Employee Benefits Guide

PLAN YEAR:

July 1, 2022 - June 30, 2023

Table of Contents

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

DISCLAIMER

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

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

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

Important Points

- ✓ Your plan year runs from July 1, 2022 to June 30, 2023. This means your benefit elections will take effect July 1, 2022 unless otherwise noted.
- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event as outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending Account and Dependent Care Account each year! It will not automatically renew.
- ✓ **Texas Life Whole Life will be coming off payroll.** To continue your Texas Life Whole Life coverage with direct bill or to cancel, contact Texas Life at 1-800-283-9233. For more information, consult with a Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ **Trustmark Universal Life has been added as part of your benefits package.** This does not replace your current Texas Life Whole Life coverage if you wish to keep it. For more information, consult with a Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ This benefits guide is equipped with mobile-friendly barcodes commonly referred to as QR Codes. Use your smartphone to scan the QR codes to view your benefit summaries.
- ✓ All policy information can be found on your employee benefits portal at https://mymarkiii.com/staffordgov/.

Qualifying Life Events

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

Examples of QLEs

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

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Welcome to Your Benefits!

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

Pre-Tax Benefit Information

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

- ✓ Anthem Medical Plans
- ✓ Health Savings Account (HSA)
- ✓ Anthem Dental
- ✓ FBA Flexible Spending Accounts (FSA)
- ✓ Manhattan Life Group Cancer
- ✓ Aflac Group Accident
- ✓ Aflac Group Hospital Indemnity

Post-Tax Benefit Information

A "**post-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. Although you do not get any savings from taxes, you have the flexibility of dropping your coverage at any time.

- ✓ Aflac Group Critical Illness
- ✓ AUL Short-Term Disability
- ✓ Trustmark Universal Life
- ✓ Legal Resources Protection

How to Enroll at Open Enrollment

Self-Service Enrollment

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

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

Call Center Enrollment

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

Call Center: 1 (833) 890-7652 *(M – F, 8:00 a.m. – 5:00 p.m. EST)*

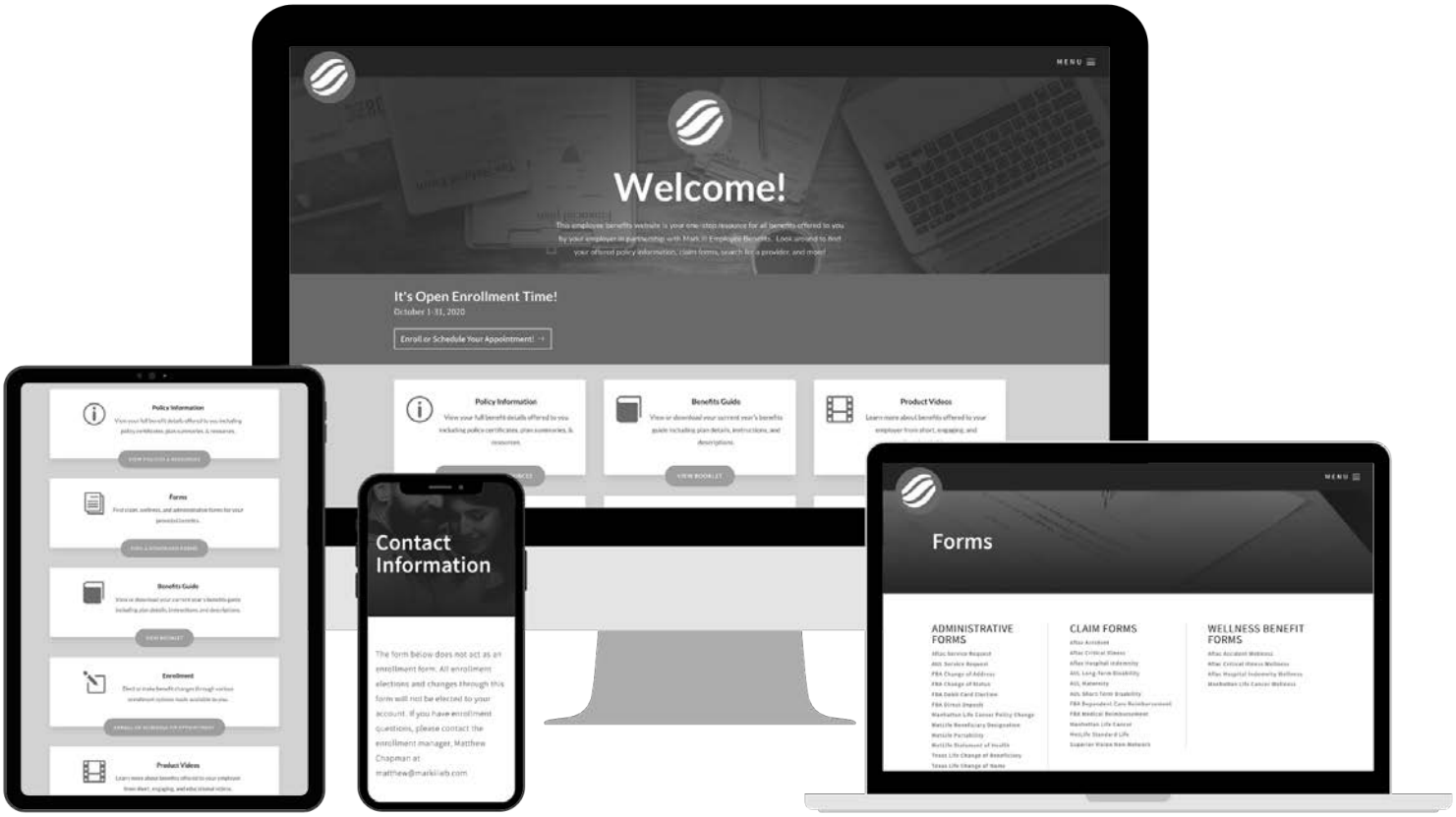
Employee Portal

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

Scan me!

