Provided by: Mark III Employee Benefits

EMPLOYEE BENEFITS HANDBOOK

October 1, 2024 - September 30, 2025

Table of Contents

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

DISCLAIMER

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

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

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

Important Points

- ✓ Your plan year runs from October 1, 2024 to September 30, 2025. This means your benefit elections will take effect October 1, 2024 unless otherwise noted.
- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event as outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending Account and Dependent Care Account each year! It will not automatically renew.
- ✓ 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/ccpsva/.

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."

Examples of QLEs

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

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Welcome to Your Benefits!

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

Pre-Tax Benefit Information

A "**pre-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or 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.

- ✓ FBA Flexible Spending Accounts
- ✓ Ameritas Vision
- ✓ Delta Dental
- ✓ Aflac Group Accident
- ✓ Aflac Group Hospital Indemnity

Post-Tax Benefit Information

A "**post-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes.

- ✓ Manhattan Life Group Cancer
- ✓ Aflac Group Critical Illness
- ✓ AUL Short-Term Disability
- ✓ AUL Long-Term Disability
- ✓ Trustmark Universal Life
- ✓ PetsBest Pet Insurance

How to Enroll at Open Enrollment

Onsite Enrollment August 6 - 9

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

Self-Service Enrollment August 1 -15

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

Self-Enroll Visit: https://mymarkiii.com/ccpsva/enrollment/

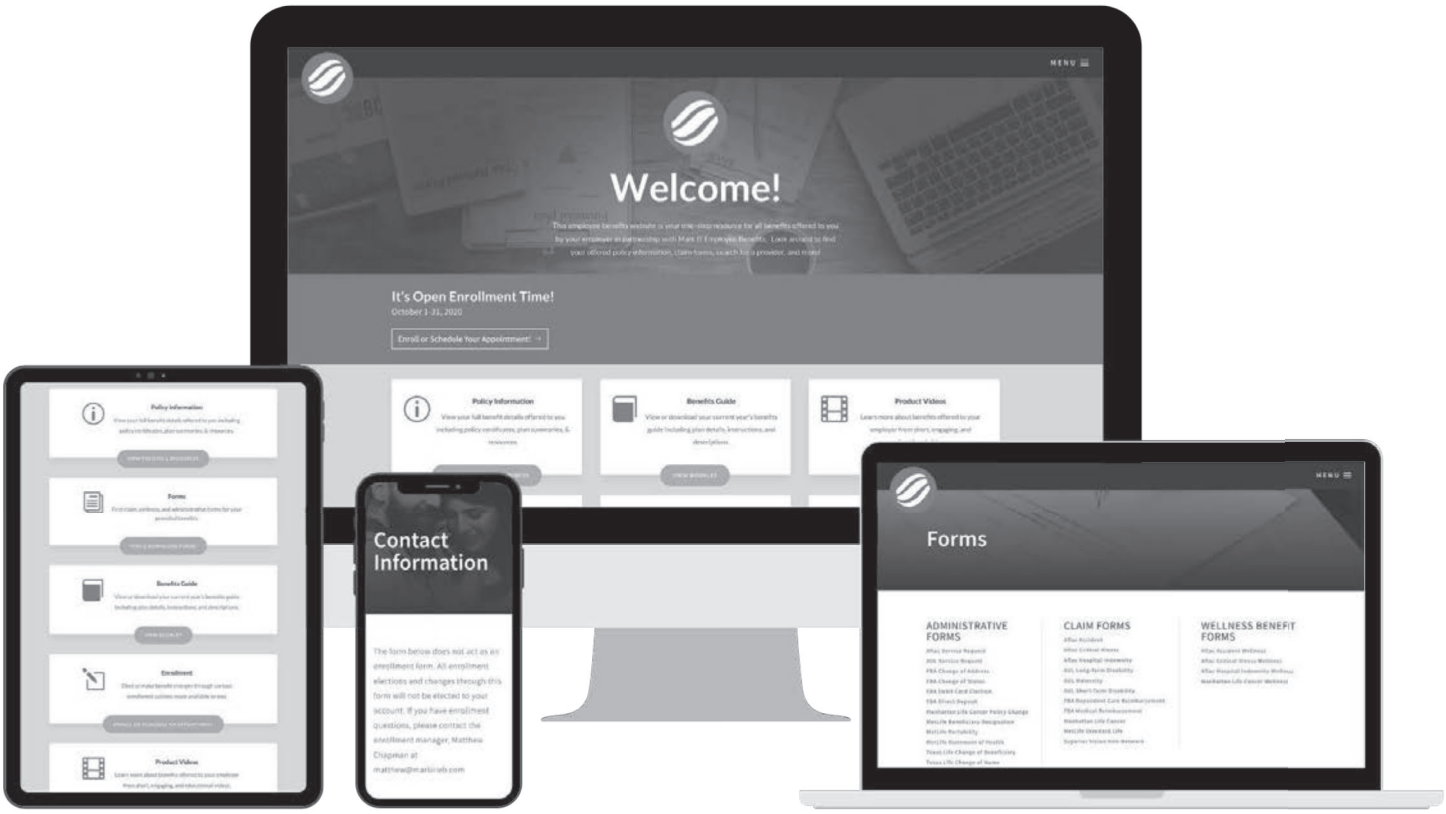
Employee Benefits Portal

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!

Scan me!

