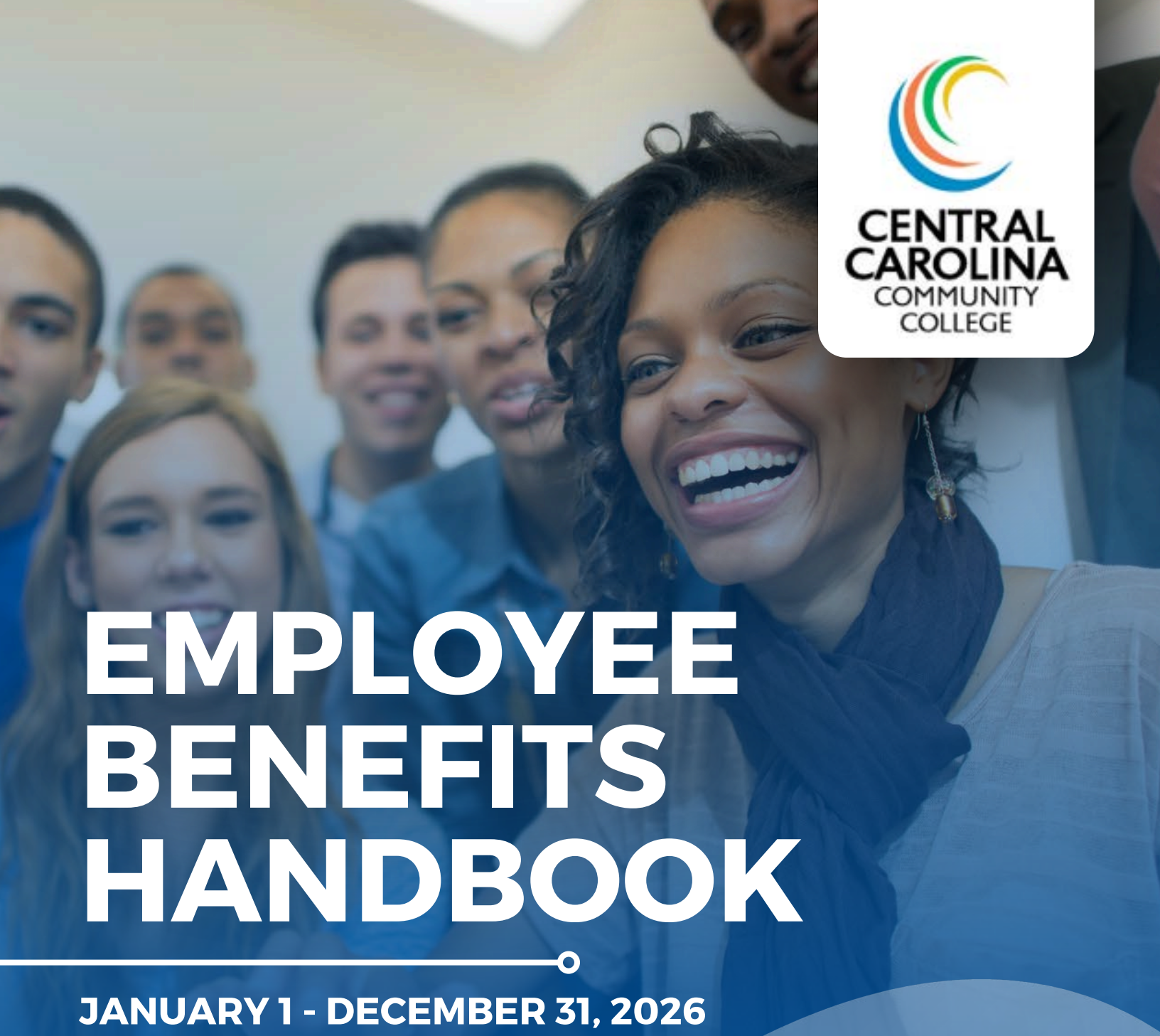

CENTRAL CAROLINA COMMUNITY COLLEGE

EMPLOYEE BENEFITS HANDBOOK

JANUARY 1 - DECEMBER 31, 2026

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

DISCLAIMER

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

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

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

Important Points

- ✓ Your plan year runs from January 1, 2026 to December 31, 2026. This means your benefit elections will take effect January 1, 2026 unless otherwise noted.
- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending and Dependent Care accounts each year! It will not automatically renew.
- ✓ 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/centralcarolinacc/.

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 cannot 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. Documentation is required.

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Welcome to Your Benefits!

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

Pre-Tax Benefit Information

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

- ✓ FBA Flexible Spending Account
- ✓ FBA Dependent Care Account
- ✓ MetLife Dental
- ✓ CEC Vision
- ✓ MetLife Group Cancer
- ✓ Aflac Group Accident
- ✓ Aflac Group Hospital Indemnity

Post-Tax Benefit Information

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

- ✓ Aflac Group Critical Illness w/ Cancer
- ✓ OneAmerica (AUL) Short-Term Disability
- ✓ OneAmerica (AUL) Long-Term Disability
- ✓ The Hartford Basic & Supplemental Life
- ✓ Trustmark Universal Life