Employee Benefits Portal

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



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

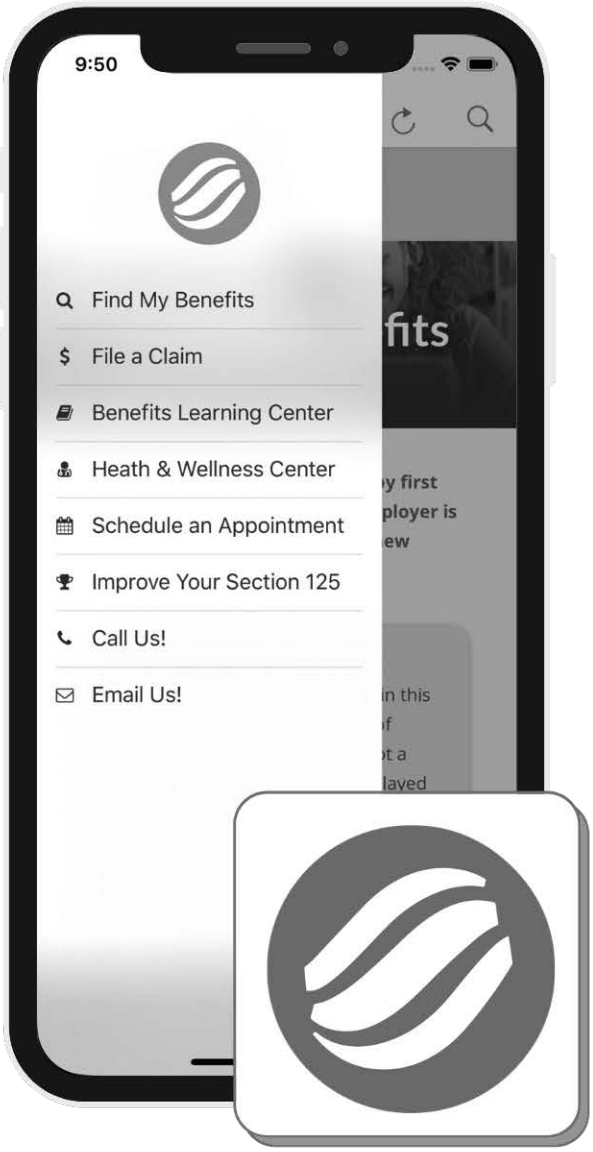
Scan me!

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

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

MyMark III Mobile App

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



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

Scan Me!

Your Trusted Benefits Partners at your fingertips!

Download on the App Store

GET IT ON Google Play

Filing a Claim

Manhattan Life Group Cancer

Visit https://mymarkiii.com/staffordgov/forms/ to download your claim form. 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

- ✓ Manhattan Life Group Cancer Wellness Benefit Amount - **$100**

Group Aflac

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

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

AUL Disability

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

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

Employee Portal

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

Visit: https://mymarkiii.com/staffordgov/

Scan me!

HEALTHY LIVING

Core Benefit options to keep you and your family healthy.

Medical Plan Summary

Anthem

In-Network Benefits	*Premium PPO*	*Core PPO*	*HDHP w/HSA*
Calendar Year Deductible (Individual/Family) Member will pay the full cost of services until they reach the deductible. After they reach their deductible, they will pay the copays and coinsurances listed below.	$200/$400	$1,000/$2,000	$1,500/$3,000
HSA Employer Funding	Not available	Not Available	$800 Employee Only $1,200 All other tiers
Outpatient Office Visits	$20 copayment for PCP $40 copayment for Specialist	$30 copayment for PCP or Specialist	Subject to calendar year deductible + 20% coinsurance
Preventive Care Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. ** During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.*	No charge*	No charge*	No charge*
Allergy Shots, Therapeutic Injections	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Diagnostic Tests Laboratory services Diagnostic x-rays Advanced diagnostic imaging services (Includes MRI, MRA, MRS, CTA, PET scans & CT scans)	Subject to deductible + 20% coinsurance $30 copay $150 copay	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Outpatient Surgery	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Emergency Room Care	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Urgent Care	$20 copayment for PCP $40 copayment for Specialist	$30 copayment for PCP or Specialist	Subject to deductible + 20% coinsurance
PHYSICAL and OCCUPATIONAL THERAPY (Combined calendar year limit of 30 visits) Speech Therapy (Calendar year limit of 30 visits)	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Cardiac, Chemo, Infusion, Radiation, Respiratory Therapy	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance

In-Network Benefits Continued	*Premium PPO*	*Core PPO*	*HDHP w/HSA*
Mental Health (Outpatient office-based treatment)	$25 copayment	$30 copayment	Subject to deductible + 20% coinsurance
Home Health Care (100 visits calendar year limit)	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Inpatient Hospital Services	$400 + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Skilled Nursing Facility Stays (100 day per stay limit)	$400 + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Other Services	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance	Subject to deductible + 20% coinsurance
Out-of-Pocket (Individual/Family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Prescription Drug Benefits Retail Mail Order (90 day supply)	 $10/$30/$50/$150 $20/$60/$100/NA	 $10/$30/$50/$150 $20/$60/$100/NA	 $10/20%/40%/$200 $20/20%/40%/NA
Out-of-Network Benefits Calendar Year Deductible (Individual/Family) Coinsurance (after deductible has been met) Out-of-Pocket (Individual/Family)	 $1,000/$2000 50% coinsurance $6,250/$12,500	 $1,750/$3,500 50% coinsurance $7,000/$14,000	 $1,500/$3,000 40% coinsurance $10,000/$20,000

Summary of Benefits & Coverage (SBC) Documents

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

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

Scan me!

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

Save With GoodRx

GoodRx

Never Over-Pay for Your Prescriptions Again!!

GoodRx is a great way to help save money on your prescriptions and the best thing is that it's completely **FREE** to use for your whole family. GoodRx compiles discount coupons that enable you to take advantage of the best pricing on your medications. You'll be surprised at how inexpensive you might be able to get your medications. Check GoodRx every time you get a prescription to see your possible savings.

Features

- ✓ **Search & Compare Prices**. Find the lowest local prices for your prescriptions at more than 70,000 U.S. pharmacies.
- ✓ **Get Free Coupons**. GoodRx coupons can save you up to 80% on your prescriptions at no cost to you.
- ✓ **Save your prescriptions**. Track prices and get notified with the latest saving alerts for your prescriptions.
- ✓ **Show To Your Pharmacist**. It's easy, just show the GoodRx app to your pharmacist when picking up your prescription.

How Do I Use GoodRx?

1. Download the the GoodRx app on the iTunes and Google Play App stores or enter your mobile number at https://www.goodrx.com/mobile to have the app texted to you.
2. Look up your prescriptions and compare prices at multiple pharmacies.
3. Click the print, email, or text button above the coupon on your computer to print or send it to your phone.
4. Show the printed coupon or the digital coupon on your phone when you drop off your prescription.

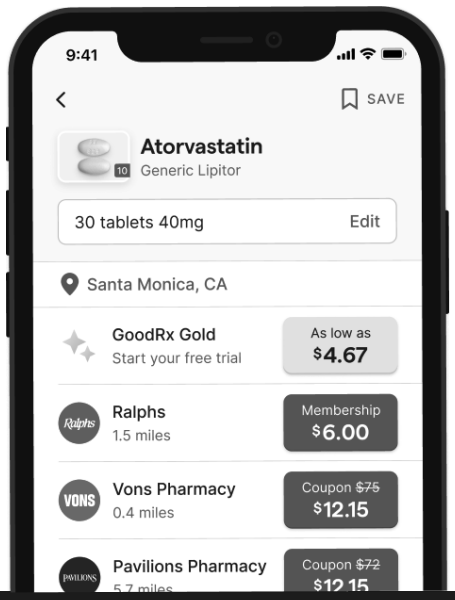
P.S. If you're picking up a prescription your doctor called in, please show your GoodRx coupon before they scan your medication to begin checkout.

