Copay/Visit Deductible does not apply	50% Coinsurance

Drug Tier	In-Network	Out-of-Network
Generic Drugs (Tier 1)	\$10 Copay/Prescription (Retail 30 Days) \$30 Copay/Prescription (Retail & Home Delivery 90 Days) Deductible Does Not Apply	Not Covered
Preferred Brand Drugs (Tier 2)	\$60 Copay/Prescription (Retail 30 Days) \$180 Copay/Prescription (Retail & Home Delivery 90 Days) Deductible Does Not Apply	Not Covered
Non-Preferred Brand Drugs (Tier 3)	\$80 Copay/Prescription (Retail 30 Days) \$240 Copay/Prescription (Retail & Home Delivery 90 Days) Deductible Does Not Apply	Not Covered
Specialty Drugs (Tier 4)	20% Coinsurance, Up To A Maximum Of \$350/Prescription (Retail & Home Delivery 30 Days) Deductible Does Not Apply	Not Covered

Tier of Coverage	Semi-Monthly Rates	Monthly Rates
Employee Only	\$27.23	\$54.45
Employee/Child	\$217.80	\$435.60
Employee/Children	\$261.36	\$522.72
Employee/Spouse	\$662.44	\$1,324.87
Employee/Family	\$860.74	\$1,721.48

This document is a highlight of plan benefits provided by Cigna 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.

Cigna Consumer Driven Plan w/ HSA Plan Summary

Benefit	In-Network	Out-of-Network
Deductible	\$1,700 Individual \$3,400 Family	\$3,000 Individual \$6,000 Family
Out-of-Pocket Limit	\$3,500 Individual \$5,000 Family	\$5,250 Individual \$7,500 Family
Primary Care Visit	20% Coinsurance/Visit	50% Coinsurance
Specialist Visit	20% Coinsurance/Visit	50% Coinsurance
Preventative Care/Screenings	No Charge Deductible does not apply	50% Coinsurance
Diagnostic Text (X-Ray, Blood Work)	20% Coinsurance X-Ray No Charge Blood Work	50% Coinsurance
Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance
Facility Fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance
Physician/Surgeon Fees	20% Coinsurance	50% Coinsurance
Emergency Room Care	20% Coinsurance	20% Coinsurance
Emergency Medical Transportation	20% Coinsurance	20% Coinsurance
Urgent Care	20% Coinsurance	50% Coinsurance

Drug Tier	In-Network	Out-of-Network
Generic Drugs (Tier 1)	20% Coinsurance/Prescription (Retail 30 Days), 20% Coinsurance/Prescription (Retail & Home Delivery 90 Days)	Not Covered
Preferred Brand Drugs (Tier 2)	20% Coinsurance/Prescription (Retail 30 Days), 20% Coinsurance/Prescription (Retail & Home Delivery 90 Days)	Not Covered
Non-Preferred Brand Drugs (Tier 3)	20% Coinsurance/Prescription (Retail 30 Days), 20% Coinsurance/Prescription (Retail & Home Delivery 90 Days)	Not Covered

Tier of Coverage	Semi-Monthly Rates	Monthly Rates
Employee Only	\$0.00	\$0.00
Employee/Child	\$108.90	\$217.80
Employee/Children	\$141.57	\$283.14
Employee/Spouse	\$403.48	\$806.95
Employee/Family	\$531.43	\$1,062.86

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.cigna.com/sp.

Scan the QR Code or visit <https://mymarkiii.com/personcountync/policy-information/> to view your SBCs.



Scan me!



This document is a highlight of plan benefits provided by Cigna 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.

Cigna Virtual Care

Employees can get care whenever and wherever with minor medical and behavioral/mental health virtual care.

Your employees' lives are demanding. It's hard for them to find time to take care of themselves as it is, never mind when they're not feeling well. That's why health plans through Cigna include access to medical and behavioral/mental health virtual care.

Whether they've got meetings all day or they just don't have the time or energy to go anywhere but home after work, employees can:

- ✓ Access care from just about anywhere via video or phone.
- ✓ Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- ✓ Schedule a behavioral/mental health virtual care appointment online in minutes.
- ✓ Access board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- ✓ Have a prescription sent directly to a local pharmacy, if appropriate.

Minor Medical Virtual Care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- ✓ Acne
- ✓ Allergies
- ✓ Asthma
- ✓ Bronchitis
- ✓ Cold and flu
- ✓ Constipation
- ✓ Diarrhea
- ✓ Earaches
- ✓ Fever
- ✓ Headaches
- ✓ Infections
- ✓ Insect bites
- ✓ Joint aches
- ✓ Nausea
- ✓ Pink eye
- ✓ Rashes
- ✓ Respiratory infections
- ✓ Shingles
- ✓ Sinus infections
- ✓ Skin infections
- ✓ Sore throats
- ✓ Urinary tract infections

MDLIVE providers can also conduct virtual wellness screenings.

Behavioral/Mental Health Virtual Care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions, such as:

- ✓ Addictions
- ✓ Bipolar disorders
- ✓ Child/Adolescent issues
- ✓ Depression
- ✓ Eating disorders
- ✓ Grief/Loss
- ✓ Life changes
- ✓ Men's issues
- ✓ Panic disorders
- ✓ Parenting issues
- ✓ Postpartum depression
- ✓ Relationship and marriage issues
- ✓ Stress
- ✓ Trauma/PTSD
- ✓ Women's issues

Virtual Care Options

Cigna partners with MDLIVE® for minor medical and behavioral/mental health virtual care.* This can be accessed via myCigna.com. Additionally, Cigna's in-network medical and behavioral providers also provide access to virtual medical and behavioral care, including virtual counseling.

Connect With Virtual Care Your Way

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on myCigna.com
- Schedule an appointment with an MDLIVE provider or licensed therapist on myCigna.com
- Call MDLIVE 24/7 at 888.726.3171

Cigna's Network Of Behavioral Health Providers

Cigna Behavioral Health provides access to virtual counseling through its own network of providers. To find a Cigna Behavioral Health network provider:

- Visit myCigna.com, go to **"Find Care & Costs"** and enter **"Virtual counselor"** under Doctor by Type.
- Or, call the number on your Cigna ID card.

**Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A primary care provider referral is not required for this service.*



SO MANY WAYS TO HELP MANAGE YOUR HEALTH

Get to know the full value of myCigna.

Now it's easier than ever to manage your health and make the most of your health plan on the myCigna* website and app.** From programs that help improve your health to tools that help manage your health spending, there's so much you can do.



View, print and send
ID cards



Find in-network doctors,
hospitals and medical services



Compare quality of care
information, including patient
reviews from Cigna customers



Manage and track
claims



See cost estimates for medical
procedures



Use the click-to-chat feature to
connect with a live Cigna rep



Feel better protected Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on myCigna.



Visit **myCigna** today. Not registered yet? **Start here.****



Download the myCigna App for your mobile device.
Disponible en Español.

Scan the QR code with your phone, and make sure to have your ID card handy, you'll need it to register.**

Together, all the way.®



Offered by Cigna Health and Life Insurance Company or its affiliates.

* Actual myCigna features may vary depending on your plan and customer profile.

** Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.

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Read full descriptions and plan details at mymarkiii.com

EXPRESS SCRIPTS PHARMACYSM

Our new home delivery pharmacy

Express Scripts has joined the Cigna family.