How to Enroll at Open Enrollment

Onsite Enrollment

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

Self-Service Enrollment

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

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

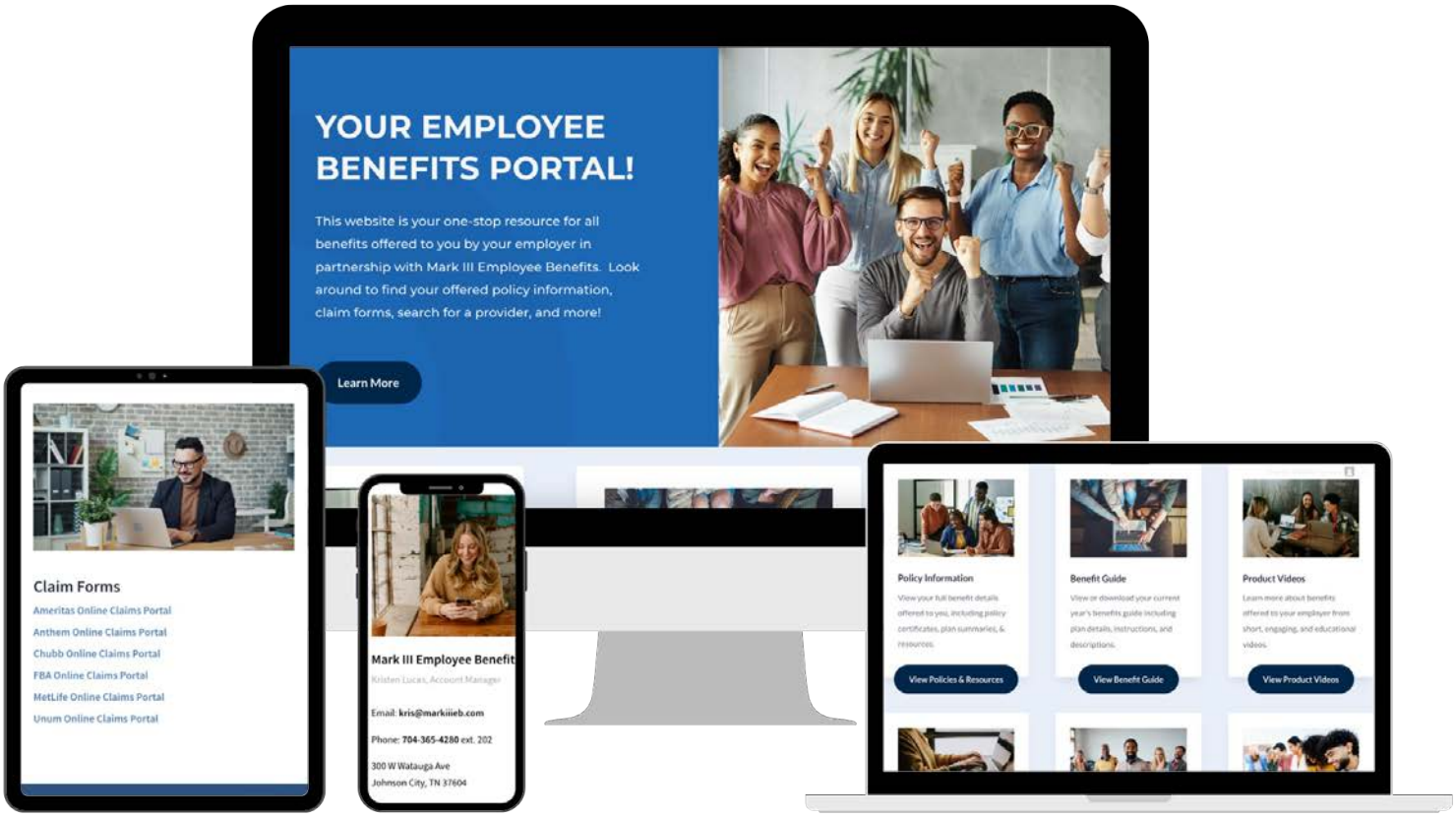
Employee Benefits Portal

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

Scan me!

Employee Benefits Portal

Find details about all of your benefits, download forms, submit claims, ask questions, and more at [https://mymarkiii.com/centralcarolinacc/.](https://mymarkiii.com/centralcarolinacc/)



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

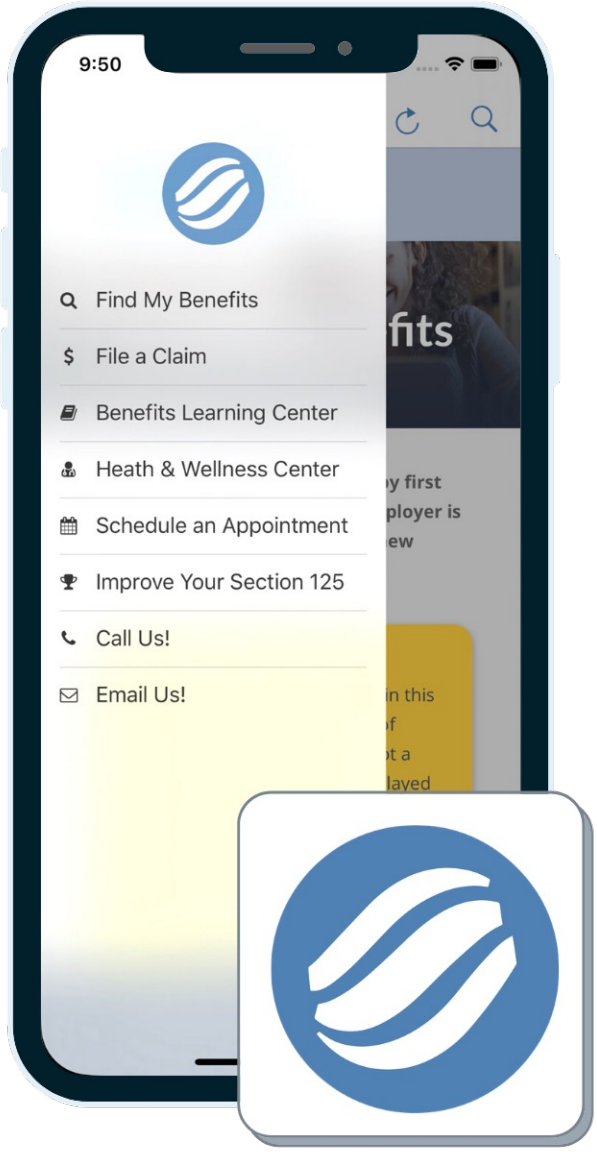
Scan me!

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

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

MyMark III Mobile App

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



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

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

Available on:

Download on the App Store

GET IT ON Google Play

Your Trusted Benefits Partners at your fingertips!

Filing a Claim

MetLife Group Cancer

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

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

Aflac Group

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

OneAmerica (AUL) Disability

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

Employee Benefits Portal

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

Visit: https://mymarkiii.com/centralcarolinacc/.

Scan me!

Wellness Benefits

What is a Wellness Benefit?

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

*Qualified Screening Tests**

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

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

Get Paid by Staying Proactive!

- ✓ MetLife Group Cancer Wellness Benefit Amount - **$100**
- ✓ Aflac Group Accident Wellness Amount - **$75**
- ✓ Aflac Group Hospital Indemnity Wellness Amount - **$50**
- ✓ Aflac Group Critical Illness Wellness Amount **- $100**

Download Your Wellness Claim(s)

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

Employee Benefits Portal: https://mymarkiii.com/centralcarolinacc/.

Scan me!

STAY WELL

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

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 January 1, 2026 and ends on December 31, 2026. You will be eligible to join the Plan if you are a full-time employee working at least 30 hours or more per week on the first of the month following your date of hire. 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 $3,300.00.**

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. 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 relievers | Allergy & Sinus Medication

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

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

Day Care/Aged Adult Care Reimbursement

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

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

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

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

How to Receive Reimbursement

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you 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 add the $660 roll-over provision to the Medical FSA. Please see the Employee Guide for more info.