Employee Benefits Portal

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



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

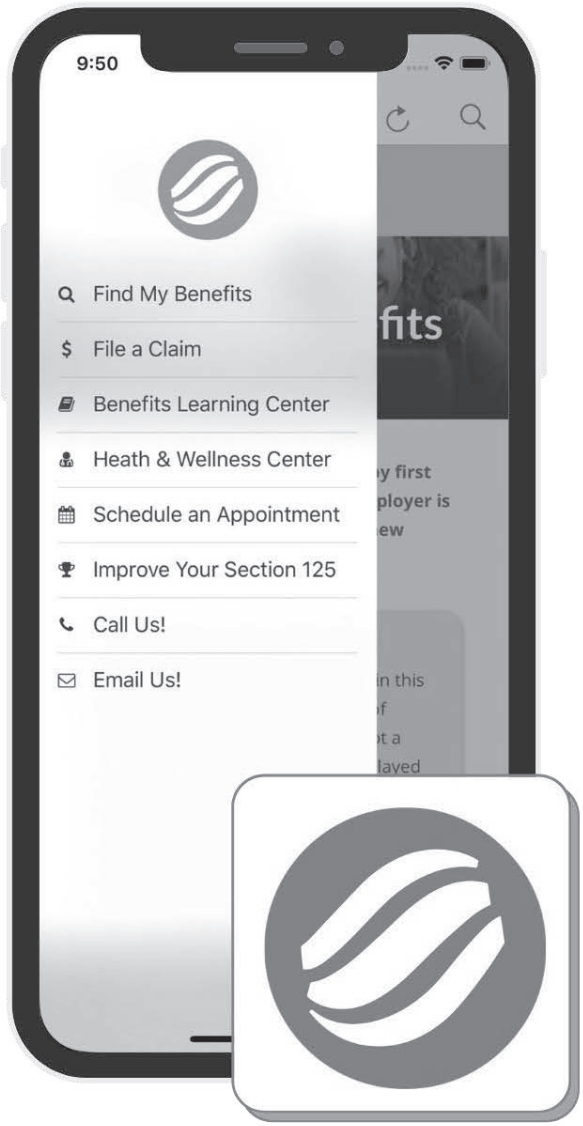
Scan me!

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

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

MyMark III Mobile App

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



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

Search for "**MyMark III**" to access benefit information on the go!

Available on:

Download on the App Store

GET IT ON Google Play

Your Trusted Benefits Partners at your fingertips!

Filing a Claim

Manhattan Life Group Cancer

Visit https://mymarkiii.com/ccpsva/forms/ to download your claim form. You may also utilize the online claims portal simply login here https://portal.bbadmin.com/users/sign_in and submit claims in minutes.

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

Group Aflac

Visit https://mymarkiii.com/ccpsva/forms/ to download your claim form or to file online visit https://www.aflacgroupinsurance.com and click on **Customer Service** and then **File a Claim**. Choose your claim form and follow the instructions. Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information.

AUL Disability

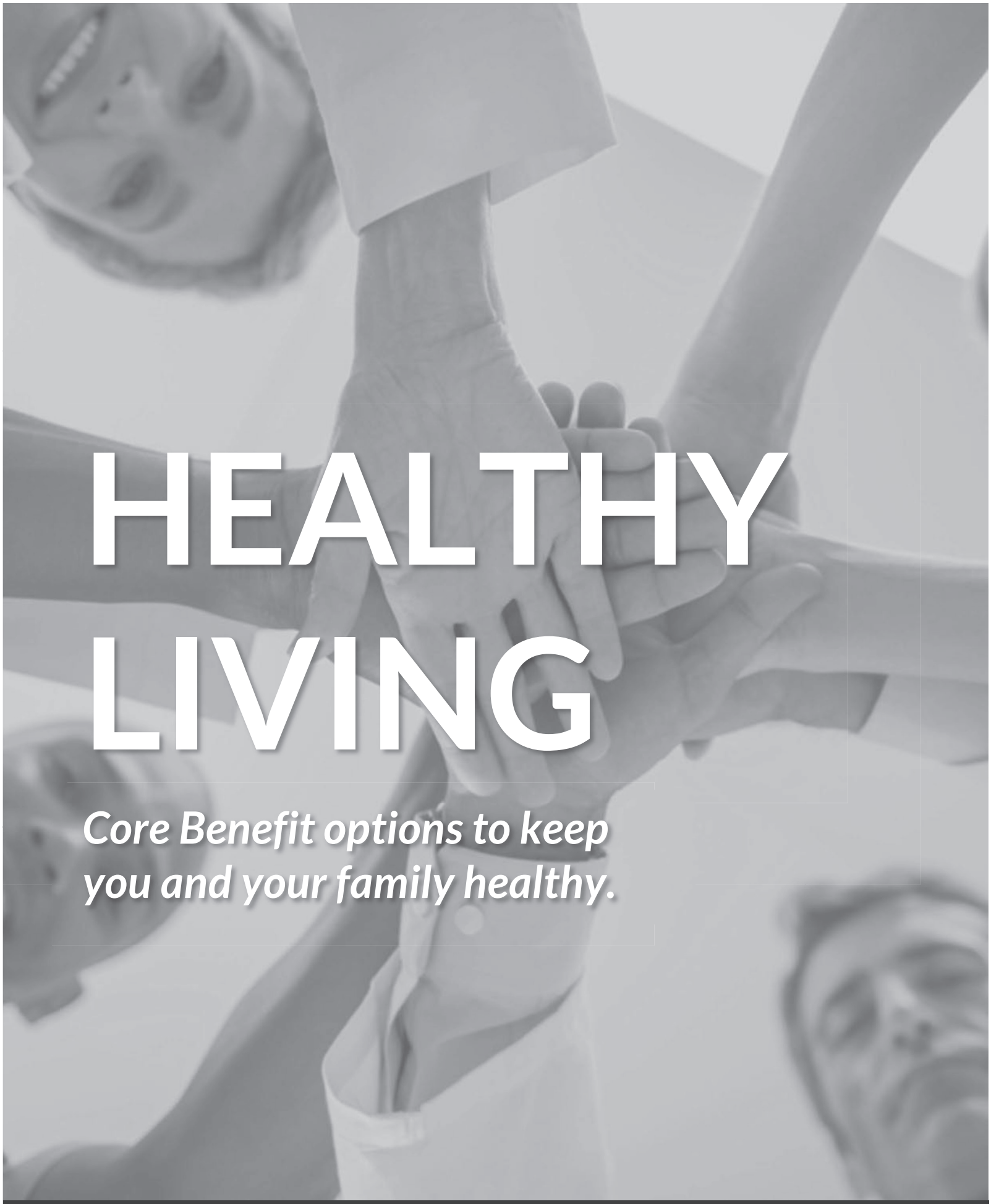
Visit https://mymarkiii.com/ccpsva/forms/ to download your claim form. Complete the form and send the form and supporting documentation by email, fax, or mail. If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

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, and much more!