Express Scripts is now a Cigna company. Because of this, Express Scripts Pharmacy, one of the country's largest home delivery pharmacies, is now our home delivery pharmacy. We look forward to working together to better serve you and all of your pharmacy, health and wellness needs.

Why choose home delivery?

If you take a medication every day to treat an ongoing health condition, Express Scripts Pharmacy may be a convenient option for you.

- › **Convenience.** Don't waste time standing in line at the pharmacy. Express Scripts Pharmacy will ship your medication to you at no extra cost. And when you sign up for automatic refills,* it's even easier to stay on track with your important medications.
- › **Safe, private delivery.** Express Scripts Pharmacy's packaging is designed to protect your privacy and stand up to bad weather.
- › **Easy refills.** Fill up to a 90-day supply of your medication at one time, so you fill less often.
- › **Free refill reminders.** Express Scripts Pharmacy will send you refill reminders** to help make sure you don't miss a dose.
- › **Track your orders.** You can refill your prescription and track your orders online or from your mobile phone.
- › **24/7 access to licensed pharmacists.** Express Scripts' pharmacists are trained to provide specialized support for conditions like diabetes, high blood pressure and high cholesterol.

- › **Payment assistance.** If you need help paying for your medication, Express Scripts Pharmacy offers an Extended Payment Plan, which gives you the option to split your bill into three smaller payments.



Two easy ways to place a new order

- 1. Electronically:** For fastest service, ask your doctor's office to send your prescription electronically to Express Scripts Home Delivery, NCPDP 2623735.
- 2. By fax:** Have your doctor's office call 888.327.9791 to get a Fax Order Form.

For current prescriptions - it's easy to move them to Express Scripts Pharmacy.

Just call 800.835.3784 and have your doctor's contact information and prescription medication name(s) and dosage(s) ready. Express Scripts Pharmacy will do the rest.

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company or its affiliates.

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Read full descriptions and plan details at mymarkiii.com

Use the myCigna® app or website. Connect to your new Express Scripts online account portal, and more.

- › **Compare your medication costs before you place your order.** You can use the “Price a Medication” feature to find out how much your medication will cost you to fill at home delivery compared to an in-network retail pharmacy.**
- › **See which medications your plan covers and search for lower-cost alternatives** (if available).
- › **Connect to your Express Scripts online account portal to manage your medications.**
 - Refill your prescriptions and/or request a new prescription
 - Check your order status and track shipments so you know when you should get your medication
 - Sign up for Express Scripts’ automatic refills and/or auto renewal program
 - See your order and medication histories
 - Update your profile information, like your contact and payment information, what allergies and/or health conditions you have, and how you’d like Express Scripts Pharmacy to contact you

Questions?

We’re available anytime, 24/7/365.

- › Talk to customer service about a benefit question: Call the number on your Cigna ID card
- › You can also chat with us online on the myCigna website, Monday–Friday, 9:00 a.m.–8:00 p.m. EST.

800.835.3784



**Place
an order**



**Talk to customer
service about
an order**



**Talk to a
pharmacist about
your medication**



* Express Scripts Pharmacy can automatically refill certain medications. You can call 800.835.3784 to sign up over the phone. Or, you can log in to the myCigna app or website to connect to your Express Scripts online account portal. From there, you can sign up for their automatic refill program.

** You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for Express Scripts' texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, simply reply to their welcome text to get started. Standard text messaging rates apply.

*** Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

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

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Express Scripts, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. “Express Scripts Pharmacy” refers to ESI Mail Pharmacy Service, Inc. and Express Scripts Pharmacy, Inc. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC). The Cigna name, logo, “Together, all the way,” and “myCigna” are owned by Cigna Intellectual Property, Inc. “Express Scripts” and “Express Scripts Pharmacy” are trademarks of Express Scripts Strategic Development, Inc.

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Weight Management Program



HealthMapRx Medical Weight Care Management

Do you struggle with the need to lose weight? Person County recognizes this struggle and how it affects your health and well-being!

What is, HealthMapRx?

A free health benefit available to employees and their dependents who are covered by Person County's health insurance. Though the benefit program is employer sponsored, the County WILL NOT have access to any personal health information.

Do YOU qualify?

If you have a **BMI (body mass index) of 35 or more** and **do not have diabetes**, you may qualify for the Medical Weight Management Program.

What's in it for YOU?

- **Education and on-going Support:** Participants engage in a series of virtual group educational activities and weekly electronic check-ins with their health coach; in addition to routine meetings (4 times per year) with their assigned **Pharmacist Care Manager**.
- **Participation Incentive:** Participants can earn up to **\$120 per year**.
- **\$0 Co-pay for Medications:** Co-pays are waived for preferred medications.
- **Self-Monitoring Technology:** Participants will receive a **digital scale** that has Bluetooth® capabilities with an app to track weekly weigh-ins.

Check Your BMI



Sponsor
Code:
1037

Program Screener



How do YOU screen for eligibility?

- Spots are limited and will be filled on a first-come, first-served basis
- Program is offered twice annually starting in July and January
- Screening for the program will start the first week of June and December
- Use the program screener QR Code (orange) or URL to complete Screener:
 - <https://c0eku388.caspio.com/dp/260030002a082049ef6a408c89d1>

For more Information: Contact HealthMapRx Program Support

- Phone: (336) 580-0340
- Email: admin@emailmm.com



Diabetes Care Management



HealthMapRx Diabetes Care Management

You may be eligible to participate in a **free health benefit** sponsored by Person County called **HealthMapRx™**. This program is **voluntary** and made available to employees, retirees, and dependents who are currently covered under the health insurance plan.

HealthMapRx™ is a confidential program and **Person County will NOT have access to your personal health information.**

How does it work?

This program is designed to help individuals manage their **Diabetes or Pre-Diabetes.**

Participant will be paired with a pharmacist care manager for private face-to-face appointments 4-6 times per year. Most sessions are scheduled for 30-45 minutes to discuss pertinent health information and allow participants an opportunity to ask any questions you may have related to your condition. For your convenience, appointments will be scheduled at the worksite and during work hours.

Do YOU qualify?

Do you take medicine for diabetes or pre-diabetes? If you answered **YES**, you qualify!

What's in it for YOU?

- **\$0 Co-pay for Medications:** Co-pays are waived for formulary preferred medications used to treat diabetes, high blood pressure, and high cholesterol.
- **\$0 Co-pay on Diabetes Supplies:** Co-pays are waived for preferred formulary diabetes testing devices and supplies; insulin and other injectable diabetes medication administration supplies.
- **Participation Incentive:** Participants can earn up to **\$120 per year.**

How do YOU enroll?

Enroll Online:

- Use Customer / Sponsor Code: **1037**

HealthMapRx Program Support

Phone: (336) 580-0340

Fax: (984) 336-1720

Email: admin@emailmm.com





Health Savings Account (HSA)

Health Savings Account (HSA)

An HSA is an individually owned benefits plan funded by you to help pay for health care expenses! Employees must be enrolled in the High Deductible Health Plan (HDHP) to be eligible.

HSAs have a triple-tax advantage, meaning distributions for qualified medical expenses and investment returns are tax-free, and contributions are tax-deductible. They can also be invested, which lets you grow your dollars!!

Employer Contributions

Your employer contributes **\$1,200** to your HSA every year. This amount is prorated according to your insurance effective date. Any unused dollars in your HSA will roll-over to the next plan year!