How to Enroll in our FSA Plan

Step 1

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

Step 2

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

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	$2,500.00	$2,500.00
Eligible Pre-Tax employer medical insurance	$0.00	$200.00
Eligible Pre-Tax medical expenses	$0.00	$100.00
Eligible Pre-Tax dependent child care expenses	$0.00	$300.00
Taxable Income	**$2,500.00**	**$1,900.00**
Federal Tax (15%)	$375.00	$291.00
State Tax (5.75%)	$143.75	$109.25
FICA Tax (7.65%)	$191.25	$145.35
After-Tax employer medical insurance	$200.00	$0.00
After-Tax medical expenses	$100.00	$0.00
After-Tax dependent child care expenses	$300.00	$0.00
Monthly Spendable Income	**$1,119.00**	**$1,360.40**

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

Online Wealthcare Portal

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

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

- ✓ Get started by visiting https://fba.wealthcareportal.com/ and click the register button.
- ✓ You will be directed to the registration page.
- ✓ Follow the prompts to create your account.
  - ✓ First Name
  - ✓ Last Name
  - ✓ Zip Code
  - ✓ Your Benefits Card Number (Optional)
  - ✓ Verification Code
  - ✓ Verify Email/Create Username & Password
- ✓ Once completed, please proceed to your account.

FBA Code: FBACCCC

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

Dental Plan

MetLife

Overview of Benefits

To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Network : PDP Plus

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services both in and out of the network. The goal is to deliver cost effective protection for a healthier smile and a healthier you.

Coverage Type	*In-Network: % of PDP Fee*	*Out-of-Network: % of R&C Fee*
Type A - Preventive	100%	100%
Type B – Basic Restorative	80%	80%
Type C – Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible[3]: Individual/Family	$50/$150	$50/$150
Annual Maximum Benefit: Per Person	$1,250	$1,250
Orthodontia Lifetime Maximum: Adult & Child	$1,250 per person	

1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Understanding Your Plan Benefits

A MetLife dental benefits plan featuring the Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice - in or out of the network.

You may save[1] more when you visit a participating dentist. That's because he or she has agreed to accept negotiated fees as payment in full for covered services that may be lower than average charges in the same geographic area.[2] Just remember, you are responsible for the portion of the negotiated fee that the plan does not pay (if any). Also, once your benefit maximum is met or if you receive non-covered services, you will be responsible for the amount the plan does not cover.

- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be higher.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation Benefits online

If you are not already registered, go to www.metlife.com/mybenefits and follow the easy registration instructions.

Important Enrollment Provisions: If Timely Request Is Made - A timely request for Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Eligibility Date.
If Late Request Is Made - If a request is not a timely request, it is a late request. Dental Expense Benefits will become effective for late requests after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

- Preventive Services ..... No waiting period
- Basic Restorative Services (Fillings) ..... 6 month waiting period
- Basic - All Other Services ..... 12 month waiting period
- Major Services ..... 24 month waiting period
- Orthodontia Services (if applicable) .....24 month waiting period

Qualifying Event: Request to be covered, or to change your coverage, upon a Qualifying Event.

*Selected Covered Services & Frequency Limitations**	
Type A - Preventive	**How Many & How Often**
Oral Examinations	Oral exams but not more than once every 6 months.
X-rays	Full mouth X-rays: once every 60 months.
Bitewing X-rays	Not more than 2 sets every 12 months for all Covered Persons.
Prophylaxis (cleanings)	Cleaning of teeth (oral prophylaxis) but not more than once every 6 months.
Topical Fluoride Applications	Topical fluoride treatment for a Dependent child under 19 years of age but not more than once in 12 months.
Sealants	Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 19, but not more than once per tooth every 60 months.
Space Maintainers	Space Maintainers for dependent children to 16 years of age.
Emergency Palliative Treatment	
Harmful Habits Appliances	
Type B – Basic Restorative	**How Many & How Often**
Fillings	Amalgam and Resin-based Fillings.
Repairs of Dentures, Crowns, Inlays, & Onlays	Simple Repairs of Cast Restorations.
Periodontal Maintenance	Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed four treatments in a calendar year
Relining & Rebasing	Relining and Rebasing of existing removable dentures but not more than once in 36 months.
Simple Extractions	
Oral Surgery	
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Consultations	Consultations, but not more than twice in a 12 month period.
Injections of Antibiotic Drugs	
Type C – Major Restorative	**How Many & How Often**
Crowns/Inlays/Onlays	Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period.
Prefabricated Crowns	Prefabricated stainless steel crowns but not more than once in any 60 month period.
Endodontics	Root canal treatment, but not more than once in any 24 month period for the same tooth.
Periodontal Surgery	Periodontal surgery but no more than one surgical procedure per quadrant in any 36 month period.
Periodontics	Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
Bridges & Dentures	Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 60 months prior to its replacement.
Implant Services	Implants but not more than once in any 10 year period.

Type D - Orthodontia

- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Benefit for initial placement of the appliance will be made representing 20% of the total benefit.
- Orthodontic benefits end at cancellation of coverage

Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out of pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

** The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.*

Common Questions

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan?
The Plan documents set forth the services covered by your plan. The List of Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist (out-of-network), your out-of-pocket costs may be higher.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.1 The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or www.metlife.com/dental or request one by calling 1-800-275-4638.

Can I get an estimate what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pretreatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services2 you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.3 Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in a MetLife dental benefits plan. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist as me?
No. You and your dependents each have the freedom to see any dentist.

[1] Due to contractual requirements, MetLife is prevented from soliciting certain providers.
[2] AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance or services provided by MetLife. Referral services are not available in all locations.
[3] Refer to your dental benefits plan summary your out-of-network dental coverage.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.

MetLife Dental Monthly Rates

MetLife Dental Coverage	*Rates*
Employee Only	$53.91
Employee & Spouse	$103.35
Employee & Child(ren)	$116.49
Employee & Family	$164.17

Vision Plan

CEC community eye care

Enjoy the Simplicity of CEC!

Vision care is essential, and CEC is dedicated to providing you with the benefits you need to keep your vision crystal-clear. All members enrolled in the CEC vision plan can take advantage of our simple and flexible benefits, where you'll receive an eye exam, a flexible eyewear allowance, and a contact lens fitting each plan year.