Visit: https://mymarkiii.com/ccpsva/.

Scan me!



HEALTHY LIVING

Core Benefit options to keep you and your family healthy.

Medical Plan Rates

All health insurance plans are PPO plans. Dental and vision insurance are included.

Key Advantage 250 Plan Monthly Rates

Deductible = Single $250/Dual $500

Tier	*Full-Time Monthly Rates*	*Part-Time Monthly Rates*
Employee	$199.00	$556.00
Employee + One (Spouse/Child)**	$413.00	$1,050.50
Employee + Family	$759.00	$1,612.00

***Employee + 1 tier = Employee & 1 Child or Employee & Spouse*

Key Advantage 500 Plan Monthly Rates

Deductible = Single $500/Dual $1,000

Tier	*Full-Time Monthly Rates*	*Part-Time Monthly Rates*
Employee	$94.00	$454.00
Employee + One (Spouse/Child)**	$219.00	$862.50
Employee + Family	$477.00	$1,337.00

***Employee + 1 tier = Employee & 1 Child or Employee & Spouse*

High Deductible Plan Monthly Rates

Deductible = Single $2,800/Dual $5,600

Tier	*Full-Time Monthly Rates*	*Part-Time Monthly Rates*
Employee	$87.00	$372.00
Employee + One (Spouse/Child)**	$232.00	$724.50
Employee + Family	$420.00	$1,098.00
Health Savings Account	$150 Employer Contribution + Desired Employee Contribution	$50 Employer Contribution + Desired Employee Contribution

HSA contribution is the same amount for all tiers.
Participants must open an HSA account with Atlantic Union Bank (Bowling Green Branch) to receive the HSA contribution.

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 October 1, 2024 and ends on September 30, 2025. You will be eligible to join the Plan if you normally work at least 20 hours or more per week as a full-time or part-time employee. If you are hired prior to the 10th of the month, you are eligible to participate as of the 1st of that month. If you are hired after the 10th of the month, you are eligible to participate on the 1st of the following month. 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 $3,200.00.**

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 relivers | 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 dependentrelatives 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:

- **$5,000 ($2,500 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 adopt the IRS offered 2 month 15-day grace period. Please see the Employee Guide for more information.

How to Enroll in our FSA Plan

Step 1

Carefully estimate your eligible Health Care and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at https://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	$145.31
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 means 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 (**FBACCPS)**
    - 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. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Please keep all your itemized receipts.

Please contact Flexible Benefit Administrators, Inc. to order additional cards. Benefits Cards are available upon request of the account holder for dependents over the age of 18.

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.

Scan me!

FlexibleBenefit ADMINISTRATORS

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

Dental Plan

DELTA DENTAL®

Delta Dental PPO – Plus Premier ™

This plan is available for employees who do not enroll in the Health plan.

Annual Deductible (Applies to Basic Services)	$25 per person; $75 per family, per contract year
Annual Maximum	$1,500 per person, per contract year
Orthodontic Lifetime Maximum	$1,500 per person
MaxOver™ Carryover	Your plan allows a portion of an enrollee's annual maximum to be carried over to the next year.
Right Start 4 Kids®	Covers children up to age 13 at 100% with no deductible when you visit an in-network dentist. (For services outlined in the plan, up to the annual maximum. Subject to any limitations, exclusions and waiting periods).
Health Smile, Healthy You® Program	Provides additional cleanings and/or fluoride for members with certain health conditions. Visit DeltaDentalVA.com to learn more or to download an enrollment form.

For the services listed below, Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.

Coverage	*Coinsurances*		
	In-Network		*Out-of-Network*
	Delta Dental PPO ™	*Delta Dental Premier ™*	
Diagnostic & Preventive Services • Oral exams and cleanings — Twice in a 12-month period. Periodontal cleaning is considered a regular cleaning and counts as a regular cleaning under your plan. • Fluoride applications — Once in a 12-month period for enrollees under age 19. • X-rays — Bitewing X-rays are limited to once in a 12-month period; limited to a maximum of four films or a set (seven to eight films) of vertical bitewings. Full-mouth X-rays are limited to once in a three-year period. • Sealants — One per tooth for members under age 16 on non-carious, non-restored first and second permanent molars.	100%	100%	100%
Basic Services • Fillings — One per surface in a 24-month period. • Endodontic services — Root canal therapy. • Periodontic services — Treatment for gum disease. • Simple extractions • Oral surgery — Surgical extractions and other surgical procedures. • Denture repair and recementation	80%	80%	80%
Major Services • Crowns — One per tooth in a 60-month period for members age 12 and older. • Prosthodontics/dentures and bridges — Once in a 60-month period for members age 16 and older. • Implants — One per site for members age 16 and older.	50%	50%	50%
Orthodontic Services • Treatment for the proper alignment of teeth — For subscriber and covered dependents.	50%	50%	50%

**Waiting periods may apply. Benefit waiting periods may be waived for new enrollees if the account is replacing a prior dental plan that covered these services. The enrollee may need to provide proof of prior credible coverage to qualify.*

Coverage is Available for:

- Enrollee and spouse
- Dependent children, only to the end of the month they reach age 26 (the "limiting age").

Choosing a Dentist

You may select the dentist of your choice. However, to get the most value from your dental benefits, make sure your dentist participates in the network listed at the top of your Delta Dental ID card. With Delta Dental PPO Plus Premier™, you have the option of visiting any dentist. However, your out-of-pocket costs may be lowest if you see a Delta Dental PPO™ network dentist and highest if you choose an out-of-network dentist. Delta Dental network dentists agree to discount their fees, submit claims on your behalf and not bill you for the difference. Visit DeltaDentalVA.com to find a participating dentist in your area.