Who Accepts GoodRx Discounts?

GoodRx is accepted at over 70,000 pharmacies in all 50 states, Puerto Rico, and the U.S. Virgin Islands. That includes major chains like CVS, Walgreens, Kroger, Rite Aid, Costco, Walmart, and many more!

Access the below medications at a discounted rate!

- ✓ Piqray (chemotherapy)
- ✓ Tremfya/Stelara/Skyrizi (psoriasis medication)
- ✓ Ozempic (Type II diabetes)
- ✓ Trulicity (diabetes)



Save Up To 80% On Your Prescriptions With The Free GoodRx App

GoodRx is the #1 free medical app for iOS and Android. Download the app today and start saving on your prescriptions!

Download on the App Store

ANDROID APP ON Google play

Insurance Selections/Opt-Out Program & Qualifying Events

Insurance Selections

Stafford County will continue to to offer three PPO insurance options as a part of the benefits package for FY2023 (July 1, 2022 – June 30, 2023), including a High Deductible Health Plan with an employer-funded Health Savings Account. All plans are offered by Anthem BlueCross and BlueShield with an extensive Nationwide and Worldwide network of providers. Whether you are at home or far away on vacation, you can rest assured that your in-network benefits are only a phone call away.

Health insurance includes medical, vision, and prescription coverage, but not dental. Dental insurance will remain unbundled for FY2023, but employees will be able to access dental and health information on the same Anthem login. Employees will be able to elect to enroll in one of two dental options whether or not they enroll in the health insurance, or they can decline dental insurance. When enrolling through the Selerix online Open Enrollment portal, or completing the Open Enrollment Plan Selection Form, employees will need to indicate their plan selections for both medical and dental.

Opt-Out Program

During open enrollment, you may choose to opt-out of the County's health insurance using the Selerix system. If you choose to opt-out, you will receive $150 per month of taxable income in your paycheck. To be eligible for the $150 per month opt-out credit, you, your spouse, and all dependents must discontinue membership in the County's health insurance program and you must show proof of health insurance coverage from another source (i.e., spouse's plan). You may elect the stand-alone dental option and still be eligible to receive the opt-out credit, but you must pay the full cost of the dental insurance rather than the subsidized rate.

Employees who are covered by Stafford County health insurance through a parent or spouse are not eligible to participate in the Opt-Out program unless both spouses choose to opt-out, in which case only one can receive the credit. The Opt-Out program is intended for employees who remove themselves, their spouse, and dependents from the County's health care plan.

If you are already enrolled in the Opt-Out program, you will need to re-enroll each year using the Selerix system. You will need to attest to having other insurance coverage.

Qualifying Events

Open Enrollment is a time period in which employees may make any changes they desire to their insurance plans. However, changes are allowed outside of open enrollment during a plan year (July 1, 2022 – June 30, 2023), if an employee or dependent experiences a "Qualifying Event."

The change must be submitted to Human Resources within 30 days of the qualifying event along with proof of the change (COBRA notice if a dependent lost coverage, Court Ordered Divorce Decree, Proof of Birth letter, marriage certificate, etc.). Common "Qualifying Events" are: marriage, birth of a child, divorce, and loss or gain of other insurance for employee, spouse or dependent.

NOTE: It is the employee's responsibility to ensure notification is made to Human Resources as soon as a dependent becomes either eligible or ineligible to participate in Stafford County's insurance plan. If a dependent is no longer eligible, such as a divorce, it may become the member's responsibility for repayment of the office visits, claims, etc., incurred during the time period as an ineligible covered member.

Contact Angela Raines at araines@staffordcountyva.gov or 540-658-5315 or
Vivian Swartz at vswartz@staffordcountyva.gov or 540-658-8658 if you have any questions about a qualifying event.

Health Savings Account (HSA) Information

Health Savings Accounts (HSAs) allow employers and employees to contribute pre-tax dollars towards qualified medical expenses. Unlike Flexible Spending Accounts, unused HSA contributions roll over from year to year. HSAs are fully portable and controlled by the employee.

HSA funds are deposited in an FDIC-insured account. Balances earn interest and may be invested, offering HSA owners the ability to set aside thousands of dollars for later health care needs.

Who Qualifies for an HSA?

In order to qualify for an HSA, employees must meet the following criteria:

- Employee must be covered by a high deductible health plan (HDHP), with minimum deductibles of $1,400 for an individual or $2,800 for a family. Stafford County's HDHP plan meets this qualification.
- Employee is not covered by another health plan.
    - This restriction includes Flexible Spending Accounts. If an employee elects the HDHP with HSA option, they cannot have an FSA through either Stafford County or a spouse's insurance.
- Employee is not eligible to be claimed as a dependent on another person's tax return.
- Employee is not entitled to Medicare benefits.

How Do I Contribute to My HSA?

Stafford County will contribute $800 for employee only coverage and $1,200 for all other enrollment tiers per plan year (July 1 – June 30) to an HSA account for employees who elect the HDHP. The Stafford County contributions will be paid twice per year for the duration of enrollment, subject to annual budget and appropriation of funds. Employees who do not activate their HSA accounts through Act Wise within 60 days of their coverage start date will become ineligible to receive the employer credit. New hires, who start before October 1st, will be eligible to receive both Stafford County Government contribution installments. New hires who start after October 1st, and prior to April 1st, will receive one contribution installment.

You will be able to contribute additional pre-tax funds to your HSA through either an ongoing payroll deduction or a direct transfer from your financial institution to your HSA account.

Because the account is controlled by the employee, the employee is responsible for ensuring that total contributions (including employer contributions) don't exceed the IRS yearly limit of $3,650 for individuals or $7,300 for families. Employees are also responsible for maintaining documentation of their HSA use, and properly reporting contributions on their taxes.

What Can I Use my HSA For?

HSA funds can be used for qualified medical expenses, which include doctor visits, screenings, x-rays, prescription drugs, ambulance and emergency room costs, braces, eye care such as contacts, glasses and Lasik, lab fees, mental health care, first aid supplies, diabetic supplies, and more. A full list of qualified medical expenses can be found in IRS Publication 502, available on the Open Enrollment section of iStafford.

If you choose to withdraw HSA funds for non-medical expenses before reaching age 65, the IRS imposes a 20% penalty tax. Once you reach age 65, your funds can be withdrawn at any time and are only subject to ordinary income tax.

What Happens If I Leave Employment With The County?

Your HSA belongs to you regardless of your employment. It is fully portable, and accumulated funds can be used to pay for medical expenses even after you retire or resign from the County. If you change plans to a non- HDHP, you can continue to use your accumulated HSA funds, but you cannot contribute additional money.

If you lose your job and elect to retain your HDHP under COBRA you can pay the COBRA premiums from your HSA.

Utilization and the Cost to You

Did you know that a visit to the Emergency Room instead of an Urgent Care for a non-life threatening injury/illness, not only costs you more money out of pocket, but may also affect the amount of premiums you pay in your paycheck?