Plan Descriptions

Benefit	*Description*	*In-Network Co-Pay*	*Out-of-Network Reimbursement*
200 Plan			
Exam	An annual routine eye exam.	$10	100% minus the copay
Retinal Screening	An enhancement to the annual eye exam where high- resolution images are taken of the inside of the eye to detect and monitor conditions like diabetes.	$39	None
Eyewear	An annual **$200 flexible allowance** for prescription and non-prescription eyewear. 20% discount on glasses/10% discount on contacts for any overages.	$0	Up to 100% minus the copay
Contact Lens Fitting	An annual fitting or evaluation.	$25	100% minus the copay

Additional Savings	
Additional Pairs of Glasses	Members receive a 20% savings on additional pairs of prescription and non-prescription glasses from most CEC in-network providers within 12 months of their last eye exam.
LASIK Discounts	Enjoy discounts up to 35% with participating providers, including QualSight LASIK, TLC Laser Eye Center, LasikPlus, and the LASIK Vision Institute.
Special Offers	A variety of special offers are available to CEC members, including savings on health, wellness, travel, entertainment, hearing aids with TruHearing , and more. To view all offers, visit cecvision.com/members/special-offers.

Experience Peace of Mind with Our 20/20 Member Guarantee - Our 20/20 Member Guarantee ensures your complete satisfaction with services received from a CEC network provider. If you aren't happy with the services or products received when using your benefit, contact our Customer Service Department for assistance.

Questions about your benefits? Visit CEC online at cecvision.com or call 888-254-4290

Flexible Eyewear Allowance
You can purchase exactly what you want—frames, lenses, contact lenses, sunglasses, special lens options, and any combination of these items. Whether you choose to shop in-network or out-of-network, if the eyewear you want is sold in an optical shop, it's covered!

Don't Need Prescription Eyewear?
Your CEC vision plan covers non-prescription eyewear, including sunglasses, safety glasses, blue-light-blocking glasses, and readers. If you don't need prescription lenses, this is a great way to use your annual eyewear allowance!

Expansive Provider Network
CEC's network includes optometrists, ophthalmologists, and national retail optical chains, ensuring you can easily find a provider that meets your needs. Visit cecvision.com/search to find an in-network provider near you.

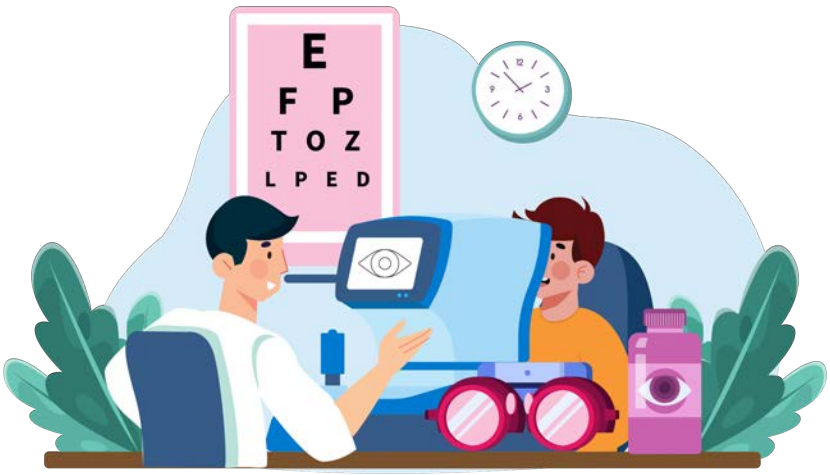
Vision Care is Important
Even with perfect vision, your annual eye exam is critical to your overall health and wellness. Signs of diseases, including glaucoma, diabetes, cardiovascular disease, and cancer, can be detected during an eye exam.

Member Portal
Our Member Portal gives you 24/7 access to find a provider, view your benefit information, check your current eligibility, print a temporary ID card, and more! Log in at: cecvision.com/members/login

Member Exclusive Offers
Members have access to a variety of special offers for additional savings on eyewear, contact lenses, LASIK, hearing aids, and more. To view all offers, visit cecvision.com/members/special-offers.

CEC Vision Monthly Rates

Vision Coverage	*Rates*
Employee Only	$10.02
Employee & Spouse	$20.04
Employee & Child(ren)	$22.19
Employee & Family	$33.24



CEC community eye care

Questions about your benefits? Visit CEC online at cecvision.com or call 888-254-4290

Cancer Plan

MetLife

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

Plan Features

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

Benefit	*Benefit Option*
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, Hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	1. $0 2. $2,500 3. $0 4. $5,000 5. $10,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or .50¢ per mile if a personal vehicle is used
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging .50¢ per mile if a personal vehicle is used
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	a. $200 b. Actual billed charges for round trip coach fare; or personal automobile expense of .50¢ per mile c. Actual billed charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay incurred expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	Up to 25% of surgical benefit paid. $100 max per covered person for skin cancer
Ambulatory Surgical Center. We will pay the incurred expenses at an Ambulatory Surgical Center. No Lifetime Maximum	$250 per day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year

Benefit	Benefit Option
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	1, 2, & 5: Incurred Expenses up to $2,500 per month 3 & 4: Incurred Expenses up to $5,000 per month
Miscellaneous Diagnostic Services. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime max of $10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to $4,000 per month
Colony Stimulating Factors. We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Incurred Expenses up to $500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if an Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges . This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non- Local Transportation Benefits of the policy.	Actual billed charges limited to a lifetime max up to $750 for evaluation. Actual billed charges limited to a lifetime max up to $350 for transportation & lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to $1,500 lifetime max per amputation
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	Up to $35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	$300 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	Up to $50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	Up to $100 per day
New or Experimental Treatment. We will pay the actual billed charges by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	Up to $50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day
Hairpiece. We will pay the actual billed charges per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual billed charges up to a lifetime max of $150
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 per day

Other Specified Diseases Covered:

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

Payment of Benefits

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

Pre-Existing Condition Limitation

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

Exceptions & Other Limitations

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

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

Termination of Coverage

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

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

Portability

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

Covered Persons

Covered Person means any of the following:

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

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

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

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

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

Hospital Intensive Care Confinement Benefit
You may choose the benefit of $325 (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 Monthly Rates

Rates					
Coverage Tier	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Employee	$19.24	$25.49	$21.40	$33.68	$32.43
Employee + Spouse	$38.78	$51.89	$42.99	$68.53	$57.40
Employee + Child(ren)	$27.46	$36.19	$30.13	$47.27	$45.96
Family	$46.98	$62.60	$51.73	$82.13	$72.51