If you visit an out-of-network dentist, Delta Dental will pay its portion of the bill and you are responsible for any coinsurance and deductible (if applicable), as well as the difference between the nonparticipating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

	PPO Network Dentist	*Premier Network Dentist*	*Non-Participating Dentist*
Dentist's Charge for Covered Procedure	$215.00	$215.00	$215.00
Delta Dental's Plan Allowance	$126.00	$169.00	$113.00
Coinsurance Percentage	80%	80%	80%
Delta Dental's Payment	$100.80	$135.20	$90.40
Patient Payment	***$25.20***	***$33.80***	***$124.60***

The example shown is for illustrative purposes only. Payment structures may vary between plans.

The preceding information is a brief description of the services covered under your plan. It is not intended for use as a summary plan description nor is it designed to serve as an Evidence of Coverage. If you have specific questions regarding benefit structure, limitations or exclusions, consult the plan document or call Delta Dental's Benefit Services Department at 800-237-6060.

Delta Dental – Stand Alone Plan Semi-Monthly Rates

This plan is available for employees who do not enroll in the Health plan.

Insured	*Full-Time & Part-Time Rates*
Employee	$23.44
Employee + One (Spouse)	$65.70
Employee + One (Child/Children)	$66.28
Employee + Family	$117.90

DELTA DENTAL®

If you have questions, please call our Customer Service team at 800-237-6060 or look online at https://www.deltadentalva.com/.

Vision Plan

Focus® Plan Summary

Ameritas

	VSP Choice Network + Affiliates	*Out-of-Network*
Deductibles	$10 Exam $10 Eye Glass Lenses or Frames*	$10 Exam $10 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in Full	Up to $45
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular Progressive	 Covered in Full Covered in Full Covered in Full Covered in Full See lens options	 Up to $30 Up to $50 Up to $65 Up to $100 N/A
Contact Lenses Medically Necessary Cosmetic (Elective)	 Covered in Full Up to $130	 Up to $210 Up to $105
Contacts Fit & Follow Up Exams	Member cost up to $60	No Benefit
Frame Allowance	$130**	Up to $70
Frequencies (months) **Exam/Lens/Frame**	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco & Walmart allowance will be the wholesale equivalent.*

*Lens Options (member cost)**

	VSP Choice Network + Affiliates (Other than Costco)	*Out-of-Network*
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance
STD. Polycarbonate	Covered in full for dependent children $33 Adult	No Benefit
Solid Plastic Dye	$15 (except Pink I & II)	No Benefit
Plastic Gradient Dye	$17	No Benefit
Photochromatic Lenses (Glasses & Plastic)	$31 - $82	No Benefit
Scratch Resistant Coating	$17 - $33	No Benefit
Anti-Reflective Coating	$43 - $85	No Benefit
Ultraviolent Coating	$16	No Benefit

**Lens Option member cost vary by prescription, option chosen and retail locations.*

Retail Chain Affiliate Providers Available With Focus Plans

Effective January 1, 2012, retail chain affiliate providers, which include Costco® Optical and Visionworks, give members added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Members enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

Additional Focus® Choice Network Features

Contact Lenses Elective. Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.

Additional Glasses. 20% off additional complete pairs of prescription glasses and/or prescription sunglasses.* Additional discount is not available at Costco, Sam's Club & Walmart.

Frame Discount. VSP offers 20% off any amount above the retail allowance.* Additional discount is not available at Costco, Sam's Club & Walmart.

Laser VisionCare. VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.

Low Vision. With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

**Based on applicable laws, reduced costs may vary by doctor location.*

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

Ameritas Focus® Plan Monthly Rates

Insured	*Monthly Rates*
Employee	$7.72
Employee & Spouse	$15.16
Employee & Child(ren)	$14.16
Family	$21.56

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

Vision Plan

ViewPointe® Plan H Summary

Ameritas

	EyeMed Insight Network	*Out-of-Network*
Deductibles	$10 Exam $10 Eye Glass Lenses	No Deductible
Annual Eye Exam	Covered in Full	Up to $35
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular Progressive	 Covered in Full Covered in Full Covered in Full 20% discount See lens options	 Up to $25 Up to $40 Up to $55 No Benefit N/A
Contact Lenses Medically Necessary Cosmetic (Elective)	 Covered in Full Up to $130	 Up to $200 Up to $104
Contacts Fit & Follow Up Exams Standard Premium (Allowance)	 Standard: Member cost up to $40 Premium: 10% off of retail	 No Benefit No Benefit
Frame Allowance	$130	Up to $65
Frequencies (months) **Exam/Lens/Frame**	12/12/24 Based on date of service	12/12/24 Based on date of service

Lens Options (member cost)

	EyeMed Insight Network	*Out-of-Network*
Progressive Lenses **Standard** **Premium** **Tier 1** **Tier 2** **Tier 3** **Tier 4**	 $65 + lens deductible $85 + lens deductible $95 + lens deductible $110 + lens deductible $65 + 80% off charge less $120 allowance	No Benefit
STD. Polycarbonate	$40	No Benefit
Tint (solid and gradient)	$15	No Benefit
Scratch Resistant Coating	$15	No Benefit
Anti-Reflective Coating **Standard** **Premium** **Tier 1** **Tier 2** **Tier 3**	$45 $57 $68 80% of the charge	No Benefit
Ultraviolent Coating	$15	No Benefit
LASIK or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No Benefit

EyeMed Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com
View plan benefit information at: eyemedvisioncare.com

Additional EyeMed Network Features

EyeMed In-Network Discount. 15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.

EyeMed In-Network Secondary Purchase Plan. Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.

Contact Lens Replacement by Mail Program. After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit www.EyeMedvisioncare.com for details.

Based on applicable laws, reduced costs may vary by doctor location.