ER visits incur a **20% coinsurance** vs. your plan copay at an Urgent Care.

The average wait time in an ER is more than 4 hours long!

Where To Get Care When You Need It Now

When you need care right away, how can you decide where to go? You can get the best care, and save time and money, by choosing the right place.

- When you or a family member is sick or hurt, your main concern is getting care as soon as possible. Your first impulse may be going to the ER. However, the ER may not always be the best choice. You may end up in the waiting room for hours and pay more for care.
- If it's not a true emergency, try calling your primary doctor to see if you can make an appointment. If that isn't possible, you have other choices:

What Do They Treat?		*When Are They Open?*
Urgent Care Center	Conditions that should be looked at right away, but aren't as bad as emergencies. They can usually do X-rays, lab tests and stitches.	Often extended hours, including weekends and evenings.
Retail Health Clinic (often in pharmacies or retail stores)	Basic health care services (such as a cough, sore throat, rash or minor fever)	Usually same hours as the pharmacy or retail store they are in.
Walk-in Doctor's Office	Routine care and common family illnesses (including mild asthma, nausea and back pain)	Hours vary depending on office.

- Always call 911 or go the Emergency Room (ER) if you think you are having a real emergency or if you think you could put your health at serious risk by delaying care.
- To learn more about how to decide between going to the ER or somewhere else for care, go to www.anthem.com/findurgentcare

How Can I Find An Urgent Care Center Or Retail Health Clinic?

- Go to www.anthem.com, click Find a Doctor and select Urgent Care. Enter your location and plan info to find a provider close to you.

Not sure where to go? Call Our 24/7 NurseLine.

- A registered nurse is available to answer your questions – any time of the day or night. Just call the toll-free number on your ID card.

Another Option Is LiveHealth Online –

- Video access to in-network, board-certified doctors anywhere with an Internet connection, 7 days a week, 365 days a year, for commonly seen conditions with a lower co-pay than a regular doctor visit, saving you time and money! Online therapy visits are also available.

Patient Protection & Affordable Care Act (ACA)

What Does It Mean To You?

Over the past few years you may have noticed benefit changes phased in so that Stafford remains in compliance with the Patient Protection and Affordable Care Act (ACA). Below is a summary of employer regulations:

ACA Benefit Coverage Requirement:

- Coverage of dependents up to age 26
- Preventative services covered at 100% for women
  - Well-woman visits
  - Gestational Diabetes Screenings
  - HPV testing and Sexually Transmitted Infection counseling
  - FDA approved contraception methods
  - Breastfeeding support, supplies and counseling
  - Domestic violence screening and counseling
- **Annual Limits**: employers will be prohibited from placing an annual limit on essential health benefits.
- **Excessive Waiting Periods**: wait periods to join a medical plan cannot be longer than 90 days.
- **Pre-Existing Conditions**: regardless of age, a pre-existing condition may not be used to exclude an individual from coverage.
- **Coverage for Clinical Trials**: participants may not be cancelled from a plan for participation in a clinical trial for cancer or life-threatening diseases.
- **Commingling of out-of-pocket maximums**: Out-of-pocket maximums will include prescription co- payments in addition to the out-of-pocket medical costs you may incur for covered services.
- In 2016, businesses with at least 50 full-time equivalent employees must offer at least 95 percent of full- time employees insurance to avoid penalties. These businesses must also pay a penalty if a full-time worker receives a tax credit or cost subsidy through the ACA Marketplace because employer-provided insurance was unaffordable or didn't meet minimum value.

Affordable Care Act Hours Requirement and Standard Measurement Periods

For large employers, the ACA mandates coverage for employees working on average more than 30 hours per week. Stafford County will be required to measure the hours that employees work from May 1 – April 15 to determine if a variable hour, or part-time employee, qualifies for insurance benefits during a plan year. If an employee becomes eligible for insurance based on this "Standard Measurement Period," they will be eligible for insurance during the following plan year from July 1 – June 30. Since this is an annual calculation, it could be possible that an employee would be eligible one year, and ineligible the following year.

For Your Reference: ACA/Healthcare Reform Key Terms

Obtained from: http://www.gsanational.com/healthcare-reform-important-terms

Standard Measurement Period

This is the period of time between three and twelve months (chosen by the employer) that will be used for determining if an ongoing employee is a full-time employee. (Stafford's Measurement Period: May 1 – April 15)

Stability Period

This is the period of time between six and twelve months (chosen by the employer subject to certain limitations) during which an employee's status as a full-time employee (or not) is fixed based on the results from the average hours worked during the Standard Measurement Period (or the Initial Measurement Period in the case of a new seasonal or variable hour employee). A Stability Period must be at least as long as the Standard Measurement Period but no shorter than 6 months. (Stafford's Stability Period: July 1 – June 30, to match with a plan year).

Initial Measurement Period

This is the period of time between three and twelve months (chosen by the employer) that will be used for determining if new Variable Hour Employees (defined below) or Seasonal Employees (defined below) are considered full-time employees. The Initial Measurement Period may begin on the date of hire or the first day of the calendar month following the date of hire. The total initial period (Measurement plus Administrative periods) may not exceed thirteen months, plus the remainder of the calendar month. The employer must re-test the employee when that employee completes the standard measurement period for ongoing employees. (Stafford's Initial Measurement Period: begins the first day of the calendar month following the date of hire, and is twelve months).

Administrative Period

This is the period between the end of the Standard Measurement Period (or of the Initial Measurement Period) and the associated Stability Period. The Administrative Period may last up to 90 days and is envisioned to be the time during which employers determine which of its employees have satisfied the requisite 30 hours per week average in order to be eligible for coverage. This is also the period in which eligible employees are provided with information about medical plan coverage options and given an opportunity to enroll. (Stafford's Administrative Period: May 16 – June 30)

Variable Hour Employee

This is an employee for whom, as of his or her start date, it cannot be determined that he or she is reasonably expected to work on average at least 30 hours per week. Even if a new employee is reasonably expected to work at least 30 hours per week for a limited period of time, the employee may be a variable hour employee if the employment for 30 or more hours per week is reasonably expected to last for a limited duration and it cannot be determined how many hours that the employee is reasonably expected to work on average over the Initial Measurement Period.

Seasonal Employee

This is an employee who performs services on a seasonal basis, such as an employee hired exclusively for the holiday season.

Minimum Value

Coverage provided under a plan will be deemed to be of "minimum value" if the plan's share of the total allowed cost of benefits provided is 60% or more of the expenses projected to be incurred by employees covered under the plan. In other words, the actuarial value of the benefits provided in the plan must equal or exceed 60% of the plan costs.