Variable Benefit Elections					
Benefit	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Hospital Confinement	$100	$100	$100	$100	$100
Surgical	$3,000	$3,000	$3,000	$3,000	$3,000
Radiation/Chemotherapy	$2,500/month	$2,500/month	$5,000/month	$5,000/month	$2,500 per month
First Diagnosis	$0	$2,500	$0	$5,000	$10,000
Colony Stimulating Factors	$500/month	$500/month	$500/month	$500/month	$500/month
Wellness	$100	$100	$100	$100	$100
Intensive Care Rider	$0	$325	$0	$625	$0

MetLife

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

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 18+
- Spouse 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

Initial Accident Treatment	*Employee*	*Spouse*	*Child*
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$500	$500	$500
ER/Urgent Care with X-Ray	$800	$800	$800
Doctor's Office	$300	$300	$300
Doctor's Office with X-Ray	$600	$600	$600
Ambulance - once per day, within 90 days of the accident			
Maximum number of payments per covered accident: 1			
Ground	$300	$300	$300
Air	$800	$800	$800
Major Diagnostic Testing - within six months of the accident			
Maximum number of diagnostic tests per covered accident: 1	$300	$300	$300
Blood/Plasma/Platelets - within six months of the accident			
Maximum number of days per covered accident: 1	$300	$300	$300
Burns - once per accident, within six months of the accident			
Second Degree Burns	Second Degree Burns	Second Degree Burns	Second Degree Burns
Less than 10%	$50	$50	$50
At least 10%, but less than 25%	$100	$100	$100
At least 25%, but less than 35%	$250	$250	$250
35% or more	$500	$500	$500

Initial Accident Treatment Category (Low) Custom	*Employee*	*Spouse*	*Child*
Burns - once per accident, within six months of the accident			
Third Degree Burns	Third Degree Burns	Third Degree Burns	Third Degree Burns
Less than 10%	$500	$500	$500
At least 10%, but less than 25%	$2,500	$2,500	$2,500
At least 25%, but less than 35%	$5,000	$5,000	$5,000
35% or more	$10,000	$10,000	$10,000
Emergency Dental Work - once per accident, within six months of the accident			
Repair with Crown	$100	$100	$100
Extraction	$50	$50	$50
Eye Injury - removal of a foreign body	$100	$100	$100
Lacerations - once per accident, within 7 days of the accident			
Lacerations requiring stitches			
Up to 2"	$50	$50	$50
2" to 6"	$100	$100	$100
Over 6"	$200	$200	$200
Outpatient Surgery and Anesthesia (per day) - within one year of the accident 1. Performed in a Hospital or Ambulatory Surgical Center (*Maximum number of payments per covered accident: 1)* 2. Performed in a Doctor's Office, Urgent Care Facility or Emergency Room (*Maximum number of payments per covered accident: 1)*	1. $150 2. $75	1. $150 2. $75	1. $150 2. $75
Inpatient Surgery and Anesthesia (per day) - within one year of the accident *Maximum number of payments per covered accident: 1*	$300	$300	$300
Transportation - within six months of the accident *Maximum number of payments per covered accident: 1* *Minimum Required Distance (miles): 100*			
Plane	$1,000	$1,000	$1,000
Any ground transportation	$1,000	$1,000	$1,000
(Surgical procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.)			

Initial Accident Treatment	*Open Reduction*			*Closed Reduction*		
	Employee	*Spouse*	*Child*	*Employee*	*Spouse*	*Child*
Dislocations - once per accident, within 90 days of the accident						
Hip	$2,000	$2,000	$2,000	$1,000	$1,000	$1,000
Knee	$1,300	$1,300	$1,300	$650	$650	$650
Shoulder	$1,000	$1,000	$1,000	$500	$500	$500
Foot/Ankle	$800	$800	$800	$400	$400	$400
Hand	$700	$700	$700	$350	$350	$350
Lower Jaw	$600	$600	$600	$300	$300	$300
Wrist	$500	$500	$500	$250	$250	$250
Elbow	$400	$400	$400	$200	$200	$200
Finger/Toe	$160	$160	$160	$80	$80	$80
Fracture – once per covered accident, within 90 days of the accident						
Hip/Thigh	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Vertebrae/Sternum	$2,700	$2,700	$2,700	$1,350	$1,350	$1,350
Pelvis	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Skull (Depressed)	$2,250	$2,250	$2,250	$1,125	$1,125	$1,125
Leg	$1,800	$1,800	$1,800	$900	$900	$900
Forearm/Hand/Wrist	$1,500	$1,500	$1,500	$750	$750	$750
Foot/Ankle/Kneecap	$1,500	$1,500	$1,500	$750	$750	$750
Shoulder Blade/Collar Bone	$1,200	$1,200	$1,200	$600	$600	$600
Lower Jaw	$1,200	$1,200	$1,200	$600	$600	$600

Initial Accident Treatment	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Skull (Simple)	$1,050	$1,050	$1,050	$525	$525	$525
Upper Arm/Upper Jaw	$1,050	$1,050	$1,050	$525	$525	$525
Facial Bones (except teeth)	$900	$900	$900	$450	$450	$450
Vertebral Processes/Sacrum	$600	$600	$600	$300	$300	$300
Coccyx/Rib/Finger/Toe	$240	$240	$240	$120	$120	$120

Hospitalization Benefits	Employee	Spouse	Child
Hospital Admission (per confinement) - once per accident, within six months of the accident *Maximum number of admissions per covered accident: 1*	$2,000	$2,000	$2,000
Hospital Confinement (per day) - within 6 months of the accident *Maximum days of confinement per covered accident: 365*	$600	$600	$600
Hospital Intensive Care (per day) - within 6 months of the accident *Maximum days of confinement per covered accident: 30*	$600	$600	$600
Family Member Lodging (per day) - within six months of the accident *Maximum days of lodging per covered accident: 30* *Minimum Required Distance (miles): 100*	$150	$150	$150

After Care Benefits	Employee	Spouse	Child
Appliances - within six months of the accident *Maximum number of appliances per covered accident: 1* Cane Ankle Brace Walking Boot Walker Crutches Leg Brace Cervical Collar	$50	$50	$50
Wheelchair Knee Scooter Body Jacket Back Brace	$200	$200	$200
Accident Follow-Up Treatment - within 6 months of the accident Initial treatment is received within 7 days of the accident *Maximum number of visits per covered accident: 4*	$300	$300	$300
Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident *Maximum number of visits per covered accident: 6*	$225	$225	$225