2026 HSA Contribution Limits

	<i>Individual</i>	<i>Family</i>
HSA Contribution Maximum	\$4,400	\$8,750
HSA Catch-Up Contribution Maximum (Age 55+)	\$1,000	\$1,000

How to Open an HSA Account

State Employees Credit Union Members: If you are a member with the State Employees Credit Union, you will need to go to the branch and tell them you want to open an HSA Account for Person County Government.

Civic Credit Union: To open an HSA Account with Civic, call 844-772-4842 or go to www.civicfcu.org/bank/savings/health-savings-account and scroll down and click on "Open Today".

- **Unit Code:** 10010

You will receive an HSA Authorization Form from the bank in which you open your account. Please be sure to return this form to Human Resources.

What to bring when opening your account:

- Name
- Social Security Number
- Date of Birth
- Beneficiary Details (SSN, DOB, Address, Phone Number)
- Carrier Name: Cigna
- Current Medical Deductible Amounts

For More Information

Person County HR: (336) 597-1725

HSA Store

Visit <https://hsastore.com/> to see all the HSA-eligible items available to you, or scan the QR code to the right for quick access to the list!



Scan me!



Flexible Spending Account



Get reimbursed for out-of-pocket healthcare & child/aged adult day care expenses with tax free dollars!!

Maximize Your Income

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars!) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save approximately \$27.65 to \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Eligibility

Participation in the Plan Begins on July 1, 2026 and ends on June 30, 2027. Full-time employees working at least 30 hours or more per week will be eligible to participate in the Plan only during the annual open enrollment period. Any new hires during the year will not be able to join until the next open enrollment period. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

The Health Care Account is a Pre-Funded Account

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions are deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Plan Year is \$3,400.00.

Election Changes

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers



Reimbursement Schedule

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

Online Access

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at <https://fba.wealthcareportal.com/> to view the following features:

- FSA Login – view balances, check status and view claims history, download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

Health Care Reimbursement

With this account, you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all of your tax dependents for healthcare services that are incurred during your plan year and while an active participant. Eligible expenses are those incurred “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” This is a broad definition that lends itself to creativity.

Examples of Eligible Health Care Expenses

Fees/Co-Pays/Deductibles for:

- Acupuncture | Prescription eyeglasses/reading glasses/contact lens and supplies | Eye Exams/Laser Eye Surgery | Physician | Ambulance | Psychiatrist | Psychologist | Anesthetist | Hospital | Chiropractor | Laboratory/Diagnostic | Fertility Treatments | Surgery | Dental/Orthodontic Fees | Obstetrician | X-Rays | Eye Exams | Prescription Drugs | Artificial limbs & teeth | Orthopedic shoes/inserts | Therapeutic care for drug & alcohol addiction | Vaccinations & Immunizations | Mileage | Take-home screening kits

Diabetic supplies | Routine Physicals | Oxygen | Physical Therapy | Hearing aids & batteries | Medical equipment | Antacids | Pain relievers | Allergy & Sinus Medication

Over-the-Counter Expense (Examples of medication and drugs that may be purchased in reasonable quantities with a prescription):

- Acne Treatment | Humidifiers | Multivitamins | Herbal Supplements | Baby Formula | Fiber Supplements

Day Care/Aged Adult Care Reimbursement

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
 - Disabled spouse
 - Children who became disabled prior to age 19.
 - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- **\$7,500 (\$3,750 if married filing separately)**
- Your wages for the year or your spouse's if less than above
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

How to Receive Reimbursement

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

Eligible Day Care/Aged Adult Expenses

- Au Pair | Nannies | Before & After Care | Day Camps | Babysitters | Daycare for an Elderly Dependent | Daycare for a Disabled Dependent | Nursery School | Private Pre Schools | Sick Child Center | Licensed Day Care Centers

Ineligible Expenses:

- Overnight Camps | Babysitting for Social Events | Tuition Expenses including Kindergarten | Food Expenses (if separate from dependent care expenses) | Care provided by children under 19 (or by anyone you claim as a dependent) | Days your spouse doesn't work (though you may still have to pay the provider) | Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary | Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill | Expenses incurred while on Leave of Absence or Vacation

Forfeiting Funds

Plan carefully! Unused funds will be forfeited back to your employer as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to add the \$680 roll-over provision to the Medical FSA. Please see the Employee Guide for more info.

How to Enroll in our FSA Plan

Step 1

Carefully estimate your eligible HealthCare and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at <http://fba.wealthcareportal.com/> to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	\$2,500.00	\$2,500.00
Eligible Pre-Tax employer medical insurance	\$0.00	\$200.00
Eligible Pre-Tax medical expenses	\$0.00	\$100.00
Eligible Pre-Tax dependent child care expenses	\$0.00	\$300.00
Taxable Income	\$2,500.00	\$1,900.00
Federal Tax (15%)	\$375.00	\$285.00
State Tax (5.75%)	\$143.75	\$109.25
FICA Tax (7.65%)	\$191.25	\$145.35
After-Tax employer medical insurance	\$200.00	\$0.00
After-Tax medical expenses	\$100.00	\$0.00
After-Tax dependent child care expenses	\$300.00	\$0.00
Monthly Spendable Income	\$1,190.00	\$1,360.40

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by \$170.40 every month! This is an annual tax savings of \$2,044.80. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

Online Wealthcare Portal

View your account status, submit claims and report your benefits card lost/stolen right from your computer. Once your account is established, you can use the same user name and password to access your account via our Mobile App!

Follow the simple steps below to establish your secure user account.

- ✓ Get started by visiting <https://fba.wealthcareportal.com/> and click the register button in the top-right corner of the homepage.
- ✓ You will be directed to the registration page.
- ✓ Follow the prompts to create your account.
 - User Name
 - Password
 - Name
 - Email Address
 - Employee ID (Your SSN, no spaces/dashes)
 - Registration ID
 - Employer ID (FBAPERS)
 - Your Benefits Card Number
- ✓ Once completed, please proceed to your account.



Benefits Card

The Benefits Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.

FBA Participant Portal, Mobile App, Benefits Card & Claim Submission

Scan the QR code with your smartphone to view the FBA Participant Portal, FBA Mobile App, FBA Benefits Card, and Claim submission information. The Participant Portal provides powerful self-service account access, plus education and decision-support tools that help put you in the driver's seat when it comes to your healthcare finances. The Mobile App offers a personalized, real-time and self-guided experience that allows you to easily manage your Benefit Account and delivers tools to help save you money. The benefits debit card eliminates the hassles of claim submission and waiting for a reimbursement check.



For more information, please call 800-437-3539
 P.O. Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com



Understanding the Difference!

Below we've outlined the key differences between HSAs, HRAs, and FSAs so you can see which is right for you and your family, the advantages to each, and why they are offered.

Health Savings Account (HSA)

- ✓ An HSA is an individually owned benefits plan funded by the employee.
- ✓ Employees must be enrolled in the High Deductible Health Plan (HDHP) to be eligible, which will lower insurance premiums.
- ✓ HSAs have a triple-tax advantage, meaning distributions for qualified medical expenses and investment returns are tax-free, and contributions are tax-deductible.
- ✓ HSAs can also be invested, which lets employees grow their dollars!
- ✓ **Contribution Limits: Individual - \$4,400 | Family - \$8,750**
- ✓ Visit www.HSAstore.com for your one-stop-destination for Health Savings Accounts where you can buy HSA eligible products, search for services and learn about your HSA.

