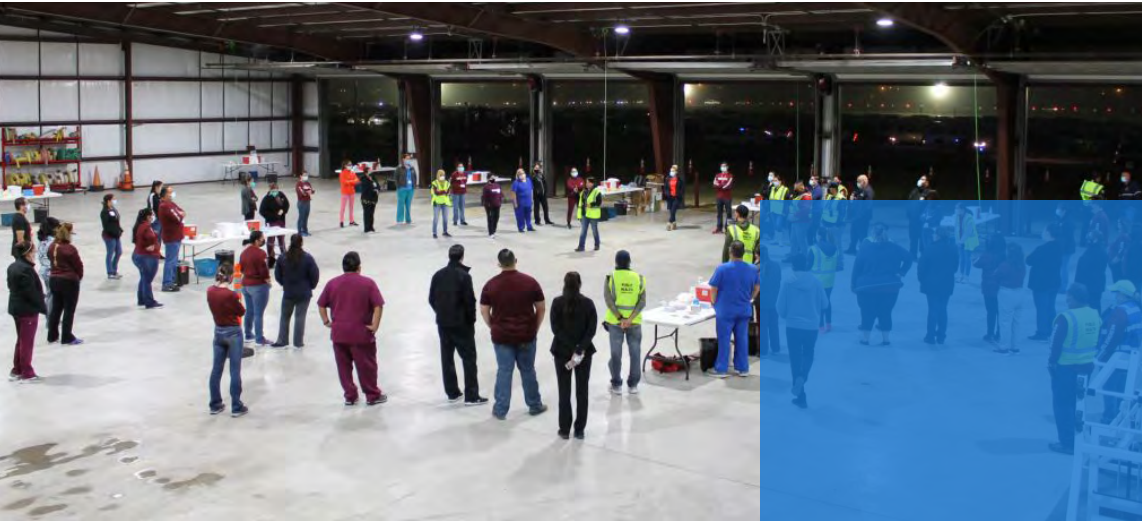




CAMERON COUNTY

EMPLOYEE BENEFITS GUIDE

2024 -2025



STRIVING TO PROVIDE A BETTER BENEFITS SOLUTION

Cameron County will be utilizing **SIG Insurance** services for our benefit communication and enrollment this year. **SIG's** Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our **2024-2025** benefit plan for **10/1/2024** to **9/30/2025**. Please read this guidebook carefully as you prepare to make your elections for the upcoming **2024-2025** Plan Year.

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This Benefits Guidebook describes the highlights Cameron County's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents and not the information in this guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Any and all elements of Cameron County's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules or otherwise as decided by Cameron County.



ENROLLMENT INSTRUCTIONS

*Avoid making quick decisions - enroll early!

You have the option of online self-service or sitting with one of our Benefits Counselors in person to learn more about your benefits and complete your enrollment process by either electing, changing or waiving benefits.

CALL CENTER ASSISTANCE

956-943-9137

Before you speak with a Benefit Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Online Enrollment

Online Enrollment Website:

<https://www.employeenavigator.com>

For online enrollment use the following 'Company Identifier': Cameron County

Example: John Doe / 123-45-6789 / 01/01/2001

First Name: John

Last Name: Doe

Company Identifier: Cameron County

PIN: 6789

Birth Date: 01/01/2001

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GETTING STARTED


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FAQs

When does coverage begin? The elections you make during Open Enrollment are effective October 1, 2024 - September 30, 2025.

New Hires: Employee medical, dental, vision, supplemental life, accidental death and dismemberment, short-term disability, accident, and critical illness coverage begins on the 1st day of the month following the 30 days of employment. FSA (flexible spending) reimbursement accounts are based on completed enrollment within the designated time frame.

Can I enroll my spouse or dependent on one plan and myself on another? No, all covered dependents, including spouse, must be on the same plan as the employee.

If I am already enrolled and not making any changes, do I have to complete the open enrollment process? Yes, it is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, do I still need to complete the open enrollment process? Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event.

Can I drop or change plans during the plan year? No, changes can only be made if there has been a qualifying life event or personal life change. See [page 6](#).

Things to Consider:

Take the following situations into account before you enroll:

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? Do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria.