Life Changing Events Benefits	Employee	Spouse	Child
Dismemberment - once per accident, within six months of the accident			
1. Single Loss	1. $5,000	1. $2,000	1. $1,000
2. Double Loss	2. $10,000	2. $4,000	2. $2,000
3. Loss of one or more fingers or toes	3. $500	3. $200	3. $100
4. Partial Dismemberment (includes at least one joint of a finger or toe)	4. $500	4. $200	4. $100
Paralysis - once per accident, diagnosed by a doctor within six months of the accident			
Paraplegia	$2,500	$2,500	$2,500
Quadriplegia	$5,000	$5,000	$5,000
Prosthesis - once per accident *Maximum number of prosthetic devices per covered accident: 2*	$500	$500	$500

Life Changing Events Benefits	Employee	Spouse	Child
Prosthesis Repair/Replacement - once per prosthetic device, within three years of initial Prosthesis payment	$500	$500	$500

Wellness Rider	Employee	Spouse	Child
Wellness Test *Maximum number of payments per calendar year, per insured: 1*	$75	$75	$75

Accidental Death Rider	Employee	Spouse	Child
Accidental Death - within 90 days of the accident Accidental Death Accidental Common-Carrier Death	 $150,000 $150,000	 $75,000 $75,000	 $37,500 $37,500

Organized Athletic Activity Rider	Employee	Spouse	Child
Aflac will pay an additional percentage of the benefit amount payable under the Aflac Group Accident plan for covered accidental injuries sustained while participating in an organized athletic event.	10%	10%	10%

Aflac Group Accident Monthly Rates

24 Hour Plan	Accident Rates
Employee	$13.88
Employee & Spouse	$22.81
Employee & Dependent Children	$26.69
Family	$35.62

This is a limited summary of benefits. Additional details and limitations/exclusions can be found in your full plan documents.

Hospital Indemnity Plan
(Non-HSA Compliant)

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. **THIS IS NOT A HEALTH PLAN.**

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

Individual Eligibility
Issue Ages:
- Employee: 18+
- Spouse: 18+
- Children: Under age 26

Spouse Coverage Available
To apply for spouse coverage, *you must also apply* and be issued coverage. *Spouse-only coverage is not available.*

Successor Insured Benefit
If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage, including any dependent child coverage in force at the time.

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

Group Hospital Indemnity Benefits | Hospitalization Benefits

Benefits	*Low*	*High*
Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured Payable when an insured is admitted to a hospital and confined as an inpatient. 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).	**$1,000**	**$1,500**
Hospital Confinement (per day) – maximum of 30 days per confinement for each covered sickness or accident for each insured Payable for each day that an insured is confined to a hospital as an inpatient.	**$150**	**$200**
Hospital Intensive Care (per day) – maximum of 15 days per confinement for each covered sickness or accident for each insured Payable for each day when an insured is confined in a Hospital Intensive Care Unit. This benefit is payable in addition to the Hospital Confinement Benefit.	**Day 1: $500** **Day 2 to 15: $100**	**Day 1: $500** **Day 2 to 15: $100**

If benefits are paid for confinement to a hospital, intensive care unit and/or intermediate intensive care step-down unit and the insured is confined again within 6 months due to the same or related condition, it will be treated as the same period of confinement.

Health Screening Benefit – Once Per Calendar Year For Each Insured

Health Screening Benefit - $50 per calendar year
Payable for health screening tests performed as the result of preventative care, including those ordered in connection with routine examinations.

Treatment Benefits

Benefit	Low	High
Major Diagnostic Exams – Once per covered sickness or accident, per calendar year, for each insured • Computerized Tomography (CT/CAT scan) • Magnetic Resonance Imaging (MRI) • Electroencephalography (EEG)	**$50**	**$50**

Surgical Benefits

Benefit	Low	High
Inpatient Surgery and Anesthesia - per day, performed in a hospital or ambulatory surgical center	**$250**	**$250**

Aflac Group Hospital Indemnity Monthly Rates

Insured	Low Option	High Option
Employee	$20.02	$27.14
Employee + Spouse	$40.20	$54.48
Employee + Child(ren)	$31.08	$42.34
Family	$51.26	$69.68

Limitations And Exclusions

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident. We will not pay for loss due to:

- **War** – active participation 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 semiprofessional 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 semiprofessional 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.

Critical Illness Plan
(with Cancer)

Aflac

Lump Sum Single Payment Policy/First Occurrence - Plan Features

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

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 **$30,000** for spouses with no participation requirement.

Individual Eligibility

Issue Ages: Employee 18+ | Spouse 18+ | Children under age 26

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

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **100%** of the employee amount, not to exceed the $30,000 maximum benefit.

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

Base Benefits	*Percentage of Face Amount/Benefit*
Heart Attack (Myocardial Infarction)	100%
Coronary Artery Bypass Surgery	25%
Major Organ Transplant *25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Coma	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Paralysis	100%

Cancer Benefits	*Percentage of Face Amount/Benefit*
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%

Health Screening Benefit	*Percentage of Face Amount/Benefit*
Health Screening *(1 per insured per calendar year; payable for employee, spouse, and dependent children)*	$100

Additional Benefits	*Percentage of Face Amount/Benefit*
Benign Brain Tumor	100%

Accident Benefits	*Percentage of Face Amount/Benefit*
Benefits are payable for loss due to, caused by, and attributed to, a covered accident	
Coma	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Paralysis	100%
Severe Burns	100%

Childhood Conditions Rider	*Percentage of Face Amount/Benefit*
Cystic Fibrosis, Cerebral Palsy, Cleft Lip or Cleft Palate, Down Syndrome, Phenylalanine Hydroxylase Deficiency Disease (PKU), Spina Bifida	100% of employee benefit
Autism Spectrum Disorder	$1000

Occupational Disease Rider	*Percentage of Face Amount/Benefit*
Occupational HIV (maximum of one payment)	100%
Occupational Hepatitis B or C (maximum of one payment per disease)	100%

Progressive Diseases Rider	*Percentage of Face Amount/Benefit*
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS)	100%
Sustained Multiple Sclerosis (MS)	100%

Additional Benefit Details

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

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

Additional Diagnosis
Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 1 consecutive months.

Reoccurrence
Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 3 consecutive months.

Health Screening Benefit
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. See Master Policy for the full list of covered health screening tests.

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

Accident Benefits
Accident Benefits are payable if the loss is solely due to, caused by, and attributed to, a covered accident.

Additional Benefit Details Cont.

Childhood Conditions Rider
Benefits are payable if a dependent child is diagnosed with one of the conditions listed. Autism benefit is not payable if the DSM severity level specifier is less than Level 1. For any subsequent childhood condition to be covered, the two dates of diagnosis must satisfy the separation period for Reoccurrence.