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

ViewPointe® Plan H Monthly Rates

Insured	*Monthly Rates*
Employee	$7.72
Employee & Spouse	$15.16
Employee & Child(ren)	$14.16
Family	$21.56

STAY WELL

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

Cancer Plan

ManhattanLife™

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

Plan Features

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

Benefit	*Benefit Option*
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, Hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	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¢ per mile if a personal vehicle is used
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	a. $200 b. Actual billed charges for round trip coach fare; or personal automobile expense of .50¢ per mile c. Actual billed charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay Incurred Expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	Up to 25% of surgical benefit paid. $100 max per covered person for skin cancer
Ambulatory Surgical Center. We will pay the actual billed charges 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
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

Benefit	*Benefit Option*
Miscellaneous Diagnostic Charges. 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 incurred expenses 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 a 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, subject to the Pre-Existing Condition Limitation, unless coverage replaces a prior plan of similar coverage that was in force when the Policy was issued.

Pre-Existing Condition Limitation

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

Pre-Existing Condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions & Other Limitations

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

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by: Specified Disease or Specified Disease Treatment; or 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 as medically necessary; 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

Monthly Rates				
Coverage Tier	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Employee	$17.65	$23.38	$19.63	$30.89
Employee + Spouse	$35.57	$47.60	$39.44	$62.87
Employee + Child(ren)	$25.19	$33.20	$27.64	$43.36
Family	$43.10	$57.43	$47.45	$75.34

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

ManhattanLife™

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

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

Group Accident Plan

Plan Features

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

Eligibility (Issue Ages)

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

The employee may purchase Accident 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 10% 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 stiches	$25

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

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

Burns (treatment within 14 days, first degree burns not covered)	
Second Degree • Less than 10% of body surface covered • At least 10%, but not more than 25% of body surface covered • At least 25%, but not more than 35% of body surface covered • More than 35% of body surface covered	 $100 $200 $500 $1,000
Third Degree • Less than 10% of body surface covered • At least 10%, but not more than 25% of body surface covered • At least 25%, but not more than 35% of body surface covered • More than 35% of body surface covered	 $1,000 $5,000 $10,000 $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 • Resulting in extractions	 $150 $50

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

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

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

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

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

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

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

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

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

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

Accident Follow-Up Treatment	$25

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

Physical Therapy	$25

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

Air Ambulance	$500
Ambulance	$100

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

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

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

Blood/Plasma	$100

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

Prosthesis	$500

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

Appliance	$100

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

Family Lodging Benefit (per night)	$100

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

Wellness	$60

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

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

Hospital Admission	$1,000

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

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

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

Hospital Confinement (per day)	$200

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

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

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

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

Hospital Intensive Care (per day)	$400

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

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

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

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

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

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

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

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

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

Limitations & Exclusions

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:
- **War** – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- **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.
- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Sports** – participating in any organized sport—professional or semiprofessional.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Aflac Group Accident Rates

24 Hour Plan	*Monthly Rates*
Employee	$16.20
Employee & Spouse	$23.16
Employee & Dependent Children	$30.90
Family	$37.86

Wellness Benefit included in rates.

Aflac®

Policy form number CAI7800VA.

Group Hospital Indemnity Plan (Non-HSA)

Aflac

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.

Continuity of Coverage

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

Group Hospital Indemnity Benefits | Hospitalization Benefits – Base Plan

Benefits	*Low*	*High*
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).	**$500**	**$1,500**
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.	**$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*
Major Diagnostic Exams – once per covered sickness or accident per calendar year 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: • Computerized Tomography (CT/CAT scan) • Magnetic Resonance Imaging (MRI) • Electroencephalography (EEG)	**$125**	**$250**

Surgical Benefits

Benefit	*Low*	*High*
Surgical Benefit (per procedure) 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.	**Up to $750**	**Up to $1,500**

Surgical Benefits Continued

Benefit	*Low*	*High*
Anesthesia Benefits 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.	**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 Monthly Rates

Covered	*Low Option*	*High Option*
Employee	$20.96	$42.32
Employee + Spouse	$41.92	$84.96
Employee + Child(ren)	$30.96	$61.76
Family	$51.92	$104.40

Group Hospital Indemnity Plan (HSA)

Aflac

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

Heath 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*
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).	**$1,500**
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.	**$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 Monthly Rates

Covered	*High Option*
Employee	$25.70
Employee + Spouse	$51.50
Employee + Child(ren)	$40.36
Family	$66.16

Group Critical Illness Plan

without Cancer

Aflac

Plan Features

- ✓ Benefits are paid directly to you, unless otherwise assigned.
- ✓ Premiums are paid through convenient payroll deduction.
- ✓ Guaranteed-issue coverage available to employee and spouse.
- ✓ Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- ✓ Benefit amounts are available from $5,000 up to $50,000 for employees and up to $30,000 for spouse.
- ✓ An annual Health Screening benefit is included.
- ✓ The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- ✓ Includes an Additional Benefits Rider with benefits for the following: Coma, Paralysis, Severe Burn, Loss of Sight, Loss of Hearing, Loss of Speech
- ✓ Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed- Issue

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

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

Individual Eligibility

Issue Ages:

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

Benefit-eligible employees, working at least **20** hours or more weekly, with at least **0** days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

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

Dependent Children Coverage at No Additional Charge

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

Portability

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

Group Critical Illness Benefits

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

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

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

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

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

Health Screening Benefit - $100

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

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

Additional Benefits Rider

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

Heart Event Rider

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

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

Limitations and Exclusions

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

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

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane;
- Illegal activities or participation in an illegal occupation;
- War, participating in way or any act of war, declared or not, or participating in the armed forces of or contracting with country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

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

Pre-Existing Condition Limitation

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

Additional Benefit Rider Limitations and Exclusions

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

Heart Event Rider Limitations and Exclusions

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

Pre-Existing Conditions Limitation

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

Exclusions

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

Policy form number CAI2800VA.