Flexible Spending Account (FSA)

- ✓ An FSA is an employer-owned account that employees use to set aside funds for qualified expenses.
- ✓ FSAs offer pre-tax savings on eligible expense like medical or dependent care services.
- ✓ FSAs will also save you money! For example, if an employee is enrolled in the Medical FSA, he/she reduces the taxable income, which reduces the amount subject to Social Security and Medicare.
- ✓ You won't have to pay Social Security or Medicare tax on funds going into an FSA.
- ✓ Visit www.FSAstore.com for your one-stop-destination for Flexible Spending Accounts where you can buy FSA eligible products, search for services and learn about your FSA.





Dental Plan

Humana.

Humana Dental Traditional Preferred 14	In-Network Dentist		Out-of-Network Dentist	
	Individual \$25	Family \$75	Individual \$25	Family \$75
Calendar-year deductible (excludes orthodontia services)	Deductible applies to all services excluding preventive services			
Calendar-year annual maximum (excludes orthodontia services)	\$750 – after you reach the annual maximum amount, you will receive 30% coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia).			
Preventive services <ul style="list-style-type: none"> Routine oral exams (2 per year) Bitewing X-rays (2 films under age 10, up to 4 films ages 10 and older) Routine cleanings (2 per year) Fluoride treatment (1 per year, through age 14) Sealants (permanent molars, through age 14) Space maintainers (primary teeth, through age 14) Oral Cancer screening (1 per year, ages 40 and older) 	100% no deductible		100% no deductible	
Basic services <ul style="list-style-type: none"> Emergency care for pain relief Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) Oral surgery (tooth extractions including impacted teeth) Stainless steel crowns Harmful habit appliances for children (1 per lifetime, through age 14) Periodontics (periodontal cleanings 4 per year, scaling/root planning and surgery 1 per quadrant every 3 years) Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment) 	80% after deductible		80% after deductible	
Major services <ul style="list-style-type: none"> Crowns (1 per tooth every 5 years) Inlays/Onlays (1 per tooth every 5 years) Bridges (1 per tooth every 5 years) Dentures (1 per tooth every 5 years) Denture relines/rebases (1 every 3 years, following 6 months of denture use) Denture repair and adjustments (following 6 months of denture use) Implants (1 every 5 years limited to crowns, bridges, & dentures. Coverage limited to equivalent cost of a non-implant service. Implant placement itself it not covered.) 	50% after deductible		50% after deductible	
Orthodontia services	Adult/Child orthodontia. - Plan pays 50\$ (no deductible) of the covered orthodontia services, up to: \$1,500 lifetime orthodontia maximum.			

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Feel Good About Choosing A Humana Dental Plan

Make regular dental visits a priority. Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your Humana Dental Traditional Preferred plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal. *www.perio.org

Go to MyDentalIQ.com. Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* Humana Dental helps you feel good about your dental health so you can smile confidently. *American Academy of Cosmetic Dentistry

Use Your Humana Dental Benefits

Find a dentist. With Humana Dental's Traditional Preferred plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the Humana Dental Traditional Preferred Network. To find a dentist in Humana Dental's Traditional Preferred Network, log on to Humana.com or call 1-800-233-4013.

Know what your plan covers. The other side of this page gives you a summary of Humana Dental benefits. Your plan certificate describes your Humana Dental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at HumanaDental.com or call 1-800-233-4013.

See your dentist. Your Humana Dental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at Humana.com.

Learn what your plan paid. After Humana Dental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at Humana.com or by calling 1-800-233-4013.

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit Humana.com

Humana Dental Rates

Tier	Semi-Monthly Rates	Monthly Rates
Employee	\$0.00	\$0.00
Employee + Spouse	\$19.06	\$38.11
Employee + Child(ren)	\$27.46	\$54.91
Family	\$47.14	\$94.27

MyHumana Mobile App

Manage your healthcare wherever you are with the MyHumana app. Review your coverage, check claims, view your Humana member ID card and find in-network providers—all with a few taps.

How it works

Sign in to the MyHumana app using your MyHumana member name and password. From the home screen, you can access great features like your Humana ID card, claims information and provider finder.

Features

- ✓ **Coverage and benefits.** View important information you need about your plan details, including deductibles and balances. Also view information for dependents and other delegated members covered under your plan. Share your coverage information directly to your provider via fax.
- ✓ **ID Cards.** View your medical, dental and pharmacy ID cards. Share your ID cards with your provider via fax.
- ✓ **Spending accounts.** View your latest transactions and account balances.
- ✓ **Claims.** See your latest claims, their status, summary and detailed information.
- ✓ **Provider finder.** Locate in-network providers by specialty. Search via your current location* or enter a ZIP code to search anywhere you need. Quickly locate hospitals or urgent care centers with one tap of your finger.*

*Requires location sharing enabled on your phone.



Humana®

Policy Number: TN-70090-HC 1/14

Humana group dental plans are offered by Humana Insurance Company, Humana Dental Insurance Company, Humana Insurance Company of New York, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc., Humana Medical Plan of Utah, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc. or DentiCare, Inc. (d/b/a CompBenefits)

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.



Vision Plan

SuperiorVision
By **MetLife**

Copayment: \$10 Exam
 \$10 Materials¹
 \$10 Contact Lens Fitting Fee (Standard & Specialty)

How to Use the Plan

Welcome to Superior Vision by MetLife 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. Visit www.metlife.com and scroll to 'How can we help you' section and click 'Find a Vision Provider'. Select 'Superior Vision by MetLife' and enter your location and complete the form.

Remember that a routine eye exam is 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 \$60.00
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 \$26.00 Up to \$34.00 Up to \$50.00 Up to \$50.00
Contact Lenses⁴	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 Materials¹

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 & Materials¹

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 costs¹ 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 Discounts¹

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.

¹Not 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	Monthly Rates
Employee Only	\$3.64	\$7.27
Employee + Spouse	\$7.27	\$14.54
Employee + Child(ren)	\$8.31	\$16.61
Employee + Family	\$12.81	\$25.62



SuperiorVision
By **MetLife**

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for your 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



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.	1. \$0 2. \$2,500 3. \$0 4. \$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 cents 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 cents 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

<i>Benefit</i>	<i>Benefit Option</i>
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	1 & 2: Incurred Expenses up to \$2,500 per month 3 & 4: 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	Up to \$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	Up to \$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	Up to \$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	Up to \$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 or 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 approved 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 (Option 2) or \$625 (Option 4) 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.

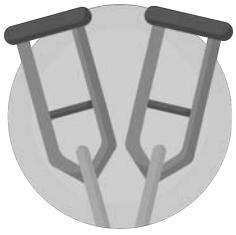
Group Cancer Rate Quote

Rates								
Coverage Tier	Option 1		Option 2		Option 3		Option 4	
	Semi-Monthly	Monthly	Semi-Monthly	Monthly	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Employee	\$9.62	\$19.24	\$12.75	\$25.49	\$10.70	\$21.40	\$16.84	\$33.68
Employee + Spouse	\$19.39	\$38.78	\$25.95	\$51.89	\$21.50	\$42.99	\$34.27	\$68.53
Employee + Child(ren)	\$13.73	\$27.46	\$18.10	\$36.19	\$15.07	\$30.13	\$23.64	\$47.27
Family	\$23.49	\$46.98	\$31.30	\$62.60	\$25.87	\$51.73	\$41.07	\$82.13

Variable Benefit Elections				
Benefit	Option 1	Option 2	Option 3	Option 4
Hospital Confinement	\$100	\$100	\$100	\$100
Surgical	\$3,000	\$3,000	\$3,000	\$3,000
Radiation/Chemotherapy	\$2,500 per month	\$2,500 per month	\$5,000 per month	\$5,000 per month
First Diagnosis	\$0	\$2,500	\$0	\$5,000
Colony Stimulating Factors	\$500 per month	\$500 per month	\$500 per month	\$500 per month
Wellness	\$100	\$100	\$100	\$100
Intensive Care Rider	\$0	\$325	\$0	\$625



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



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 Plus 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 150% 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 150% 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 150% 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 150% 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 150% 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 150% 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 150% 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 stitches	\$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	\$400
• Multiple	\$600
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.	
Ruptured Disc (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	\$100
• Injury occurs after first certificate year	\$400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	\$100
• Injury occurs after first certificate year	\$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
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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
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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.