Vision at a Glace

Anthem®

Blue View Vision Summary

Vision Care Services	*In-Network*	*Out-of-Network*
Annual routine eye exam (one allowed every calendar year)	$15 copay	$30 allowance
Eyeglass frames	$130 allowance then 20% off remaining balance	$45 allowance
Eyeglass lenses (Standard)*		
• Standard plastic single vision	$25 copay	$25 allowance
• Standard plastic bifocal	$25 copay	$40 allowance
• Standard plastic trifocal	$25 copay	$55 allowance
Contact lenses		
• Elective conventional lenses	$130 allowance	$105 allowance
• Elective disposable lenses	$130 allowance	$105 allowance
• Non-Elective contact lenses	Covered in full	$210 allowance
Contact lens fitting & follow-up		
• Standard contact fitting	Covered in full	$35 allowance
• Premium contact fitting	10% off retail, then $55 allowance	$35 allowance
Additional pair of complete eyeglasses	40% discount	N/A

**Each calendar year you may receive only one pair of eyeglasses.*

Dental at a Glance

Dental Plan Options: Effective July 1, 2022

Anthem®

Services	*Core Plan (In-Network)*	*Premium Plan (In-Network)*
Diagnostic & Preventive Services Exams & cleanings, x-rays (not subject to deductible)	100%	100%
Basic Services Emergency treatment for relief of pain, amalgam or composite restoration (fillings)	80%	80%
Endodontics Pulpotomies on primary teeth for dependent children, root canal therapy on permanent teeth	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%
Oral Surgery Surgical/Nonsurgical extractions, all other oral surgery	80%	80%
Major Restorative Crowns	50%	50%
Prosthetic Repairs & Adjustments Denture adjustments & repairs, bridge repair	50%	50%
Prosthetics Dentures (full & partial), bridges	50%	50%
Orthodontics Treatment for the prevention/correction of malocclusion	Not Covered	50%
Deductible Per person/per family (calendar year) No deductible for diagnostic & preventive services or orthodontics	$50/$150	$50/$100
Calendar Year Plan Maximum Per Person	$1,250	$1,250
Lifetime Ortho Maximum	Not Covered	$1,500

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary by contacting Anthem.

Network & Contact Information

- **Finding a Dentist**: Go online to **anthem.com** or call Anthem Dental Customer Service at **(866) 956-8607**.
- **Participating Providers** are dentists who have contracted with us to provide dental care to our members at a negotiated rate. When using a participating dentist, you will only be responsible for your deductible and coinsurance amounts, if applicable.
- **Non-Participating Providers** are dentists who have not contracted with us and therefore may charge their usual fee for services they provide to you. When using a non-participating dentist, you will be responsible for your deductible and coinsurance amounts, if applicable, plus any amount over our Covered Expense, up to the dentist's billed charges. While the percentage we pay is the same whether you receive dental services in-network or out-of-network, you may end up paying more out-of-pocket when you visit a non-participating provider.

The in-network Dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem BlueCross BlueShield

Dental Plan Limitations & Exclusions

Diagnostic and Preventive Services
Oral evaluations (exam). Limited to two per Calendar Year. Prophylaxis (cleaning). Limited to two per Calendar Year. Intraoral x-rays, single film. Limited to four films per 12-month period.

Complete series x-rays (panoramic or full-mouth). Limited to once every 36 months.

Restorative Services – applicable if these services are covered under your plan

Fillings. Limited to once per surface per tooth in any 24 months.

Crowns. Limited to once per tooth in a five year period.

Fixed and removable prosthodontics – dentures, partials, bridges Covered once in any five-year period. Benefits are provided for the replacement of an existing bridge, denture, or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy. Limited to once per lifetime per tooth. Coverage is for permanent teeth only.

Periodontal surgery. Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is 5 millimeters or greater.

Periodontal scaling and root planing. Limited to once per quadrant in 36 months when the tooth pocket has a depth of 4 millimeters or greater.

Additional Limitation for Orthodontic Services
Orthodontia. Limited to one course of treatment per member per lifetime. Coverage is only available for High Option Dental Plan.

Exclusions — Below is a partial listing of non-covered services. Please see your Certificate of Coverage for a full list.

Services provided before or after the term of this coverage. Services received before your effective date or after your coverage ends, unless otherwise specified in the plan certificate.

Cosmetic dentistry. Any services performed for cosmetic purposes including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers.

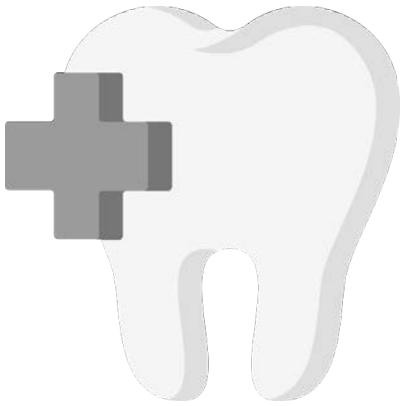
Drugs and medications. Intravenous conscious sedation, IV sedation and general anesthesia when performed with non-surgical dental care.

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions. Surgical removal of asymptomatic, non-pathologic third molars.

Call
Refer to the toll-free number indicated on the back of your plan identification card or call (866) 956-8607 to speak in-person with a U.S. based customer service representative during normal business hours. Calling after-hours? We may still be able to assist you with our interactive voice-response system at (866) 956-8607.

Write
Refer to the back of your plan identification card for the address.



Anthem®

Health Insurance Employee Contributions

Rates effective July 1, 2022 – June 30, 2023

Rates apply to full-time employees who work 40+ hours per week. Rates are for health insurance only.

Premium PPO (PPO w/ Anthem BCBS)	*Full Monthly Cost (including Stafford & Employee Contributions)*	*Monthly Cost to Employee*	*Per Paycheck Cost to Employee*
Employee Only	$659	$99	$49.50
Employee + Child	$988	$165	$82.50
Employee + Children	$1,186	$204	$102
Employee + Spouse	$1,384	$244	$122
Employee + Family	$1,779	$323	$161.50

Core PPO (PPO w/ Anthem BCBS)	*Full Monthly Cost (including Stafford & Employee Contributions)*	*Monthly Cost to Employee*	*Per Paycheck Cost to Employee*
Employee Only	$635	$32	$16
Employee + Child	$953	$64	$32
Employee + Children	$1,143	$83	$41.50
Employee + Spouse	$1,334	$102	$51
Employee + Family	$1,715	$140	$70

HDHP w/ HSA (PPO w/ Anthem BCBS)	*Full Monthly Cost (including Stafford & Employee Contributions)*	*Monthly Cost to Employee*	*Per Paycheck Cost to Employee*
Employee Only	$521	$26	$13
Employee + Child	$781	$52	$26
Employee + Children	$937	$68	$34
Employee + Spouse	$1,093	$83	$41.50
Employee + Family	$1,405	$115	$57.50

Dental Insurance Employee Contributions

Rates effective July 1, 2022 – June 30, 2023

Rates apply to full-time employees who work 40+ hours per week. Rates are for health insurance only.