Aflac Group Critical Illness w/out Cancer – Rates

NON-TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$5.52	$7.54	$9.56	$11.57	$13.59	$15.61	$17.63	$19.65	$21.67	$23.69
30-39	$6.89	$10.27	$13.66	$17.04	$20.43	$23.82	$27.20	$30.59	$33.97	$37.36
40-49	$10.44	$17.38	$24.32	$31.26	$38.20	$45.14	$52.08	$59.02	$65.96	$72.90
50-59	$15.20	$26.89	$38.59	$50.28	$61.98	$73.67	$85.37	$97.06	$108.76	$120.45
60 - 69	$25.34	$47.18	$69.02	$90.86	$112.71	$134.55	$156.39	$178.23	$200.07	$221.91

NON-TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*	*$30,000*
18-29	$5.52	$6.53	$7.54	$8.55	$9.56	$10.57	$11.57	$12.58	$13.59	$15.61
30-39	$6.89	$8.58	$10.27	$11.96	$13.66	$15.35	$17.04	$18.74	$20.43	$23.82
40-49	$10.44	$13.91	$17.38	$20.85	$24.32	$27.79	$31.26	$34.73	$38.20	$45.14
50-59	$15.20	$21.04	$26.89	$32.74	$38.59	$44.43	$50.28	$56.13	$61.98	$73.67
60 - 69	$25.34	$36.26	$47.18	$58.10	$69.02	$79.94	$90.86	$101.79	$112.71	$134.55

TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$6.61	$9.72	$12.83	$15.94	$19.04	$22.15	$25.26	$28.37	$31.48	$34.59
30-39	$8.85	$14.20	$19.55	$24.90	$30.24	$35.59	$40.94	$46.29	$51.64	$56.99
40-49	$17.21	$30.92	$44.63	$58.34	$72.05	$85.76	$99.47	$113.18	$126.88	$140.59
50-59	$26.68	$49.86	$73.04	$96.22	$119.41	$142.59	$165.77	$188.95	$212.13	$235.31
60 - 69	$45.28	$87.06	$128.85	$170.63	$212.41	$254.19	$295.98	$337.76	$379.54	$421.32

TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*	*$30,000*
18-29	$6.61	$8.16	$9.72	$11.27	$12.83	$14.38	$15.94	$17.49	$19.04	$22.15
30-39	$8.85	$11.52	$14.20	$16.87	$19.55	$22.22	$24.90	$27.57	$30.24	$35.59
40-49	$17.21	$24.06	$30.92	$37.77	$44.63	$51.48	$58.34	$65.19	$72.05	$85.76
50-59	$26.68	$38.27	$49.86	$61.45	$73.04	$84.63	$96.22	$107.82	$119.41	$142.59
60 - 69	$45.28	$66.17	$87.06	$107.96	$128.85	$149.74	$170.63	$191.52	$212.41	$254.19

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 (06/23)

Short-Term Disability Plan

ONEAMERICA®

Class Description
All Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

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

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

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

Benefit Duration
This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks. Employees enrolled in the 26 week & 52 week prior to the addition of the LTD can remain on the 26 or 52 week if they do not elect the LTD coverage.

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 Rates

Benefit Duration
13 weeks

Monthly Benefit	Monthly Premium
$500	$10.36
$600	$12.43
$700	$14.50
$800	$16.57
$900	$18.64
$1,000	$20.71
$1,100	$22.78
$1,200	$24.85
$1,300	$26.92
$1,400	$28.99
$1,500	$31.07
$1,600	$33.14
$1,700	$35.21
$1,800	$37.28
$1,900	$39.35
$2,000	$41.42

ONEAMERICA®

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

ONEAMERICA®

LTD Class Description
All Full-Time Eligible Employees working a minimum of 20 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 Monthly Rates

Monthly Benefit Amount	*Age 0 - 29*	*Age 30 - 39*	*Age 40 - 49*	*Age 50 - 59*	*Age 60 +*
$500	$3.75	$6.25	$8.15	$22.00	$33.00
$1,000	$7.50	$12.50	$16.30	$44.00	$66.00
$1,500	$11.25	$18.75	$24.45	$66.00	$99.00
$2,000	$15.00	$25.00	$32.60	$88.00	$132.00

ONEAMERICA® | AMERICAN UNITED LIFE INSURANCE COMPANY®
a ONEAMERICA® *company*

Universal Life Plan

Trustmark
benefits beyond benefits

Trustmark Universal Life

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. Universal Life can help. Whether you are married, a parent or single and starting out, Universal Life helps take care of the people important to you if tragedy happens. You can choose a plan and benefit amount that provides the right protection for you. Universal Life insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the ending of one story won't stop the beginning of another.

Plan Features

- ✓ Universal Life is **flexible permanent** life insurance designed to last a lifetime.
- ✓ The younger you are when you enroll, the **more benefit** you receive for the same premium.
- ✓ **No medical exams** or blood work – just answer a few simple questions.

Long-Term Care

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal Life includes a long-term care (LTC) benefit that can help pay for these services at any age. With either option, this benefit remains at the same level throughout your life, so the full amount is always available when you most need it.

How it Works: You can collect 4% of your Universal Life death benefit per month for up to 25 months to help pay for long-term care services, **PLUS** if you collect a benefit for LTC, your full death benefit is still available for your beneficiaries, as much as doubling your benefit.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.

Additional Advantages

- ✓ Keep your coverage at the same price and benefits if you change jobs or retire.
- ✓ Apply for coverage for family members: spouse, children and grandchildren.
- ✓ Convenient payroll deduction; pay via direct bill, bank draft or credit card if you leave your employer.
- ✓ Buy term life insurance for your children. They can later simply convert this rider to a permanent Universal Life policy.
- ✓ Benefits for terminal illness – use part of your death benefit to help manage cost if you're diagnosed with a terminal illness.

What Can Universal Life Benefits Help Pay For?

- ✓ Funeral and burial costs
- ✓ Tuition and loans
- ✓ Rent or mortgage payments
- ✓ Credit card bills
- ✓ Retirement savings
- ✓ Medical expenses

Universal Life Sample Rates

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	*$25,000 Universal Life policy*
30	From $5.06 - $6.27
40	From $7.42 - $9.44
50	From $11.92 - $15.44

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/ or by your employer. An application for insurance must be completed to obtain coverage.