<i>Transportation (within 90 days)</i>	
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
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If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	\$500
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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
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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
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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
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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
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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
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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
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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 Semi-Monthly Rates

24 Hour Plan	Accident Rates
Employee	\$8.10
Employee & Spouse	\$11.58
Employee & Dependent Children	\$15.45
Family	\$18.93

Wellness Benefit included in rates.





Hospital Indemnity Plan (Non-HSA) (THIS IS NOT A HEALTH PLAN)



Plan Description

The Aflac Group Hospital Indemnity plan provides cash benefits *directly to you* (unless otherwise assigned) that help pay for some of the costs—medical and nonmedical—associated with a covered hospital stay due to a sickness or accidental injury.

Plan Features

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- Premiums paid through convenient payroll deduction
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

Additional Rider Available

- Waiver of Premium

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-Issue

Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first and second anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

Late Enrollee Eligibility

For late enrollees who are not eligible for guaranteed-issue: All applicants are required to answer underwriting questions.

Individual Eligibility

Issue Ages:

- Employee: 18+
- Spouse or Domestic Partner: 18+
- Children: Under age 26

Spouse or Domestic Partner Coverage Available

To apply for spouse or domestic partner coverage, *you must also apply* and be issued coverage. *Spouse/Domestic Partner-only coverage is not available.*

Dependent Children Coverage Available

Dependent children under the age of 26 can be covered. To apply for dependent child coverage, *you must also apply* and be issued coverage. If you do not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, you must apply for coverage for the child and pay any required premium. *Children-only coverage is not available.*

Successor Insured Benefit

If spouse or domestic partner coverage is in force at the time of the primary insured's death, the surviving spouse or domestic partner may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.

Portability

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

Group Hospital Indemnity Benefits | Hospitalization Benefits – Base Plan

Benefits	Low	High
<p>Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured</p> <p>We will pay the amount shown when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental 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, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).</p>	\$500	\$1,500
<p>Hospital Confinement (per day) – maximum of 180 days per confinement for each covered sickness or accident for each insured</p> <p>We will pay this benefit in the amount shown for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, the insured must be confined to a hospital within six months of the date of the covered accident. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</p>	\$100	\$150

*Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement only.

Health Screening Benefit – Once Per Calendar Year For Each Insured

Benefit	Benefit Amount
Health Screening Benefit	\$50 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Treatment Benefits

Benefit	Low	High
<p>Major Diagnostic Exams – once per covered sickness or accident per calendar year</p> <p>We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams:</p> <ul style="list-style-type: none"> • Computerized Tomography (CT/CAT scan) • Magnetic Resonance Imaging (MRI) • Electroencephalography (EEG) 	\$125	\$250

Surgical Benefits

Benefit	Low	High
<p>Surgical Benefit (per procedure)</p> <p>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.</p>	Up to \$750	Up to \$1,500

Surgical Benefits Continued

Benefit	Low	High
<p>Anesthesia Benefits</p> <p>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.</p>	Up to \$187.50	Up to \$375

Waiver of Premium Rider

If the employee becomes totally disabled due to a covered sickness or accidental injury, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Limitations & Exclusions (applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity.
- **Custodial Care** – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- **Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.**
- **Services performed by a Family Member.**
- **Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.**
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services or Treatment.**
- **Cosmetic Surgery**, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

Aflac Group Hospital Indemnity Semi-Monthly Rates

Insured	Low Plan	High Plan
Employee	\$10.48	\$21.16
Employee + Spouse	\$20.96	\$42.48
Employee + Child(ren)	\$15.48	\$30.88
Family	\$25.96	\$52.20





Hospital Indemnity Plan (HSA) (THIS IS NOT A HEALTH PLAN)



Plan Description

The Aflac Group Hospital Indemnity plan provides cash benefits **directly to you** (unless otherwise assigned) that help pay for some of the costs—medical and nonmedical—associated with a covered hospital stay due to a sickness or accidental injury.

Plan Features

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- Premiums paid through convenient payroll deduction
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

Additional Rider Available

- Waiver of Premium

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-Issue. Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first and second anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

Late Enrollee Eligibility. For late enrollees who are not eligible for guaranteed-issue: All applicants are required to answer underwriting questions.

Individual Eligibility

Issue Ages:

- Employee: 18+
- Spouse or Domestic Partner: 18+
- Children: Under age 26

Spouse or Domestic Partner Coverage Available

To apply for spouse or domestic partner coverage, **you must also apply** and be issued coverage. **Spouse/Domestic Partner-only coverage is not available.**

Dependent Children Coverage Available

Dependent children under the age of 26 can be covered. To apply for dependent child coverage, **you must also apply** and be issued coverage. If you do not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, you must apply for coverage for the child and pay any required premium. **Children-only coverage is not available.**

Successor Insured Benefit

If spouse or domestic partner coverage is in force at the time of the primary insured's death, the surviving spouse or domestic partner may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.

Portability

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

Waiver of Premium Rider

If the employee becomes totally disabled due to a covered sickness or accidental injury, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Health Screening Benefit – Once Per Calendar Year For Each Insured

Health Screening Benefit - \$50 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Group Hospital Indemnity Benefits | Hospitalization Benefits – Base Plan

Benefits	High
<p>Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured We will pay the amount shown when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental 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, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).</p>	\$1,500
<p>Hospital Confinement (per day) – maximum of 180 days per confinement for each covered sickness or accident for each insured We will pay this benefit in the amount shown for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, the insured must be confined to a hospital within six months of the date of the covered accident. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</p>	\$150

*Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement only.

Limitations & Exclusions (applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity.
- **Custodial Care** – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- **Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.**
- **Services performed by a Family Member.**
- **Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.**
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services or Treatment.**
- **Cosmetic Surgery**, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

Aflac Group Hospital Indemnity Semi-Monthly Rates

Covered	High Option
Employee	\$12.85
Employee + Spouse	\$25.75
Employee + Child(ren)	\$20.18
Family	\$33.08





Critical Illness Plan

without Cancer



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
- There are no pre-existing condition limitations
- The plan doesn't have a waiting period for benefits
- Benefits do not reduce as insureds get older
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Guaranteed-Issue coverage is available (which means you may qualify for coverage without having to answer health questions).

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+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **30 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of \$5,000. To apply for spouse coverage, **the employee must also apply**.

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 be limited to face amounts between \$5,000 and \$30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. **Children-only coverage is not available**.

Waiver of Premium

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Portability

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

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Heart Attack	100%
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Transient Ischemic Attack (TIA)	\$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Additional Diagnosis. Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence. Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	\$100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children.