*Low Option Dental *Does not cover orthodontia*	*Full Monthly Cost (including Stafford & Employee Contributions)*	*Monthly Cost to Employee*	*Per Paycheck Cost to Employee*
Employee Only	$30	$5	$2.50
Employee + Child	$60	$11	$5.50
Employee + Children	$66	$12	$6
Employee + Spouse	$57	$10	$5
Employee + Family	$94	$17	$8.50

High Option Dental	*Full Monthly Cost (including Stafford & Employee Contributions)*	*Monthly Cost to Employee*	*Per Paycheck Cost to Employee*
Employee Only	$35	$5	$2.50
Employee + Child	$70	$12	$6
Employee + Children	$77	$14	$7
Employee + Spouse	$66	$11	$5.50
Employee + Family	$109	$20	$10

*Employees who receive the Opt-Out Credit and elect dental coverage must pay the full monthly cost for dental insurance.

Per Paycheck Cost w/ Opt-Out Credit	*Low Option Dental *Does not include Orthodontia*	*High Option Dental*
Employee Only	$15	$17.50
Employee + Child	$30	$35
Employee + Children	$33	$38.50
Employee + Spouse	$28.50	$33
Employee + Family	$47	$54.50

Open Enrollment Information

Open Enrollment is May 2nd through May 20th

Open Enrollment is the annual opportunity for employees to make changes to their benefits without a qualifying event. All changes made during open enrollment will be effective July 1, 2022.

Stafford County Supplemental Benefits Enrollment Information

Stafford County along with Mark III will be hosting open enrollment presentations. See HR communications for specific dates and times. Dedicated Mark III representatives will be available to assist Stafford County employees by phone with any Mark III benefit plan questions and/or enrollment. During this time period all benefit-eligible employees will be able to:

- ✓ Get information about their benefits being offered for the July 1, 2022 - June 30, 2023 plan year
- ✓ Speak to a dedicated Mark III benefits consultant by phone
- ✓ Review current benefit elections
- ✓ Make necessary benefit changes
- ✓ Enroll in new plans

The following benefits are offered:

- ✓ FBA -Flexible Spending Accounts (FSA) and Dependent Care Accounts (DCA)
- ✓ Aflac Accident
- ✓ Manhattan Life Cancer
- ✓ Aflac Hospital Indemnity
- ✓ Aflac Critical Illness
- ✓ American United Life (AUL) Short-Term Disability
- ✓ Trustmark Universal Life Life
- ✓ Legal Resources

This will be the only time during the year that you can enroll/make changes to your benefits unless you experience a qualifying life event outlined by the Internal Revenue Service (marriage, divorce, birth of a child, etc.).

For additional information on qualifying life events, please contact the Human Resources Department.

New Enrollment: employees will enroll through the Selerix system to elect supplemental benefits including Flexible Spending Accounts. If you have questions about the Mark iii optional benefits, please call Mark iii directly at 833-890-7652.

FBA Health & Dependent Care Flexible Spending Accounts (FSA)

The FSA plan allows you to set aside pre-taxed dollars to pay for health care related items such as co- pays, deductibles, prescription drugs and dependent care expenses. Each employee may set aside up to $2,850 annually for Health Care Flexible Spending Accounts and $5,000 annually for Dependent Care Flexible Spending Accounts.

Please remember that the Health Care and Dependent Care Spending Account balances DO NOT carry over from one year to the next. Any unused balance will be forfeited under the IRS regulation, "Use It or Lose It".

Employees who select the High Deductible Health Plan with HSA option are not eligible to participate in the Medical FSA.

You MUST re-elect and re-fund your Health Care and/or Dependent Care accounts each year if you wish to participate.

With the FBA Health Care and Dependent Care FSA, you have the convenience of a debit card paying at the point of service so you do not have to submit claims and wait for reimbursement. **But remember – keep your receipts and Explanation of Benefits (EOBs) in case FBA asks you to verify a debit card transaction. Please note** that credit card receipts and cancelled checks are not valid forms of verification. An acceptable form of verification will include the date of service, cost and procedure or item purchased. An acceptable receipt would be a walk out statement from your doctor or an Explanation of Benefits from your insurance carrier. Due to the availability of ineligible expenses such as toothbrushes and teeth whitening procedures, all dental expenses will need to be substantiated as well as other dermatologist and chiropractic services. This means for every dental, dermatologist and chiropractic service, you will be required to fax an acceptable receipt to the Flexible Benefits Administration (FBA).

If you re-enroll in the Health and/or the Dependent Care Spending Accounts, you can continue to use the same debit card you received last year. For more information about debit cards, contact Mark III directly.

If you have any questions, please contact Mark III Employee Benefits at 800-532-1044 (Kim Ward X 230).

Flexible Spending Account

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

Maximize Your Income

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

Eligibility

Participation in the Plan Begins on July 1, 2022 and ends on June 30, 2023. You will be eligible on the first of the month following 30 days of employment if you are a full-time employee working 30 or more hours per week or a regular part-time employee working at least 25 or more hours per week. Seasonal or Temporary employees are not eligible to participate in the Plan. 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 on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions which are taken from your paycheck on a pre-tax basis.

Contribution Limits: **The maximum you may place in this account for the Plan Year is $2,850.00.**

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 health care 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 dependent relatives that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Eligible dependents are further defined as:

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

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

- **$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 in your Employee Guide or 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	$60.00
Eligible Pre-Tax dependent child care expenses	$0.00	$300.00
Taxable Income	**$2,500.00**	**$1,940.00**
Federal Tax (15%)	$375.00	$291.00
State Tax (5.75%)	$125.00	$97.00
FICA Tax (7.65%)	$191.25	$148.41
After-Tax employer medical insurance	$200.00	$0.00
After-Tax medical expenses	$60.00	$0.00
After-Tax dependent child care expenses	$300.00	$0.00
Monthly Spendable Income	**$1,248.75**	**$1,403.59**

By taking advantage of the Flexible Benefit Plan, this employee was able to increase his/her spendable income by $154.84 every month! This means an annual tax savings of $1,858.08. 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 (**FBASTAF**)
    - Your Benefits Card Number
- ✓ Once completed, please proceed to your account.

Benefits Card

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

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

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

Scan me!

FlexibleBenefit ADMINISTRATORS

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

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

Cancer Plan

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BAY BRIDGE ADMINISTRATORS

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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

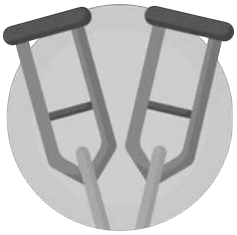
Semi-Monthly Rates				
Coverage Tier	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Employee	$8.83	$11.69	$9.82	$15.45
Employee + Spouse	$17.79	$23.80	$19.72	$31.44
Employee + Child(ren)	$12.60	$16.60	$13.82	$21.68
Family	$21.55	$28.72	$23.73	$37.67

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

THE MANHATTAN LIFE INSURANCE COMPANY SM

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

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

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

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

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

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

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

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

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

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

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

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

Accident Follow-Up Treatment	$25

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

Physical Therapy	$25

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

Air Ambulance	$500
Ambulance	$100

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

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

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

Blood/Plasma	$100

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

Prosthesis	$500

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

Appliance	$100

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

Family Lodging Benefit (per night)	$100

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

Wellness	$60

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

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

Hospital Admission	$1,000

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

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

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

Hospital Confinement (per day)	$200

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

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

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

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

Hospital Intensive Care (per day)	$400

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

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

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

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

Dismemberment means:

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

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

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

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

Common carrier means:

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

Limitations & Exclusions

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- **War** – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- **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 Semi-Monthly Rates

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

Wellness Benefit included in rates.