Note: Your rate is "**locked in**" at your age at purchase! Once you have a policy, your rate will never increase due to age.

This provides a brief description of your benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state. This policy contains a provision that guarantees against lapse for a period of 10 years (14 years in OR; 15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value. You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled. A policy illustration will be delivered with your policy. Your policy will contain complete information. For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/ disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Trustmark® is a registered trademarks of Trustmark Insurance Company.

Pet Insurance

Flexible Pet Insurance Coverage

Be the best pet parent you can be. You have an unbreakable bond with your pet which is why our coverage eliminates the stress, heartache, and uncertainty associated with unexpected events. When your pet gets sick or injured, they can get treatment they need, when they need it.

- ✓ Use any licensed veterinarian in the US or Canada — including specialty and emergency clinics
- ✓ Exclusive employee discount on a BestBenefit plan*
- ✓ Optional coverage for routine care
- ✓ Around the clock support from the 24/7 pet helpline
- ✓ Easy claims submission
- ✓ Self-service through our mobile app
- ✓ Enjoy an exclusive up to 10% employer discount

How Pet Insurance Works

1. **Attend to Your Pet** - When your pet gets sick or injured, they can get treatment from any licensed veterinarian in the US or Canada.
2. **File a Claim** - You can easily file a claim through our app or online, and you don't need to send us medical records unless we ask for them.
3. **Easy Reimbursement** - Your reimbursement can be conveniently and easily deposited directly into your bank account, so you never have to wonder where your money is.

Enroll Today!

To begin, enroll at www.petsbest.com/CCPSPETS or call 888-984-8700. Reference discount code: CCPSPETS

Plan Overview

Plan Coverage	*Essential*	*Plus*	*Elite*
Annual Coverage Limit for Unexpected Accidents and Illness	**$5,000 – Unlimited**	**$5,000 – Unlimited**	**$5,000 - Unlimited**
Annual Deductible	**$50 - $1,000**	**$50 - $1,000**	**$50 - $1,000**
Reimbursement Percentage*	**70% - 90%**	**70% - 90%**	**70% - 90%**
Accidents, Illnesses, Cancer, Hereditary Conditions, Emergency Surgeries & Rx Meds**	✓	✓	✓
Accidents & Illness Exam Fees Associated with the Diagnosis of Your Pet for an Eligible Injury or Illness. *This is not intended to cover routine exams.*		✓	✓
Rehabilitative, Acupuncture & Chiropractic Coverage to Treat Eligible Injuries and Illnesses.			✓
Wellness Add-On for Routine Care *Coverage to help pay for regular and expected veterinary visits. Please see Wellness Plans Summary for pricing information.*	✓	✓	✓

*Disclaimer: *Select a plan that reimburses 70%, 80%, or 90% of the cost of eligible veterinary treatment. Limited to covered expenses.*
***Most plans cover prescription medications. Download our formulary at petsbest.com/coverage. $7/month for cats and $10/month for dogs in WA. Coverage applies to eligible conditions only and is subject to all terms, conditions, limitations and exclusions in the policy. Please review policy form for complete details.*

Accident-Only Coverage

If your pet currently has Addison's Disease, Cushing's Disease, Diabetes, Cancer, Feline Leukemia or Feline Immunodeficiency Virus, they can enroll for Accident Only coverage, but will be ineligible for illness coverage. The Accident Only plan does not cover medical issues such as illness or cancer, but provides up to $10,000 in annual coverage for things like broken legs, snake bites, accidental swallowing and more. Coverage starts at $9 per month for dogs, and $6 per month for cats.*

Routine Care Coverage

Routine care coverage for dogs and cats helps pay for regular veterinary visits. From regular checkups, to dental cleanings and blood work, routine care helps catch diseases early to ensure a longer, happier, and healthier life for your pet. Routine care coverage is an excellent way to budget for your pet's expected medical expenses, especially if you have a new kitten or puppy.

There are two tiers of routine care coverage that can be added to one of our pet health insurance plans for an additional premium at the time you enroll, or at your annual renewal. Benefits are available to you on your policy start date, so you can start using your routine care plan as soon as your policy goes into effect.

Covered Benefits	*Essential Wellness - $16/Month* *Pays up to the following, per year, with no deductible*	*BestWellness™ - $26/Month* *Pays up to the following, per year, with no deductible*
Spay/Neuter + Teeth Cleaning	$0	$150
Rabies	$15	$15
Flea/Tick Prevention	$50	$65
Heartworm Prevention	$30	$30
Vaccination/Titer	$30	$40
Wellness Exam	$50	$50
Heartworm Text or FELV Screen	$25	$30
Blood/Fecal/Parasite Exam	$50	$70
Microchip	$20	$40
Urinalysis or ERD	$15	$25
Deworming	$20	$20
Total Annual Benefits	**$305**	**$535**

Routine care plans not sold as a stand-alone plan and if purchased must be added to a BestBenefit Accident and Illness Plan.

How long are Pets Best's waiting periods?
A waiting period is how long it takes coverage to begin after enrolling. Pets Best has some of the shortest waiting periods in the industry: 3 days following the policy effective date for accidents, 14 days for illnesses, and 6 months for cruciate ligament events and any related conditions. Routine care plans can be used the day after your policy starts. Waiting periods are waived for continuous, uninterrupted policy renewals.

When can I insure my pet with Pets Best?
You can enroll your pet as young as 7 weeks. Like children, puppies and kittens have the highest risk of accidents. Their immune systems aren't mature, so they're more susceptible to infectious diseases. Pets Best plans have no upper age limits, so senior dogs and cats get the same great coverage as kittens and puppies.

My pet is already sick or injured. Can pet insurance help?
Pet insurance is for unexpected accidents and illnesses. It does not cover preexisting conditions. However, many future accidents and illnesses should be covered if something happens. We also offer accident-only coverage for pets with severe chronic conditions, and wellness coverage to help manage the cost of routine care for your pet.