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1 - Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%*
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2 - Invasive Procedures and Techniques of the Heart	
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%

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

Limitations & Exclusions (Applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts; this does not include terrorism.
 - Insurrection or riot.
 - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
 - Abuse of legally-obtained prescription medication.
 - Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.



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

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	\$2.26	\$3.00	\$3.73	\$4.46	\$5.20	\$5.93	\$6.66	\$7.39	\$8.13	\$8.86
30-39	\$2.67	\$3.80	\$4.94	\$6.08	\$7.21	\$8.35	\$9.49	\$10.62	\$11.76	\$12.90
40-49	\$4.14	\$6.76	\$9.37	\$11.98	\$14.59	\$17.21	\$19.82	\$22.43	\$25.04	\$27.66
50-59	\$5.82	\$10.11	\$14.40	\$18.69	\$22.98	\$27.27	\$31.57	\$35.86	\$40.15	\$44.44
60-69	\$8.55	\$15.57	\$22.59	\$29.61	\$36.63	\$43.65	\$50.67	\$57.69	\$64.71	\$71.74

NON-TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$2.26	\$3.00	\$3.73	\$4.46	\$5.20	\$5.93
30-39	\$2.67	\$3.80	\$4.94	\$6.08	\$7.21	\$8.35
40-49	\$4.14	\$6.76	\$9.37	\$11.98	\$14.59	\$17.21
50-59	\$5.82	\$10.11	\$14.40	\$18.69	\$22.98	\$27.27
60-69	\$8.55	\$15.57	\$22.59	\$29.61	\$36.63	\$43.65

TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.91	\$4.30	\$5.68	\$7.07	\$8.45	\$9.83	\$11.22	\$12.60	\$13.98	\$15.37
30-39	\$4.22	\$6.91	\$9.61	\$12.30	\$14.99	\$17.68	\$20.37	\$23.06	\$25.76	\$28.45
40-49	\$7.22	\$12.90	\$18.59	\$24.28	\$29.97	\$35.65	\$41.34	\$47.03	\$52.72	\$58.40
50-59	\$10.46	\$19.39	\$28.32	\$37.25	\$46.18	\$55.11	\$64.04	\$72.97	\$81.90	\$90.83
60-69	\$16.69	\$31.85	\$47.01	\$62.17	\$77.33	\$92.49	\$107.65	\$122.81	\$137.97	\$153.13

TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$2.91	\$4.30	\$5.68	\$7.07	\$8.45	\$9.83
30-39	\$4.22	\$6.91	\$9.61	\$12.30	\$14.99	\$17.68
40-49	\$7.22	\$12.90	\$18.59	\$24.28	\$29.97	\$35.65
50-59	\$10.46	\$19.39	\$28.32	\$37.25	\$46.18	\$55.11
60-69	\$16.69	\$31.85	\$47.01	\$62.17	\$77.33	\$92.49





Critical Illness Plan

with Cancer



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
- There are no pre-existing condition limitations
- The plan doesn't have a waiting period for benefits
- Benefits do not reduce as insureds get older
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Guaranteed-Issue coverage is available (which means you may qualify for coverage without having to answer health questions).

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+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **30 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of \$5,000. To apply for spouse coverage, **the employee must also apply**.

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 be limited to face amounts between \$5,000 and \$30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. **Children-only coverage is not available**.

Waiver of Premium

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Portability

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

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis+

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Cancer (Internal or Invasive) ++	100%
Heart Attack	100%
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer ++	25%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Skin Cancer ++	\$250 (once per calendar year/insured)
Transient Ischemic Attack (TIA)	\$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

++For employees who have chosen the without cancer plan option, these cancer benefits do not apply.

Additional Diagnosis +

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence +

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

+ If the claim is for a cancer diagnosis, the insured must be treatment-free from cancer for at least 12 months and must be in complete remission before the date of a subsequent cancer diagnosis.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	\$100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children.

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1 - Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%*
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2 - Invasive Procedures and Techniques of the Heart	
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%

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

Limitations & Exclusions *(Applies to all riders unless otherwise noted)*

Cancer Diagnosis Limitation

Benefits are payable for Cancer and/or Non-Invasive Cancer as long as the Insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts; this does not include terrorism.
 - Insurrection or riot.
 - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
 - Abuse of legally-obtained prescription medication.
 - Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

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.

EXP (04/24)



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

Aflac Group Critical Illness w/ 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	\$3.20	\$4.87	\$6.53	\$8.20	\$9.86	\$11.52	\$13.19	\$14.85	\$16.52	\$18.18
30-39	\$4.13	\$6.72	\$9.32	\$11.91	\$14.50	\$17.09	\$19.68	\$22.28	\$24.87	\$27.46
40-49	\$7.03	\$12.53	\$18.02	\$23.52	\$29.01	\$34.51	\$40.00	\$45.49	\$50.99	\$56.48
50-59	\$11.64	\$21.75	\$31.85	\$41.95	\$52.06	\$62.16	\$72.26	\$82.37	\$92.47	\$102.57
60-69	\$20.17	\$39.81	\$57.44	\$76.07	\$94.70	\$113.34	\$131.97	\$150.60	\$169.23	\$187.87

NON-TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$3.20	\$4.87	\$6.53	\$8.20	\$9.86	\$11.52
30-39	\$4.13	\$6.72	\$9.32	\$11.91	\$14.50	\$17.09
40-49	\$7.03	\$12.53	\$18.02	\$23.52	\$29.01	\$34.51
50-59	\$11.64	\$21.75	\$31.85	\$41.95	\$52.06	\$62.16
60-69	\$20.17	\$39.81	\$57.44	\$76.07	\$94.70	\$113.34

TOBACCO: Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$3.99	\$6.44	\$8.88	\$11.33	\$13.78	\$16.23	\$18.67	\$21.12	\$23.57	\$26.02
30-39	\$5.92	\$10.29	\$14.67	\$19.05	\$23.42	\$27.80	\$32.17	\$36.55	\$40.93	\$45.30
40-49	\$10.88	\$20.21	\$29.55	\$38.89	\$48.22	\$57.56	\$66.90	\$76.24	\$85.57	\$94.91
50-59	\$18.94	\$36.34	\$53.73	\$71.13	\$88.53	\$105.93	\$123.32	\$140.72	\$158.12	\$175.52
60-69	\$33.41	\$65.29	\$97.16	\$129.03	\$160.90	\$192.78	\$224.65	\$256.52	\$288.39	\$320.27

TOBACCO: Spouse

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18-29	\$3.99	\$6.44	\$8.88	\$11.33	\$13.78	\$16.23
30-39	\$5.92	\$10.29	\$14.67	\$19.05	\$23.42	\$27.80
40-49	\$10.88	\$20.21	\$29.55	\$38.89	\$48.22	\$57.56
50-59	\$18.94	\$36.34	\$53.73	\$71.13	\$88.53	\$105.93
60-69	\$33.41	\$65.29	\$97.16	\$129.03	\$160.90	\$192.78





Short-Term Disability Plan

OneAmericaSM
Financial

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 \$3,000. 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

Maternity claims are standardly paid at 6 weeks for normal delivery and 8 weeks for c-section, minus the elimination period. If there are any complications with supporting medical documentation, benefits could be extended after review from the claims analyst. 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

<i>Monthly Benefit</i>	<i>Semi-Monthly Premium</i>
\$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	\$13.46
\$1,400	\$14.50
\$1,500	\$15.54
\$1,600	\$16.57
\$1,700	\$17.61
\$1,800	\$18.64
\$1,900	\$19.68
\$2,000	\$20.71
\$2,100	\$21.75
\$2,200	\$22.78
\$2,300	\$23.82
\$2,400	\$24.85
\$2,500	\$25.89
\$2,600	\$26.92
\$2,700	\$27.96
\$2,800	\$28.99
\$2,900	\$30.03
\$3,000	\$31.07



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

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.