Helpful Tips and Reminders

- Take the time to carefully review the guide for any changes and updates. Choose the right coverage level, such as individual or family. Open Enrollment is an excellent time to ensure that the person designated as your beneficiary is correct regarding your insurance and retirement benefits.
- Gather the correct information for your dependents such as social security numbers and birth dates.
- Make sure your address and personal information is current. If your information is not current you may miss out on important information such as insurance cards, plan documents, etc.
- Visit each vendor's website for additional information. Don't forget to review each provider directory.
- You may select any combination of Medical, Dental and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself.
- Benefits premiums are deducted on a pre-tax basis, which lessens your tax liability. Except for voluntary life & AD&D, short term disability, accident and critical illness.

ELIGIBILITY

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Cameron County encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible full-time employees have access to Cameron County's comprehensive Benefits Program. Cameron County may conduct an audit requesting supporting documentation on all eligible dependents at any time during the plan year.

Please thoroughly review this Benefits Guide to learn more about these options.

EMPLOYEE ELIGIBILITY

Full-time employees who work a minimum of 30 hours per week and are at least age 18 are eligible to participate in the benefits program, **with an effective date of the first of the month following a 30-day waiting period.**

Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Legal spouse, domestic partnership, common law
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (QLE), such as getting married or having a baby, please contact Human Resources (HR); proof of the QLE must be submitted to your HR department within 30 days to change current benefit election.

QLE Examples:

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- An entitlement to Medicare or Medicaid;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.



MEDICAL

The medical programs, administered by Aetna, provides the framework for your health and well-being. To better meet the varying needs of our employees, Cameron County offers the medical plan described below:

Medical Plan Summary	Aetna Choice POS II--ASC
Active Employee	Monthly Rate
Employee Only	\$15.00
Employee & Spouse	\$168.75
Employee + 1 Child	\$93.75
Employee + Children	\$125.00
Employee + Fam	\$250.00

Plan Features	Max Savings	Standard Savings	Out-of-Network
Deductible (please read plan design & benefits for detail information)			
Individual	\$500	\$1,000	\$2,000
Family	\$1,500	3,000	\$6,000
Member coinsurance	You pay 15%	You pay 30%	You pay 50%
Out-of-pocket limit (please read plan design & benefits for detail information)			
Individual	\$3,000	\$4,500	\$8,000
Family	\$7,000	\$10,000	\$18,000
Payment for out-of-network care	Not applicable	Not applicable	Professional: Prevailing charges Facility: Facility charge review
Primary care physician selection	Optional	Not applicable	Does not apply
Referral requirements	Not required	Not required	None
Telehealth consultations	You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to Aetna.com to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	Max Savings	Standard Savings	Out-of-Network
Preventive services	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Medications	Certain over-the-counter preventative medications covered 100% in network		

PHYSICIAN SERVICES		Max Savings	Standard Savings	Out-of-Network
Office Visits Copay (PCP)	\$10; no deductible	\$30; no deductible	50%; after deductible	
Telehealth Consultations	You can access covered services for telehealth visits from different kinds of providers in your plan Log on to Aetna.com to see list of telehealth providers. You'll also find more about your options, including cost share amounts			
Specialist office visit	\$45; no deductible	\$65; no deductible	50%; after deductible	
DIAGNOSTIC PROCEDURES		Max Savings	Standard Savings	Out-of-Network
Diagnostic X-ray	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible	
Diagnostic laboratory	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible	
EMERGENCY MEDICAL CARE		Max Savings	Standard Savings	Out-of-Network
Urgent Care provider	\$75 office visit; no deductible	\$75 office visit; no deductible	50%; after deductible	
Emergency room	15% after \$250 copay; no deductible	15% after \$250 copay; no deductible	same as in-network care	
HOSPITAL CARE		Max Savings	Standard Savings	Out-of-Network
Inpatient coverage	15%; after deductible	30%; after deductible	50%; after deductible	
when you're admitted into a hospital for the care you need, your cost amount counts toward all covered benefits you receive				
Outpatient hospital	15%; after deductible	30%; after deductible	50%; after deductible	
When you receive outpatient care at a hospital but don't stay overnight, your cost amount counts toward all covered benefits during your visit				
PHARMACY		IN-NETWORK	OUT-OF-NETWORK	
Generic Drugs				
Retail	\$15 copay	NOT COVERED		
Mail order	\$30 copay	NOT COVERED		
Preferred Brand-Named Drugs				
Retail	\$40 copay	NOT COVERED		
Mail order	\$80 copay	NOT COVERED		
Non-preferred Brand-Named Drugs				
Retail	\$60 copay	NOT COVERED		
Mail order	\$120 copay	NOT COVERED		