Occupational Diseases Rider
Payable once for the initial positive diagnosis (subject to test and notice requirements outlined in the master policy) of occupational HIV and/or occupational hepatitis B or C if the diagnosis results from an occupational-specific injury. After a benefit is paid for each of the three diseases, rider coverage will terminate.

Progressive Diseases Rider
One benefit per disease is payable if an insured is diagnosed with one of the diseases listed. For any subsequent progressive disease to be payable, the two dates of diagnosis must satisfy the separation period for Reoccurrence.

Limitations & Exclusions

Exclusions
We will not pay for loss due to:
Self-Inflicted Injuries - injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
Suicide - committing or attempting to commit suicide, while sane or insane
Illegal Acts - participating or attempting to participate in an illegal activity, or working at an illegal job

Diagnosis must be made and treatment must be received in the United States or its territories.

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

All limitations and exclusions that apply to the critical illness plan also apply to the riders unless amended by the riders.

Occupational Diseases Rider Exclusions
The benefits specified in this rider are subject to all of the exclusions in the policy as well as the following additional exclusions: We will not pay an occupational disease benefit if the insured:

- Becomes HIV positive or hepatitis positive as a result of a transmission other than an occupational-specific covered injury,
- Tested HIV positive or hepatitis positive prior to the occupational-specific covered Injury, unless the insured previously tested positive on a screening test and subsequently tested negative for that disease prior to the date of the occupational-specific covered injury, or
- Becomes HIV positive or hepatitis positive as a result of intravenous drug use or sexual transmission.

Aflac Group Critical Illness w/ Cancer – Rates

NON-TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.10	$4.20	$6.30	$8.40	$10.50	$12.60	$14.70	$16.80	$18.90	$21.00
30-39	$2.82	$5.65	$8.47	$11.30	$14.12	$16.94	$19.77	$22.59	$25.42	$28.24
40-49	$5.12	$10.24	$15.37	$20.49	$25.61	$30.73	$35.86	$40.98	$46.10	$51.22
50-59	$9.63	$19.27	$28.90	$38.53	$48.17	$57.80	$67.44	$77.07	$86.70	$96.34
60 - 69	$16.74	$33.48	$50.22	$66.96	$83.70	$100.44	$117.18	$133.92	$150.66	$167.40
70+	$29.05	$58.09	$87.14	$116.18	$145.23	$174.27	$203.32	$232.36	$261.41	$290.45

NON-TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.10	$4.20	$6.30	$8.40	$10.50	$12.60	$14.70	$16.80	$18.90	$21.00
30-39	$2.82	$5.65	$8.47	$11.30	$14.12	$16.94	$19.77	$22.59	$25.42	$28.24
40-49	$5.12	$10.24	$15.37	$20.49	$25.61	$30.73	$35.86	$40.98	$46.10	$51.22
50-59	$9.63	$19.27	$28.90	$38.53	$48.17	$57.80	$67.44	$77.07	$86.70	$96.34
60 - 69	$16.74	$33.48	$50.22	$66.96	$83.70	$100.44	$117.18	$133.92	$150.66	$167.40
70+	$29.05	$58.09	$87.14	$116.18	$145.23	$174.27	$203.32	$232.36	$261.41	$290.45

TOBACCO: Employee

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.21	$4.42	$6.63	$8.84	$11.05	$13.26	$15.47	$17.68	$19.89	$22.10
30-39	$3.36	$6.72	$10.08	$13.43	$16.79	$20.15	$23.51	$26.87	$30.23	$33.58
40-49	$7.41	$14.82	$22.23	$29.64	$37.05	$44.46	$51.87	$59.28	$66.69	$74.10
50-59	$17.25	$34.49	$51.74	$68.99	$86.23	$103.48	$120.73	$137.97	$155.22	$172.47
60 - 69	$34.65	$69.29	$103.94	$138.58	$173.23	$207.87	$242.52	$277.16	$311.81	$346.45
70+	$60.91	$121.81	$182.72	$243.62	$304.53	$365.43	$426.34	$487.24	$548.15	$609.05

TOBACCO: Spouse

	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$2.21	$4.42	$6.63	$8.84	$11.05	$13.26	$15.47	$17.68	$19.89	$22.10
30-39	$3.36	$6.72	$10.08	$13.43	$16.79	$20.15	$23.51	$26.87	$30.23	$33.58
40-49	$7.41	$14.82	$22.23	$29.64	$37.05	$44.46	$51.87	$59.28	$66.69	$74.10
50-59	$17.25	$34.49	$51.74	$68.99	$86.23	$103.48	$120.73	$137.97	$155.22	$172.47
60 - 69	$34.65	$69.29	$103.94	$138.58	$173.23	$207.87	$242.52	$277.16	$311.81	$346.45
70+	$60.91	$121.81	$182.72	$243.62	$304.53	$365.43	$426.34	$487.24	$548.15	$609.05

Short-Term Disability Plan

OneAmerica℠ Financial

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

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

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $3,000. The minimum monthly benefit is $500.

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

Benefit Duration
This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks, or fifty-two (52) weeks.

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

Maternity Coverage
Maternity claims are standardly paid at 6 weeks for normal delivery and 8 weeks for c- section, minus the elimination period. If there are any complications with supporting medical documentation, benefits could be extended after review from the claims analyst. Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

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

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

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

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

Exclusions and Limitations

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

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

AUL Short-Term Disability Rates

Monthly Benefit	*13 Week Duration Monthly Rate*	*26 Week Duration Monthly Rate*	*52 Week Duration Monthly Rate*
$500	$10.36	$15.00	$19.72
$600	$12.43	$18.00	$23.66
$700	$14.50	$21.00	$27.60
$800	$16.57	$24.00	$31.54
$900	$18.64	$27.00	$35.49
$1,000	$20.71	$30.00	$39.43
$1,100	$22.78	$33.00	$43.37
$1,200	$24.85	$36.00	$47.32
$1,300	$26.92	$39.00	$51.26
$1,400	$28.99	$42.00	$55.20
$1,500	$31.07	$45.00	$59.15
$1,600	$33.14	$48.00	$63.09
$1,700	$35.21	$51.00	$67.03
$1,800	$37.28	$54.00	$70.97
$1,900	$39.35	$57.00	$74.92
$2,000	$41.42	$60.00	$78.86
$2,100	$43.49	$63.00	$82.80
$2,200	$45.56	$66.00	$86.75
$2,300	$47.63	$69.00	$90.69
$2,400	$49.70	$72.00	$94.63
$2,500	$51.78	$75.00	$98.58
$2,600	$53.85	$78.00	$102.52
$2,700	$55.92	$81.00	$106.46
$2,800	$57.99	$84.00	$110.40
$2,900	$60.06	$87.00	$114.35
$3,000	$62.13	$90.00	$118.29

OneAmerica℠ Financial

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

Long-Term Disability Plan

OneAmerica℠ Financial

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

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

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

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

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

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

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

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

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

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

Pre-Existing Condition Exclusion

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

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

Portability

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

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

Annual Enrollment

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

Exclusions and Limitations

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

AUL Long-Term Disability Monthly Rates

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

OneAmerica℠ Financial

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

Basic & Supplemental Term Life Plan

The group term Life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

Basic Life Coverage Information

Applicant	*Life Coverage*
Employee	Benefit: $40,000

Your employer pays 100% of the premium for your coverage.