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 Semi-Monthly Rates

Covered	Low Option	High Option
Employee	$10.48	$21.16
Employee + Spouse	$20.96	$42.48
Employee + Child(ren)	$15.48	$30.88
Family	$25.96	$52.20

Group Hospital Indemnity Plan (HSA)

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.

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.**

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.

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

Exclusions

We will not pay for loss due to:

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

Aflac Group Hospital Indemnity Semi-Monthly Rates

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

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 $25,000 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 **$30,000** for employees and up to **$15,000** for spouses with no participation requirement.

For employee amounts over **$30,000** and spouse amounts over **$15,000**:
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 25 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 50% of the employee amount, not to exceed the $25,000 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 $25,000.

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%

If diagnosis occurs after age 70, benefits are reduced by 50%.

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%

If diagnosis occurs after age 70, benefits are reduced by 50%.

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%

If diagnosis occurs after age 70, benefits are reduced by 50%.

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

If diagnosis occurs after age 70, benefits are reduced by 50%. 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

If diagnosis occurs after age 70, benefits are reduced by 50%. 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

If diagnosis occurs after age 70, benefits are reduced by 50%. 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 – Semi-Monthly Rates

NON-TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.68	$3.60	$4.53	$5.45	$6.38	$7.30	$8.23	$9.15	$10.08	$11.00
30-39	$3.28	$4.80	$6.33	$7.85	$9.38	$10.90	$12.43	$13.95	$15.48	$17.00
40-49	$4.85	$7.95	$11.05	$14.15	$17.25	$20.35	$23.45	$26.55	$29.65	$32.75
50-59	$6.73	$11.70	$16.68	$21.65	$26.63	$31.60	$36.58	$41.55	$46.53	$51.50
60 - 69	$9.75	$17.75	$25.75	$33.75	$41.75	$49.75	$57.75	$65.75	$73.75	$81.75

NON-TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*
18-29	$2.68	$3.14	$3.60	$4.06	$4.53	$4.99	$5.45	$5.91	$6.38
30-39	$3.28	$4.04	$4.80	$5.56	$6.33	$7.09	$7.85	$8.61	$9.38
40-49	$4.85	$6.40	$7.95	$9.50	$11.05	$12.60	$14.15	$15.70	$17.25
50-59	$6.73	$9.21	$11.70	$14.19	$16.68	$19.16	$21.65	$24.14	$26.63
60 - 69	$9.75	$13.75	$17.75	$21.75	$25.75	$29.75	$33.75	$37.75	$41.75

TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$3.15	$4.55	$5.95	$7.35	$8.75	$10.15	$11.55	$12.95	$14.35	$15.75
30-39	$4.18	$6.60	$9.03	$11.45	$13.88	$16.30	$18.73	$21.15	$23.58	$26.00
40-49	$7.90	$14.05	$20.20	$26.35	$32.50	$38.65	$44.80	$50.95	$57.10	$63.25
50-59	$11.58	$21.40	$31.23	$41.05	$50.88	$60.70	$70.53	$80.35	$90.18	$100.00
60 - 69	$17.05	$32.35	$47.65	$62.95	$78.25	$93.55	$108.85	$124.15	$139.45	$154.75

TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*
18-29	$3.15	$3.85	$4.55	$5.25	$5.95	$6.65	$7.35	$8.05	$8.75
30-39	$4.18	$5.39	$6.60	$7.81	$9.03	$10.24	$11.45	$12.66	$13.88
40-49	$7.90	$10.98	$14.05	$17.13	$20.20	$23.28	$26.35	$29.43	$32.50
50-59	$11.58	$16.49	$21.40	$26.31	$31.23	$36.14	$41.05	$45.96	$50.88
60 - 69	$17.05	$24.70	$32.35	$40.00	$47.65	$55.30	$62.95	$70.60	$78.25

Notices

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

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

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

EXP (04/23)

Value Added Services

Aflac. | Value Added Services

Health Care Doesn't Have to be Hard

Meet Health Advocacy and Medical Bill Saver,™ available through Aflac. Dealing with health care and health coverage can be complicated — and often stressful. But now you have Health Advocacy and Medical Bill Saver.

With Health Advocacy, you have a team of experts who can help solve your health care and insurance-related questions. They can assist you with a variety of needs like finding specialists, clarifying coverage, addressing claim issues, getting second opinions — and even help negotiating medical bills.

Medical Bill Saver™

Medical Bill Saver™ gives you access to skilled negotiators who can help reduce your out-of-pocket costs from medical or dental bills not covered by insurance. And it's as easy as just sending in your bill.

Get Care for Your Health Care

Health advocacy and medical bill saver can help:

- ✓ Find doctors and treatment centers
- ✓ Coordinate care and second opinions
- ✓ Untangle medical bill and claim issues
- ✓ Negotiate bills $400 or more
- ✓ Available 24/7, anytime, anywhere

Get Confidential, Personalized Help w/ Health Advocate

- ✓ Find doctors, specialists, hospitals and other providers
- ✓ Schedule appointments for treatments and tests
- ✓ Coordinate second opinions and care
- ✓ Resolve issues, from claims problems and medical bills, to coordinating benefits
- ✓ Get help with eldercare issues, including Medicare and related healthcare issues for your parents and parents-in-law
- ✓ Get answers about your test results, treatments, prescriptions and more
- ✓ Work with your insurance companies to get approvals and clarify coverage
- ✓ Transfer medical records, lab results and X-rays
- ✓ Here for you 24/7 by convenient app or phone

Here's How It Works:

1. Send in your medical or dental bills of $400 or more.
2. Your negotiator contacts the provider to negotiate a discount.
3. If an agreement is reached, the provider approves payment terms and conditions.
4. You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms.

Need Help for Life's Highs and Lows?

Introducing the Telephonic EAP Program, available through Aflac. We never know what life can bring from one day to the next. But you can be sure you have help when you need it. Health Advocate's Telephonic Employee Assistance Program provides support for a range of personal, family and work/life balance matters.

Telephonic EAP provides 24/7 phone access to licensed, professional counselors, prepared to help with your personal situation. They can also provide referrals for long-term counseling or specialized care, with customized plans to meet your specific needs.