Specialty Drugs		
Preferred Brand-Named Drugs	\$80 copay	NOT COVERED
Non-preferred Brand-Named Drugs	\$80 copay	NOT COVERED
If eligible and enrolled in Prudent Rx program		
If eligible and not enrolled in Prudent Rx program	30% coinsurance	



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.			
Deductible (per calendar year)	\$500 per Individual \$1,500 per Family	\$1,000 per Individual \$3,000 per Family	\$2,000 per Individual \$6,000 per Family
Covered expenses add up separately toward your maximum savings, standard savings, and out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.			
Member coinsurance	You pay 15%	You pay 30%	You pay 50%
Applies to all expenses except as noted.			
Out-of-pocket limit (per calendar year)	\$3,000 per Individual \$7,000 per Family	\$4,500 to per Individual \$10,000 per Family	\$8,000 per Individual \$18,000 per Family
Covered expenses add up separately toward your maximum savings, standard savings, and out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses do not count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.			
Lifetime maximum Unlimited except where otherwise indicated.			
Payment for out-of-network care**	Not Applicable	Not Applicable	Professional: Prevailing Charges Facility: Facility Charge Review
Primary care physician selection	Optional	Not Applicable	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$250. Refer to your plan documents for a full list of services that need this approval.			
Referral requirement	Not required	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to Aetna.com to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.			
PREVENTIVE CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Routine adult physical exams/ immunizations 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine well child exams/immunizations	Covered 100%; no deductible	Covered 100%; no deductible	Covered 100%; after deductible



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- 7 exams in the first 12 months
- 3 exams from age 13 to 24 months
- 3 exams from age 25 to 36 months
- 1 exam every 12 months thereafter until age 22

Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine mammogram Recommended: One per year for members	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Women's health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Prostate-specific antigen test Recommended: For members recommended age 45 & over	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Colorectal cancer screening Recommended: For members no age limit	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine eye exams	Covered 100%; no deductible	Covered 100%; no deductible	Not Covered
Routine hearing screening	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Medications	Certain over-the-counter preventive medications covered 100% in network.		
PHYSICIAN SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Office visits to member's selected primary care physician (PCP)	\$10 office visit copay; no deductible	\$30 office visit copay; no deductible	50%; after deductible
Telehealth consultation with non-specialist	\$35 office visit copay; no deductible	\$35 office visit copay; no deductible	50%; after deductible
Specialist office visits This is how much you pay for the services of an internist, general physician, family practitioner, or pediatrician if the physician is not your PCP.	\$45 office visit copay; no deductible	\$65 office visit copay; no deductible	50%; after deductible
Telehealth consultation with specialist This is how much you pay for routine care from an internist, general physician, family practitioner, or pediatrician. Also includes the diagnosis and treatment of an illness or injury.	\$45 office visit copay; no deductible	\$65 office visit copay; no deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered	Not Covered
Walk-in clinics	\$35 copay; no deductible	\$35 copay; no deductible	50%; after deductible



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Designated Walk-in clinics	Designated Walk-in clinics
Does not apply	Does not apply

Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services.

Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.

Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it. Designated Walk-in clinics Does not apply	Your cost sharing amount depends on the type of service and where you receive it. Designated Walk-in clinics Does not apply	50%; after deductible
We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.			

Teladoc – 24/7/365 access to doctors by telephone & online	\$10 copay; deductible waived	\$10 copay; deductible waived	Not covered
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Covered 100%; deductible waived.	Covered 100%; deductible waived	Your cost sharing amount depends on the type of service and where you receive it.

DIAGNOSTIC PROCEDURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services)	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.			
Diagnostic laboratory	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.			
Diagnostic complex imaging	15%; after deductible	30%; after deductible	50%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.			

EMERGENCY MEDICAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Urgent care provider	\$75 office visit copay; no deductible	\$75 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	\$75 office visit copay; no deductible	\$75 office visit copay; no deductible	50%; after deductible
Emergency room	15% after \$250 copay; no deductible	15% after \$250 copay; no deductible	Same as in-network care
Copay waived if admitted			
Non-emergency care in an emergency room	15% after \$250 copay. No Deductible	15% after \$250 copay. No deductible	50%; after deductible
Emergency use of ambulance	15%; no deductible	15%; no deductible	15%; no deductible