Can I use my own veterinarian?
Yes. Pets Best has no networks, so you can use any licensed veterinarian in the US or Canada. We also have no schedule of benefits and no pre-authorization procedures. We want your pet to receive the best possible care, which is why we also cover visits to specialists and emergency after-hours clinics.

Do I need to have the Routine Care option?
Not at all! You can simply pay the annual expenses of routine care, like dental cleaning, vaccinations and blood work, on your own. However, our routine care options are designed to save you money on expected and preventative care for your pet.

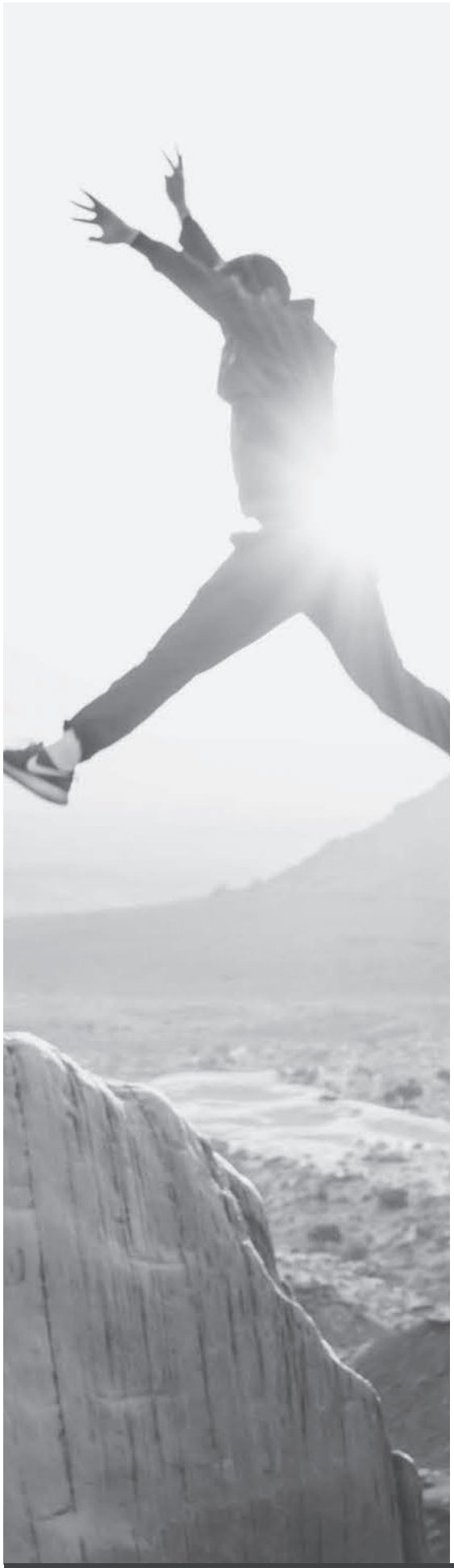
Will Pets Best cover my pet's dental needs?
Good dental care is incredibly important to your pet's overall health. Our BestBenefit plans include coverage for periodontal disease and other dental issues if proper preventative care as outlined in the policy document has been performed.

How do I file a claim?
The easiest and fastest way to file a claim is through your customer account or one of our mobile apps. Once you log in you can submit and view claims, and sign up for direct deposit. You can also send your claim via email, fax, or standard mail. It's up to you!

Do you use a benefit schedule?
No, our BestBenefit plan does not use a benefit schedule but our BestWellnes plan does, which is a list that puts a limit on what each type of treatment can cost. Instead, we reimburse your choice of up to 90%* of your vet bill after the deductible of your choice, up to your plan's maximum benefit.

Pets Best
PET HEALTH INSURANCE

Pet Insurance coverage is offered and administered by Pets Best Insurance Services, LLC and is underwritten by American Pet Insurance Company, a New York insurance company headquartered at 6100 4th Ave. S. Suite 200 Seattle, WA 98108. Please visit www.americanpetinsurance.com to review all available pet health insurance products.



Continuation of Benefits

If You Leave Employment

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

AUL Short & Long-Term Disability
Once an employee is on the AUL disability plan 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 port your coverage by calling **AUL at 1-800-553-5318.**

FBA Flexible Spending Account
If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. 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 claims were not incurred prior to the date of termination. To obtain your balance, please call **FBA at 1-800-437-3539.**

Health, Dental, and/or Vision Plan(s)
Under the Health, Dental and/or Vision Plan(s), you and your covered dependents are eligible to continue coverage through COBRA according to the "qualifying events". If you and your dependents are enrolled in the plan(s), you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan(s), if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan(s), your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions **you may contact your Finance Department at (804) 633-5088 or Flexible Benefit Administrators at (800) 437-3539.**

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

PetsBest Pet Insurance
When you leave employment, you may continue your pet insurance coverage. For more information, contact **PetsBest at 1-877-738-7237.**

Trustmark Universal Life
When you leave employment, you may continue your Universal 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 **Trustmark at 1-800-918-8877.**

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

Ameritas
VSP Care Center: 1-800-877-7195
EyeMed Care Center: 1-866-289-0614
www.ameritas.com

Delta Dental
Phone: 1-800-237-6060
www.DeltaDentalVA.com/members

Flexible Benefit Administrators
509 Viking Drive, Suite F | P.O. Box 8188
Virginia Beach, VA 23450
Phone: 1-800-437-3539
Fax: 757-431-1155
FlexDivision@flex-admin.com
www.mywealthcareonline.com

Manhattan Life
Bay Bridge Administrators, Inc.
Phone: 1-800-845-7519
Fax: 512-275-9350
www.bbadmin.com

PetsBest
Phone: 1-877-738-7237
www.petsbest.com

Trustmark Insurance Company
Phone: 1-800-918-8877
www.trustmarkbenefits.com

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

Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits

300 W. Watauga Ave.
Johnson City, TN 37604

(800) 532-1044
(704) 365-4280