Long-Term Disability Plan

OneAmericaSM
Financial

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

<i>Monthly Benefit Amount</i>	<i>Age 0 - 29</i>	<i>Age 30 - 39</i>	<i>Age 40 - 49</i>	<i>Age 50 - 59</i>	<i>Age 60 +</i>
\$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



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.



Additional Term Life Plan



Additional Life Insurance

Standard Insurance Company has developed this document to provide you with information about the optional coverage you may select through your employer. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please refer to the Additional Life Employee Brochure included in your packet or check with your human resources representative.

Employer Plan Effective Date

Your employer will provide Basic Life coverage from The Standard in the amount of \$10,000 at no cost to you. If you qualify for Basic Life, you may also apply for Additional Life coverage to supplement your Basic Life amount.

Eligibility

To be eligible for this plan:

- You must be insured for Basic Life
- You must be an active employee of Person County excluding temporary or seasonal employees, full-time members of the armed forces, leased employees or independent contractors
- You must be regularly working at least 30 hours each week
- Your spouse or children must not be full-time members of the armed forces of any country

Employee Coverage Amount

You may elect Additional Life coverage in units of \$25,000 to a maximum of \$100,000.

All late applications and requests for coverage increases are subject to medical underwriting approval. However during the employer's one time open enrollment period employees who are eligible but not enrolled under the plan can elect coverage up to \$100,000 without medical evidence.

Dependents Life insurance from Standard Insurance Company is also included in this plan.

Dependent Life Insurance Amount

You may choose from one of the following options for your spouse and eligible child(ren).

- Option 1: \$5,000 for your spouse; \$2,500 for your eligible child(ren)
- Option 2: \$10,000 for your spouse; \$5,000 for your eligible child(ren)

All late applications and requests for coverage increases are subject to medical underwriting approval. However during the employer's one time open enrollment period employees who are eligible but not enrolled under the plan can elect coverage for their spouse and eligible child(ren) without medical evidence.

Suicide Exclusion

This plan includes an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death. This is subject to state variations.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage. Please see your human resources representative for additional information. This is subject to state variations.

Age Reductions

Under this plan, coverage reduces by 35 percent at age 65 and 50 percent at age 70. If you or your spouse are age 65 or over, ask your human resources representative for the amount of coverage available.

Accelerated Benefit

If an insured is diagnosed as terminally ill and is expected to die within 12 months they may receive up to 75% of their life benefit.

Employee Rates

If you elect Additional Life insurance, your monthly premium rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Age (as of July 1)	Rate (Per \$1000 of Total Coverage)
<30	\$0.065
30 - 34	\$0.074
35 - 39	\$0.091
40 - 44	\$0.139
45 - 49	\$0.210
50 - 54	\$0.329
55 - 59	\$0.550
60 - 64	\$0.830
65 - 69	\$1.710
70+	\$5.140

To calculate your premium:

1. Amount Elected: (Write this amount on the Additional/Optional Life Requested Amount line on your Enrollment and Change Form.) Line 1: _____
2. Line 1 divided by \$1,000 = Line 2. Line 2: _____
3. Select your rate from the rate table and enter on Line 3. Line 3: _____
4. Line 2 multiplied by Line 3 = Your monthly cost. See page 3 for more information pertaining to rate calculation. Line 4: _____

Dependent Life Rates

If you elect Dependents Life insurance for your spouse and eligible child(ren), your monthly premium rate per member for this coverage is \$2.06 for Option 1 and \$4.12 for Option 2 regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from your paycheck.

Employee Coverage Effective Date

Please contact your human resources representative for more information regarding the following requirements that must be satisfied for your insurance to become effective

Waiver of Premium Provision

The Standard may continue your Life insurance without premium payments if you:

- Become totally disabled prior to age 55, while insured under the group policy
- Are under the age of 60
- Complete the waiting period of 180 days
- Give us satisfactory proof of loss

When Spouse and Child Coverage Ends

Your brochure includes information about when your insurance ends. Any spouse and child coverage will automatically end on the earliest of the following:

- Five months after the date you die
- The date your Life insurance ends
- The date Dependents Life insurance terminates under the group policy
- The date your employer's coverage under the group policy for Dependents Life insurance terminates
- The date the last period ends for which a premium was paid for your Dependents Life insurance
- When the dependent ceases to be an eligible dependent
- For your spouse the date of your divorce or legal separation
- For a child who is disabled, 90 days after we mail you a proof of disability request, if proof is not given

Group Insurance Certificate

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Standard Insurance Company.





Whole Life Plan



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 from¹ 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 Eligible²

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

Accelerated Death Benefit Provisions³

As the certificate owner, you can receive an advance, or acceleration, of a portion of the death benefit under your certificate, if the insured is diagnosed with a terminal illness or if the insured has a chronic illness that has been certified by a Qualified Medical Practitioner.

- **Terminal Illness:** In most states, 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 Illness is payable when the insured meets the definition of Chronic Illness, generally having a permanent loss of two activities of daily living (eating, toileting, transferring, bathing, dressing, and continence) due to loss of functional capacity, or requiring substantial supervision due to permanent severe cognitive impairment. In North Carolina and Washington, generally, Chronic Illness is any medical condition that requires continuous confinement in an Eligible Institution, where the Insured is expected to remain there for the rest of their life.

Waiver of Premium

The waiver of premium rider ensures that your life insurance protection will stay in place, and your cash value will continue to grow, if you, the insured, are totally disabled and may not be able to pay the premiums. This rider is attached to each certificate for employees age 18–60 and activates following a continuous six-month waiting period. When activated, the premium for the certificate and any riders included with the certificate will be waived for the duration of the insured's disability. It will terminate when the insured reaches the attained age of 67 (state variations may apply). This rider is attached to each certificate. Your employer has elected this rider and it has an additional cost. You can elect to cancel the rider at any time; once canceled it cannot be reinstated.

Whole Life Premiums

Sample rates are listed on the next page. Please refer to the Group Whole Life Insurance rate cards for full rate information. Visit <https://mymarkiii.com/personcountync/policy-information/> to view the full set of rates or scan the QR code below.



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.

³ Except in Washington and North Carolina, the acceleration of the death benefit is intended to receive favorable tax treatment under §101(g) of the Internal Revenue Code. Accessing other similar benefits may cause the per diem limit to be exceeded. The insured must be chronically ill or terminally ill, as defined in 26 USC 7702B. Certificate owners should seek advice from a tax advisor prior to requesting a benefit payment. Receipt of accelerated death benefits may be taxable. For group policies issued in Washington or North Carolina, the Chronic Care Benefit defines a chronic illness in accordance with state insurance requirements, and may be taxable, as the state prescribed definition differs from the federal tax law definition.

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. Certificate owners who have exercised the Accelerated Death Benefit for Terminal Illness benefit cannot use the Chronic Care Benefit. However, the Terminal Illness Benefit will still be available on the remaining face amount after a Chronic Care Benefit payment has been made.