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Non-emergency use of ambulance	Not Covered	Not Covered	Not Covered
HOSPITAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient surgery - hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient surgery - freestanding facility When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
MENTAL HEALTH SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Mental health office visits	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Mental health telehealth consultations	\$45 office visit copay; no deductible	\$45 office visit copay; no deductible	50%; after deductible
Other mental health services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
SUBSTANCE ABUSE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Residential treatment facility When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Substance abuse office visits	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Substance abuse telehealth consultations	\$45 office visit copay; no deductible	\$45 office visit copay; no deductible	50%; after deductible
Other substance abuse services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

THERAPY SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Spinal manipulation therapy Limited to 35 visits per year (Airrosti Rehab Centers have a reduced copay to \$35)	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Outpatient short-term rehabilitation Limited to 30 visits per year Includes physical, occupational, and speech therapies.	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Habilitative physical therapy	100%; no deductible	100%; no deductible	50%; after deductible
Habilitative occupational therapy	100%; no deductible	100%; no deductible	50%; after deductible
Habilitative speech therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related physical therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related occupational therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related speech therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	100%; no deductible	100%; no deductible	50%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
OTHER SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Skilled nursing facility Limited to 25 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Home health care Limited to 60 visits per year Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Not Covered	Not Covered	Not Covered
Durable medical equipment (ie: foot orthotics under diabetic mandate)	15%; after deductible	30%; after deductible	50%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Diabetic supplies -- (if not covered under the prescription drug benefit)	Follows Diabetic Mandate	Follows Diabetic Mandate	50%; after deductible
Infusion therapy - home/office	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	15%; after deductible	30%; after deductible	50%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. 15%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Your cost sharing amount depends on the type of service and where you receive it. 30%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	15%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	30%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not covered	Not covered	Not covered
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.			
Acupuncture- use of needles to alleviate pain and to treat various conditions	100%; after \$10 copay	100%; after \$30 copay	Not covered
FAMILY PLANNING	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.			
Advanced Reproductive Technology (ART)	Not covered	Not covered	Not covered
ART coverage is limited to three cycles per member's lifetime and includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Ovulation induction (OI) limited to six cycles per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.			
Fertility preservation	Not covered	Not covered.	Not covered.
Includes coverage for cryopreservation for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment			
Vasectomy	15%; after deductible	30%; after deductible	50%; after deductible
Tubal ligation	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

GENERAL PROVISIONS		
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.	
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
If the drug cost is lower than the copay, the member pays the lower cost.		
Generic Drugs		
	Retail \$15 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$30 copay	
Preferred Brand-Name Drugs		
	Retail \$40 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$80 copay	
Non-Preferred Brand-Name Drugs		
	Retail \$60 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$120 copay	
Specialty Drugs		
Preferred Brand Specialty	\$80 copay	NOT COVERED – Member pays total cost of prescription
Non-Preferred Brand Specialty	\$80 copay	NOT COVERED – Member pays total cost of prescription
If eligible and enrolled in the Prudent Rx program	\$0 copay	
If eligible and not enrolled in the Prudent Rx program	30% coinsurance	
Pharmacy Day Supply and Requirements		
	Retail	Up to a 30 day supply with 1 x retail copay or a 31-90 day supply for 2 x retail copay option available from Aetna National with Extended Day Supply Network
	Mail Order Specialty	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy Up to a 30 day supply CVS Caremark® Specialty Pharmacy Specialty fills must be through our preferred specialty pharmacy network. Aetna Standard Plan Specialty Drug List
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy. Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction. Oral fertility drugs included. Precertification for specialty drugs included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

****We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.**

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

This amount is based on the out-of-network plan you or your employer picks.

- For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

- For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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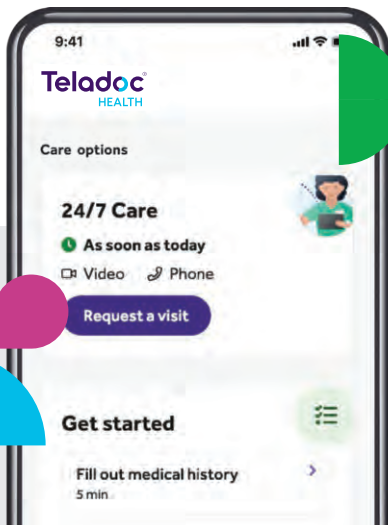


Welcome to healthcare for the whole you

J-000000-T00-P00-000458



SAMUEL SAMPLETON
1 SAMPLING ST
SAMPLEVILLE, AZ 29401



Hello Samuel

You now have access to Teladoc Health through Cameron County

If you're like the millions of people who are striving to be healthier, let me be the first to welcome you to Teladoc Health.