Use Any Combination of Tools, Anytime

- ✓ 24/7 phone access to trained counselors
- ✓ Long-term referrals and treatment plans
- ✓ Support for full range of personal and work/life issues

Whatever Life Brings, Call on EAP for Help

- ✓ Confidential telephone counseling sessions with highly trained, licensed professionals
- ✓ 24/7 phone access to professional counselors
- ✓ Referrals for long-term counseling or specialized care
- ✓ Customized treatment plans
- ✓ Resource website for work/life matters
- ✓ Help for depression and other mental health issues
- ✓ Stress management
- ✓ Support for dealing with grief and loss
- ✓ Substance abuse counseling

HealthAdvocate℠

Health care just got easier with Health Advocacy and Medical Bill Saver.™
Count on Telephonic EAP to be here when you need it.
When your coverage begins, call 855.423.8585 or visit healthadvocate.com/aflac
Available through Aflac, powered by Health Advocate.

Short-Term Disability Plan

ONEAMERICA®

Class Description
All Eligible Employees working a minimum of 25 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, twenty-six (26) weeks, or fifty-two (52) weeks.

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

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

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

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

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

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

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

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

AUL Short-Term Disability Semi-Monthly Rates

Benefit Duration
13 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.28
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.53
$1,600	$16.57
$1,700	$17.60
$1,800	$18.64
$1,900	$19.67
$2,000	$20.71

Benefit Duration
26 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$7.50
$600	$9.00
$700	$10.50
$800	$12.00
$900	$13.50
$1,000	$15.00
$1,100	$16.50
$1,200	$18.00
$1,300	$19.50
$1,400	$21.00
$1,500	$22.50
$1,600	$24.00
$1,700	$25.50
$1,800	$27.00
$1,900	$28.50
$2,000	$30.00

Benefit Duration
52 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$9.86
$600	$11.83
$700	$13.80
$800	$15.77
$900	$17.74
$1,000	$19.72
$1,100	$21.69
$1,200	$23.66
$1,300	$25.63
$1,400	$27.60
$1,500	$29.57
$1,600	$31.54
$1,700	$33.52
$1,800	$35.49
$1,900	$37.46
$2,000	$39.43

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.

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.

Legal Protection

LEGAL RESOURCES

Protect Yourself and Your Family For Only $19.00 Per Month - $9.50 Per Paycheck!

Legal Resources protects you and your family from paying the high cost of attorney fees associated with everyday life events. Will preparation, traffic matters and real estate transactions are only a few of the many covered services. It's affordable. It's comprehensive...and... it's time to enroll.

Plan Highlights

There are no deductibles, copays or usage limits. You, your spouse and dependent children (up to age 19 or age 23 if they are enrolled as a full-time student) are covered by your monthly fee. Employees call Legal Resources at 1.800.728.5768 when a legal need arises and will be given a selection of attorneys to choose from. This exclusive network is made up of highly qualified law firms.

Fully Covered Services

Legal resources covers 100% of the attorney fees for fully covered legal.

General Advice and Consultation
- ✓ Unlimited in-person or telephone advice and consultation for fully covered services

Family Law
- ✓ Uncontested domestic adoption
- ✓ Uncontested divorce
- ✓ Uncontested name change

Elder Law
- ✓ Estate advice
- ✓ Powers of attorney for members' parents

Criminal Matters[2]
- ✓ Defense of misdemeanor
- ✓ Misdemeanor defense of juveniles (Fully covered for first offense involving alcohol or illegal drugs)

Wills and Estate Planning
- ✓ Will preparation and periodic updates
- ✓ Advance medical directive
- ✓ Financial powers of attorney
- ✓ Contingent trust for minor children

Traffic Violations
- ✓ Traffic infractions and misdemeanors
- ✓ Speeding
- ✓ Reckless driving
- ✓ Driving under the influence 1st Offense

Civil Actions
- ✓ Representation as defendant
- ✓ Representation as plaintiff
- ✓ Insurance matters
- ✓ Initial administrative hearing
- ✓ Small Claims Court advice

Preparation and Review of Routine Legal Documents
- ✓ Unlimited pages and occurrences

Real Estate
- ✓ Purchase, sale, or refinance of primary residence
- ✓ Deed preparation
- ✓ Tenant-Landlord matters
- ✓ Landlord-Tenant consultation

Consumer Relations and Credit Protection
- ✓ Warranty disputes
- ✓ Billing disputes
- ✓ Collection agency harassment

Identity Theft
- ✓ Prevention assistance
- ✓ Education services
- ✓ Identity recovery assistance

How the Plan Works

1. Choose a law firm that best suits your needs from our highly rated law firm network. Use our Law Firm Finder at LegalResources.com to find a firm near you. If you need to transfer to another Plan Law Firm, call Member Services.
2. Certified paralegals in our Member Services Department provide backup and support to assist you with any coverage or attorney-related questions.

What Happens Next?

Once enrolled, you will receive a welcome packet with information on how to create an online profile and view your plan benefits. Participating employees agree to a 12 month commitment and cancellation may only occur during open enrollment. Relax...you're covered January 1, 2022!

Your Legal Needs Will Be Covered

Don't see your legal need listed? The Legal Resources Plan covers pre-existing legal matters as well as **ANY** less commonly needed legal service at a 25% discount.[3]

[1]Member is responsible for all non-attorney costs such as filing fees, fines, court costs etc. The Plan covers the individual, spouse and qualifying dependents. 12 month commitment required. Courtroom representation, when necessary, is fully covered through General District Court for claims in excess of $400. The definition of General District Court may vary by state.
[2]Offenses involving illegal drugs, alcohol (except 1st offense DUI) and firearms are covered at a 25% discount.
[3]Since your employer is the participating sponsor, you may not use the Plan in a dispute with your employer.

This **SUMMARY OF COVERAGE** is intended to provide a broad general overview of plan coverage and is not a contract. Coverage may vary by organization. For specific coverage questions, please call Member Services at 800.728.5768. Member is responsible for all non-attorney costs such as filing fees, court costs, fines, etc.

Please contact our Member Services Department with any questions. We look forward to serving you and your family.
LegalWise@LegalResources.com | 800.728.5768 | LegalResources.com | Facebook: legalresources | Twitter: legal_resources

Continuation of Benefits

If You Leave Employment

Aflac Group Policies

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

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 apply for portability by calling AUL at 1-800-553-5318.**

FBA Flexible Spending Accounts

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

Manhattan Life Group Cancer

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

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
Customer Service: 800-433-3036
Aflacgroupinsurance.com

American United Life (AUL)
Claims Toll-Free: 1-855-517-6365
Customer Service: 1-800-553-5318
www.oneamerica.com

Flexible Benefit Administrators, Inc.
Phone: 1-800-437-3539
Fax: 1-757-431-1155
www.flex-admin.com

Legal Resources
Phone: 1-800-728-5768
Fax: 757-498-4114
www.flex-admin.com

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

Mark III Employee Benefits
300 W. Watauga Ave.
Johnson City, TN 37604
Phone: 704-365-4280
Toll-Free: 1-800-532-1044
www.markiiieb.com

Trustmark Insurance Company
Phone: 1-800-918-8877
Fax: 847-615-4943
www.trustmarkbenefits.com

NOTES

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