Accelerating the payment of your death benefit may affect your eligibility for public assistance programs, including MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI"). Contact the Medicaid Unit of the local Department of Public Welfare and the Social Security Administration Office for more information.

An acceleration of the death benefit will reduce the certificate's death benefit, any cash value and any loan values. The certificate's premium payments will be based on the reduced amount of insurance at the current rate. There is no premium required for either the chronic care or terminal illness benefits, however, there is a fee if the chronic care benefit provision is exercised. The fee for the Chronic Care Benefit is a present value adjustment shown as a percentage of the Eligible Amount for the Chronic Care Benefit. The percentage depends on the Insured's age at the time the benefit is exercised: 18% for ages 45 and above; 27% for ages 44-35; 36% for under age 35. In the situs states of Kansas, Minnesota, North Carolina and Washington the term "fee" is replaced with "Actuarial Discount." For Montana, "fee" is replaced with "Reduction."

Please carefully read the accelerated death benefit disclosure provided at application. Restrictions and limitations will apply.



∴ MassMutual

The information provided is not written or intended as specific tax or legal advice. MassMutual, its subsidiaries, employees and representatives are not authorized to give tax or legal advice. Individuals are encouraged to seek advice from their own tax or legal counsel.

MassMutual@WORK Group Whole Life Insurance Sample Semi-Monthly Rates

Sample rates are shown below. Rates are tobacco distinct and employee's will answer a yes or no question at the time of application to determine their rate. Rates are based on nonsmoker, unisex rates with Waiver. Rates will differ for tobacco users.

<i>Issue Age</i>	<i>\$10,000</i>	<i>\$25,000</i>	<i>\$50,000</i>
18	\$5.01	\$9.22	\$16.23
19	\$5.07	\$9.36	\$16.51
20	\$5.12	\$9.49	\$16.78
21	\$5.18	\$9.63	\$17.06
22	\$5.23	\$9.77	\$17.33
23	\$5.29	\$9.91	\$17.61
24	\$5.34	\$10.04	\$17.88
25	\$5.40	\$10.18	\$18.16
26	\$5.51	\$10.46	\$18.71
27	\$5.73	\$11.01	\$19.81
28	\$5.89	\$11.42	\$20.63
29	\$6.06	\$11.83	\$21.46
30	\$6.28	\$12.38	\$22.56
31	\$6.50	\$12.93	\$23.66
32	\$6.72	\$13.48	\$24.76
33	\$6.99	\$14.17	\$26.13
34	\$7.16	\$14.58	\$26.96
35	\$7.21	\$14.72	\$27.23
36	\$7.54	\$15.54	\$28.88
37	\$7.98	\$16.64	\$31.08
38	\$8.37	\$17.61	\$33.01
39	\$8.75	\$18.57	\$34.93
40	\$9.19	\$19.67	\$37.13
41	\$9.58	\$20.63	\$39.06
42	\$9.96	\$21.59	\$40.98
43	\$10.40	\$22.69	\$43.18
44	\$10.79	\$23.66	\$45.11
45	\$10.84	\$23.79	\$45.38
46	\$11.56	\$25.58	\$48.96
47	\$12.27	\$27.37	\$52.53
48	\$13.04	\$29.29	\$56.38
49	\$13.81	\$31.22	\$60.23
50	\$14.53	\$33.01	\$63.81
51	\$15.30	\$34.93	\$67.66
52	\$16.07	\$36.86	\$71.51
53	\$16.78	\$38.64	\$75.08
54	\$17.55	\$40.57	\$78.93
55	\$17.61	\$40.71	\$79.21
56	\$18.82	\$43.73	\$85.26
57	\$20.08	\$46.89	\$91.58
58	\$21.35	\$50.06	\$97.91
59	\$22.61	\$53.22	\$104.23
60	\$23.88	\$56.38	\$110.56
61	\$22.86	\$54.13	\$106.26
62	\$24.06	\$57.13	\$112.26
63	\$25.21	\$60.01	\$118.01
64	\$26.36	\$62.88	\$123.76
65	\$26.41	\$63.01	\$124.01
66	\$28.11	\$67.26	\$132.51
67	\$30.46	\$73.13	\$144.26
68	\$32.06	\$77.13	\$152.26
69	\$34.56	\$83.38	\$164.76
70	\$36.06	\$87.13	\$172.26
71	\$37.61	\$91.01	\$180.01
72	\$39.26	\$95.13	\$188.26
73	\$41.06	\$99.63	\$197.26
74	\$43.06	\$104.63	\$207.26
75	\$45.31	\$110.26	\$218.51



FOR YOUR REFERENCE

*Additional benefit information
from your employer.*



Walk or Work Out Program Guidelines

The Walk or Work Out Program allows full-time Person County employees time to be physically active three times a week for 45 minutes!

Failure to comply with the following program guidelines can result in losing this privilege:

- ✓ Your job tasks are priority and must be completed first.
- ✓ It is up to your department head and supervisor as to when during the day it is permissible to use the time.
- ✓ You must use your department's policy for signing in/out and noting where you are going (i.e. walking, gym, etc.).
- ✓ If you go to another site to walk or workout, travel time must be included in the 45 minutes.
- ✓ This is a 3 day/week program. If you do not use 45 minutes each day, you cannot use the balance other days.





Continuation of Benefits

If You Leave Employment

Aflac Group Accident, Hospital Indemnity & Critical Illness

If you are no longer employed and would like to keep your current Aflac Group plans in place, you may be able to port your plans. 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**.

AUL Short & Long-Term Disability

Once an employee is on the AUL disability plans for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact **AUL to port your coverage by calling 1-800-553-5318**.

FBA Flexible Spending Accounts

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do so by selecting one of the COBRA options. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **Flexible Benefit Administrators at 1-800-437-3539**.

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 1-844-975-7522**.

Medical/Dental/Vision Plan

Under the group medical, dental and vision plan, you and your covered dependents are eligible to continue coverage through COBRA if you experience certain qualifying events. If you and your dependents are enrolled in these plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plans, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA. Also, while you are covered under the plans, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA.

MetLife Cancer

You may continue your MetLife Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information, contact **Bay Bridge Administrators (TPA) at 1-800-845-7519**.

The Standard Term Life

When you leave your 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 1-888-937-4783**.

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

Contact Information

Aflac

Phone: 1-800-433-3036

Email: cscmail@Aflac.com

www.aflacgroupinsurance.com

American United Life (AUL)

Claims Toll-Free Number: 1-855-517-6365

Customer Service: 1-800-553-5318

www.oneamerica.com

Cigna Medical

Phone: 1-800-Cigna24

www.mycigna.com

Flexible Benefit Administrators, Inc.

Phone: 1-800-437-3539

Fax: 1-757-431-1155

www.flex-admin.com

HealthMapRx Program Support

Phone: (336) 580-0340

Fax: (984) 336-1720

Email: admin@emailmm.com

MassMutual Insurance Company

Phone: 1-844-975-7522

www.massmutual.com

MetLife

Bay Bridge Administrators, LLC.

Phone: 1-800-845-7519

Fax: 512-275-9350

www.bbadmin.com

Superior Vision by MetLife

Phone: 1-833-393-5433

www.mybenefits.metlife.com

The Standard Insurance Company

Phone: 1-888-937-4783

www.standard.com





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

Arranged and Enrolled by Mark III Brokerage, Inc.



1 (833) 890-6527
www.markiiieb.com