We believe that when you have a full picture of your health all in one place, you can achieve your goals with confidence.

With Teladoc Health, you get compassionate care from U.S. board-certified doctors via phone or video. We not only help you get healthy, but live healthy.



Stay well,

Dr. Vidya Raman-Tangella
Chief Medical Officer, Teladoc Health

Get started

- ✔ Download the app
- ✔ Set up your account
- ✔ Schedule a visit

Get care

Talk to a board-certified doctor by phone or video.

See back of letter for service details.

Get started today

Download the app |

Teladoc.com/Aetna | 1-855-TELADOC (835-2362)

Get care for what's now and what's next

Your Teladoc Health experience includes:

✔ Care for you physically

Manage your health virtually with a U.S. board-certified doctor.

General Medical

\$10/visit

Talk to a U.S. board-certified doctor by phone or video 24/7 from wherever you are.

Our doctors can diagnose, treat and even prescribe medicine if needed for common conditions and non-urgent needs, such as prescription refills, coughs, colds, UTIs and more. Whether you're at home, work or on the road, we're here to listen, answer questions and help you feel better faster.

- Allergies
- Bronchitis
- Flu
- Pink eye
- Rashes
- Sinus infections
- Sore throats
- Stomachaches
- And more



"I have a very busy schedule, and in order for me to stay healthy, this is the perfect avenue for me."

Carolee M.

Log in to your Teladoc Health account to see all services available to you.



Get started today

Download the app  | 

Teladoc.com/Aetna | 1-855-TELADOC (835-2362)

The testimonials, opinions and statements reflect one member's personal experience with Teladoc Health. Results and experiences may vary from person to person and will be unique to each member. The testimonials are voluntarily provided and are not paid.

Teladoc Health is not available internationally.

Teladoc Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Para obtener ayuda en su idioma, llame sin costo alguno al número que aparece en su tarjeta de identificación. (TTY: 1-855-636-1578) T'áá shí shizaad k'ehjí shiká a'doowol nínizingo naaltsoos bee atah nílínígíí nanítínígíí béesh bee hane'é bikáá' áají' hodíílnih. (TTY: 1-855-636-1578)

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Program includes trends and support on your secure Teladoc Health account and mobile app but does not include a phone, tablet or smartwatch.

For the most current pricing of your Teladoc Health services, please log in to your TeladocHealth.com account.

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Know your options when you need care

You have several affordable and convenient options for immediate care. Keep this chart handy to help you make a smart choice the next time you need medical care. You may save time and money. Just text **"GETAPP"** to **90156** for a link to the **Aetna HealthSM app**. You'll be able to find network providers and facilities near you. Message and data rates apply.*



In-person options for care				
	Non-emergency	Non-emergency	Urgent	Emergency
Care options	 <p>Primary care physician (PCP**)</p> <p>Your PCP is the best option for in-person, non-emergency care.</p> <p>To find in-network PCPs near you, log in to your member website.</p>	 <p>MinuteClinic[®]</p> <p>MinuteClinic offers convenient care 7 days a week from certified nurse practitioners and physician assistants at select CVS Pharmacy[®] and Target stores nationwide.</p>	 <p>Urgent care center</p> <p>Urgent care centers provide quick care for serious, but not life-threatening, situations. Many urgent care centers offer imaging, X-ray and lab services.</p>	 <p>Emergency room</p> <p>The emergency room (ER) is for emergencies that can permanently impair or endanger your life. Using the ER for non-life-threatening issues can be very costly and probably means a very long wait time.</p>
When to use	<ul style="list-style-type: none"> • Physicals (wellness, screening) • Vaccinations & injections • Chronic condition management (heart disease, diabetes, arthritis, etc.) • Acute care (sinus infections and injuries) • Urgent care may be available by appointment 	<ul style="list-style-type: none"> • Minor illnesses & injuries • Screenings & monitoring • Skin conditions • Vaccinations & injections • Wellness & physicals • Women's services • Travel health <p>Visit minuteclinic.com to confirm services available at your location</p>	<ul style="list-style-type: none"> • Back/neck pain • Cuts that require stitches • Minor burns • Flu • Sprains • Fractures • Bronchitis • Headaches and more 	<ul style="list-style-type: none"> • Chest pain • Severe abdominal pain • Trouble breathing • Uncontrollable bleeding • Symptoms that may put your life at risk
Availability	Weekdays during business hours <i>(May be open extended hours and/or Saturdays)</i>	7 days a week <i>(including evenings and weekends)</i>	Many open 7 days a week with extended hours	24 hours a day 7 days a week 365 days a year
How to access	By appointment only	At select CVS Pharmacy and Target stores Schedule an appointment at minuteclinic.com or through the CVS Pharmacy App	Walk in	Walk in
Average wait time	Average wait time of 22 minutes upon arrival ¹	Make an appointment at minuteclinic.com	15 - 45 minutes ²	2 - 4 hours for non-emergency care ²
Average cost to you	<p>\$\$</p> <ul style="list-style-type: none"> • Pay your copay at appointment, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance. 	<p>\$</p> <ul style="list-style-type: none"> • No-cost or low-cost access to all covered services.*** • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance. 	<p>\$\$\$</p> <ul style="list-style-type: none"> • Pay your copay at time of visit, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance. 	<p>\$\$\$\$</p> <ul style="list-style-type: none"> • Pay your copay at time of visit, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance.