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

Supplemental Life Insurance Coverage Options

Applicant	*Life Coverage*
Employee	Benefit: Increments of $10,000 | GI: $150,000 | Maximum: 7x annual earnings or $300,000 (whichever is less).
Spouse	Benefit: Increments of $5,000 | GI: $20,000 | Maximum: The lesser of 100% of your supplemental coverage or $300,000
Child(ren)	Benefit: Increments of $1,000 | Maximum: $5,000

Employee: If you are newly eligible and elect an amount that exceeds the guaranteed issue amount, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Spouse: If you are newly eligible and elect an amount that exceeds the guaranteed issue amount, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Child(ren): This insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

When Does This Insurance Begin?

Subject to any eligibility waiting period established by your employer, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage). You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

When Does This Insurance End?

This insurance will end when you (or your dependents) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I Keep This Insurance If I Leave My Employer Or Am No Longer A Member Of This Group?

Yes, you can take this life coverage with you. Coverage may be continued for you under an individual conversion life certificate. The specific terms and qualifying events for conversion are described in the certificate.

Compassionate Support For You

Grief is hard. And when you add things like estate planning and probate management, immediate arrangements and taxes, it can be overwhelming and stressful. But you don't have to deal with it all on your own. You have access to resources and real, trained professionals who are there to listen and offer support during this difficult time thanks to your loved one's Life insurance.

How We Can Help Support You:

Easy-to-use App: Access resources and services in one place to help you navigate the challenges of loss.

Grief Counseling: Licensed social workers are available to listen and give support.

Funeral Planning: Detailed instructions and on-demand assistance are available to manage the logistics of funeral planning, burial, cremation and other related services.

Estate Administration: Guidance is available for navigating estate and probate processes.

Account Deactivation: Get help closing unneeded financial accounts, memberships and subscriptions.

Identity Theft Protection: Step-by-step instructions to freeze credit and protect the identity of your loved one.

How To Access These Services?

Register online at join.empathy.com/hartford
Once you register, access these services by calling **270-681-1364**

Premiums Per $1,000 Benefit Amount

Age	*Employee & Spouse Cost Per $1,000 Benefit*
< 25	$0.06
25 - 29	$0.06
30 - 34	$0.08
35 - 39	$0.09
40 - 44	$0.10
45 - 49	$0.15
50 - 54	$0.24
55 - 59	$0.44
60 - 64	$0.68
65 - 69	$1.31
70 - 74	$2.12
75+	$2.12

Age (no matter how many children)	*Child Cost Per $1,000 Benefit*
Child(ren) must be under age 26	$0.20

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[3]Estate Guidance® services are provided through The Hartford by ComPsych®. A simple will does not cover printing or certain other features. These features are available at an additional cost to you. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Estate Guidance is a registered trademark of ComPsych. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
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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.
- ✓ Cariloop's Caregiver Support Platform® includes personalized care guidance with 24/7 digital access for adult/elder care services and one month per calendar year of free professional Care Coaching.

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 monthly 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	$23.26
40	$34.46
50	$55.21

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.

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 plans in place, you may be able to port your plans. Visit http://www.aflacgroupinsurance.com/, under Customer Service > Service Requests > Continuation of Coverage. Follow the steps to port your Aflac Group plans. For more information, contact **Aflac at 1-800-433-3036.**

OneAmerica (AUL)
Short and/or Long-Term Disability

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

MetLife Group Cancer

You may continue your Cancer policy for yourself and eligible dependents who are covered when you terminate employment if you have been covered under the policy for 6 months. You must request portability and pay the first month's premium within 30 days after the date that your coverage would end. For more information, contact **Bay Bridge Administrators at 1-800-845-7519.**

MetLife Dental

Under the group dental, you and your covered dependents are eligible to continue coverage through COBRA according to the same qualifying events listed by the IRS. For more information contact **FBA at 1-800-437-3539.**

Community Eye Care (CEC) Vision

Existing CEC members who terminate employment will be able to enroll in the CEC portability plan within 60 days of their termination date. Coverage will commence on the first day of the month following receipt of the member's completed form. New membership cards will be mailed to the member prior to their new effective date. For more information, contact **CEC at (888) 254-4290**.

FBA Flexible Spending Account

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. For more information contact **FBA at 1-800-437-3539.**

The Hartford Term Life

You may continue your Term Life policy for yourself and eligible dependents who are covered when you terminate employment. For more information, please contact **The Hartford at 1-800-523-2233.**

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 Group
P.O. Box 84075 | Columbus, GA 31993
Phone: 1-800-433-3036
www.aflacgroupinsurance.com

Community Eye Care (CEC)
Phone: 1-888-254-4290
info@cecvision.com
www.CECVision.com

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

OneAmerica (AUL)
One America Square | P.O. Box 368
Indianapolis, IN 46206-0368
Claims Toll-Free Number: 1-855-517-6365
Customer Service: 1-800-553-5318
www.oneamerica.com

MetLife Insurance (Cancer)
Bay Bridge Administrators, LLC
Customer Service: 1-800-845-7519
www.bbadmin.com

MetLife Insurance (Dental)
Customer Service: 1-800-438-6388
https://www.metlife.com/

The Hartford Insurance
Customer Service: 1-800-523-2233
www.thehartford.com

Trustmark Life Insurance Company
P.O. Box 7937 | Lake Forest, IL 60045
Customer Service: 1-800-918-8877
customercare@trustmarksolutions.com

Claims Information:
1-877-201-9373 (phone)| 1-508-853-2867 (fax)
www.trustmarkins.com

View additional benefits information
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