¹ "Vitals' Annual Physician Wait Time Report," <http://www.vitals.com/about/wait-time>. ² Urgent Care Locations, LLC. Urgent care center vs. emergency room. Available at: www.urgentcarelocations.com/urgent-care-101/faq/urgent-care-center-vs-emergency-room. Accessed April 4, 2018. *Terms and Conditions: bit.ly/2nlJFYG. Privacy Policy: aetna.com/legal-notices/privacy.html. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna HealthSM app. Consent is not required to download the app. You can also download by going to the App Store or Google Play. **In Texas, PCP is known as physician (primary care). In the State of Washington, PCP refers to primary care provider. ***Applies only to covered services at MinuteClinic. Not applicable for HSA plans. Video Visits are not a covered service under this benefit. Members in health maintenance organization (HMO) and indemnity plans are not eligible for this benefit. Such members should refer to their benefits plan documents in order to determine coverage and applicable cost share for walk-in clinic benefits and services, as applicable. Visit MinuteClinic.com for age and service restrictions. This is not available for fully insured groups in AL, AK, AR, CA, CO, DE, GA, HI, IA, ID, MA, ME, MS, MT, ND, NM, NY, OR, SD, UT, VT, WA, WV and WY. ****Lab, tests and additional services may result in additional charges. Labs and tests cannot be purchased separately and are only performed as part of a standard visit.

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Helping you take charge

Staying healthy is important. So is taking control of your health care and benefits. But with everything else you have going on, managing it all can be a challenge. The Aetna Health app can help.

With the Aetna Health app, you can:



View your health plan summary and get detailed information about what's covered.



See claims details and pay claims for your whole family.



Search for providers, procedures and medications.



Get cost estimates before you get care.



Track spending and progress toward meeting your deductibles for you and your family.



Talk with a doctor anytime by phone or video chat from the comfort and safety of home.



Access your ID card whenever you need it.



Receive personalized health reminders.



**Download the
Aetna Health
app today**

Text **"AETNA"** to **90156**
for a link to download
the Aetna Health app.

Message and data rates may apply.*



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[Aetna.com/AetnaHealthApp](https://aetna.com/AetnaHealthApp)

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90.03.369.1-NMEP C (11/20)



Better access

Getting health care in Mexico with your Aetna cross-border coverage



Wherever you go in Mexico, our international expertise and partnership with Sinergia Médica has you covered.

Your cross-border plan and digital, Sinergia Médica local ID card give you access to:

- Sinergia Médica network of 9,000 hospitals, clinics and physicians
- Providers in all 32 Mexican states
- No upfront costs with in-network providers
- Emergency care
- Hospital inpatient care
- Outpatient care and consultations
- Prescription medications
- Appointment coordination
- Discounted rates and lower costs



Example of a digital Sinergia Médica local ID card

How to find and access care

It's customary under Mexico's health care system for you to pay for outpatient care at the time of service. However, Sinergia Médica can help you find a provider and coordinate direct payment to providers at our negotiated local rates. This means you won't have upfront costs.

For outpatient care:

1. Contact Sinergia Médica by submitting a service request through the online portal at SinergiaMédica.info.
For additional information, view the portal instructions in [English](#) or [Spanish](#).
2. Bring and show your digital, Sinergia Médica local ID card and your authorization letter on the day of your appointment.
3. Sinergia Médica will coordinate direct payment with the in-network outpatient provider.

For inpatient care (including scheduled surgeries) and emergency care:

1. Go directly to the hospital, clinic or emergency department.
2. Present your Sinergia Médica digital ID card. The care facility will work with Sinergia Médica to arrange direct payment.
3. Sinergia Médica will coordinate direct payment with the in-network inpatient providers.



How to contact us

Call Sinergia Médica 24/7 if you have questions about outpatient care in Mexico or an emergency:

From Mexico:
(55) 5249 83 83 or
800 000 0277, option 1

From the U.S.:
+ **(011) (52) 55-5249-8383** and select
option 1 when prompted

For all other needs or for care inside the U.S., call the Aetna Member Service team using the number on your ID card.

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Aetna does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to Aetna.com.

Aetna.com

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Mejor acceso

Obtenga cuidado de salud en México con la cobertura transfronteriza de Aetna



En cualquier lugar de México, nuestra experiencia internacional y la asociación con Sinergia Médica le brindan lo que necesita.

Su plan transfronterizo y su tarjeta de identificación digital local de Sinergia Médica le brindan acceso a lo siguiente:

- Una red de mas de 9,000 hospitales, clinicas y medicos.
- Proveedores en los 32 estados mexicanos.
- Proveedores de la red sin tener que pagar cargos iniciales.
- Cuidado médico de emergencia.
- Cuidado durante el internamiento.
- Consultas y cuidado médico ambulatorios.
- Medicamentos con receta.
- Coordinación de citas.
- Tarifas con descuento y costos más bajos.



Ejemplo de una tarjeta de identificación digital local de Sinergia Médica

Cómo buscar cuidado médico y acceder a él

Es habitual en el sistema de cuidado de salud de México que usted pague el cuidado médico ambulatorio en el momento del servicio. Sin embargo, Sinergia Médica puede ayudarlo a encontrar un proveedor y coordinar el pago directo a nuestras tarifas locales negociadas. Esto significa que no tendrá que pagar cargos iniciales.

Para cuidado médico ambulatorio:

1. Comuníquese con Sinergia Médica enviando una solicitud de servicio a través del portal en línea, en SinergiaMédica.info.

Para obtener información adicional, consulte las instrucciones del portal en [inglés](#) o [español](#).

2. Lleve y muestre su tarjeta de identificación digital local de Sinergia Médica y la carta de autorización el día de la cita.
3. Sinergia Médica coordinará el pago directo con el proveedor de servicios ambulatorios dentro de la red.

Para cuidado durante el internamiento (incluidas las cirugías programadas) y cuidado médico de emergencia:

1. Vaya directamente al hospital, a la clínica o a la sala de emergencias.
2. Muestre su tarjeta de identificación digital de Sinergia Médica. El centro de cuidado médico acordará con Sinergia Médica el pago directo.
3. Sinergia Médica coordinará el pago directo con el proveedor de servicios durante el internamiento.



Cómo comunicarse con nosotros

Llame a Sinergia Médica las 24 horas del día, los 7 días de la semana si tiene preguntas sobre el cuidado médico ambulatorio en México o si tiene una emergencia:

Desde México:

(55) 5249 83 83 u
800 000 0277, opción 1

Desde los Estados Unidos:

+ **(011) (52) 55-5249-8383** y seleccione
la opción 1 cuando se le solicite

Para obtener ayuda con todas las demás necesidades o para recibir cuidado médico dentro de los Estados Unidos, llame al equipo de Servicios al Cliente de Aetna al número que figura en su tarjeta de identificación.

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Aetna no proporciona cuidado médico ni garantiza acceso a servicios de salud. No todos los servicios de salud están cubiertos. La cobertura está sujeta a las leyes y reglamentaciones aplicables, incluidas las sanciones económicas y comerciales. Consulte los documentos del plan para obtener una descripción completa de los beneficios, las exclusiones, las limitaciones y las condiciones de cobertura. La información es precisa a partir de la fecha de la elaboración del plan; sin embargo, está sujeta a cambios. Para obtener más información, consulte Aetna.com.

Aetna.com

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Flexible Spending Account (FSA)

You can pay for eligible health care and dependent care expenses with pre-tax income through a Flexible Spending Account. You do not pay federal income tax on your deposit.

The Flexible Spending Account reimburses you for eligible health care expenses that are not covered by insurance. Expenses may be incurred by you, your spouse, and your dependent children, regardless of whether they are covered by the County's medical, dental or vision plans.

The Flexible Spending Account also reimburses you for certain dependent care expenses incurred while you and/or your spouse work.

How the Spending Accounts Work

You choose to contribute part of your earnings into the Medical Flexible Spending Account and/or the Dependent Care Flexible Spending Account. The accounts are maintained separately and you cannot make transfers between them. These accounts will reimburse you for eligible expenses that you submit throughout the year.



Health Care Flexible Spending Account

- ✓ Estimate your annual health care expenditures on items not reimbursed by insurance.
- ✓ Decide how much money you want to contribute to the account from \$1 to \$3,050 per year. The money is deducted before taxes, so taxes are withheld on a lower amount of your earnings.
- ✓ The County offers a debit card that allows eligible expenses to be deducted directly from your account.
- ✓ You may also file a paper or online claim when you have eligible health care expenses.
- ✓ The grace period allows you to incur expenses until December 15th, 2024. (75 days after plan year ends)
- ✓ The Rollout period allows you to submit claims for reimbursement until December 29th, 2024. (90 days window following end of plan year)

Dependent Care Flexible Spending Account

- ✓ Estimate your dependent care expenses for the coming year.
- ✓ Decide how much money you want to contribute to the account with a \$5,000 maximum per year. The money is deducted before taxes are taken out, so taxes are withheld on a lower amount of your earnings (pre-tax basis).
- ✓ File a claim when you have eligible dependent care expenses.
- ✓ You will be reimbursed for eligible claims up to the current contributed amount available in your account.

Note: Dependent care deposits must be received and posted to your individual account before they can be used.





Calculating Flexible Spending Account Contributions

Medical Care Flexible Spending Account Worksheet

Enter your annual out-of-pocket expenses for each of the following. Do not include any amounts for medical, dental or vision care premiums.

Health care \$ _____

Dental care \$ _____

Vision care \$ _____

Prescription drugs \$ _____

Total lines above \$ _____



- The largest selection of guaranteed eligible products
- Using pre-tax dollars lets you save on healthcare needs
- Use your FSA card, skip the paperwork
- 24/7 support and educational resources
- Free shipping on orders over \$50

Visit [FSAstore.com/AMF19](https://www.fsastore.com/AMF19) and use coupon code **AMF19** for \$5 off your first purchase.




Copays, deductibles, and other payments you are responsible for under your health plan.



Routine exams, dental care, prescription drugs, eye care, and hearing aids.



Prescription glasses and sunglasses.



Certain over-the-counter (OTC) healthcare expenses such as Band-aids, medicine, First Aid supplies, etc. **Note:** OTC medicines require a doctor's prescription to be eligible.



Diabetic equipment and supplies, durable medical equipment, and qualified medical products or services provided by a doctor.

Dependent Care Flexible Spending Account Worksheet

Weekly day care costs \$ _____

Total lines above \$ _____

Number of weeks you will incur expenses **X** _____

Multiply total by weeks \$ _____

(cannot exceed \$5,100 married; \$2,500 single)



Daycare



Summer day camp



Custodial care for dependent adults



Nursery school



Before and after school programs



Private sitter



Nanny service



Pre-school



Keep smiling

Delta Dental PPO™



Stay in network to save

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

If you can't find a PPO dentist, consider a Delta Dental Premier[®] dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to

provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



PREMIER



NON-DELTA DENTAL

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: Cameron County

Group No: 22541

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	\$50 per person / \$150 per family each calendar year			
	Yes			
Maximums D & P counts toward maximum?	\$1,800 per person each calendar year			
	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental DPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %
Basic Services Fillings	80 %	80 %	80 %
Endodontics (root canals) Covered under Basic Services	80 %	80 %	80 %
Periodontics (gum treatment) Covered under Basic Services	80 %	80 %	80 %
Oral Surgery Covered under Basic Services	80 %	80 %	80 %
Major Services Crowns, onlays and cast restorations	50 %	50 %	50 %
Prosthodontics Bridges and dentures	50 %	50 %	50 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %	50 %
Orthodontic Maximums	\$1,500 Lifetime	\$1,500 Lifetime	\$1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	Customer Service 800-521-2651	Claims Address P.O. Box 1809 Alpharetta, GA 30023-1809
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

VISION



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Your vision health is an important part of complete wellness. Davis Vision is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health. This plan encourages yearly exams along with the frames and lenses you want.

The plan will pay for a comprehensive exam, lenses and contact lenses once every 12 months and will pay for frames once every 12 months. A single copay covers both frames and/or eyeglass lenses, or contact lenses instead of eyeglass frames and/or lenses. **Discounts are available on additional pairs of eyewear and contact lenses.**

Vision Plan Summary	Vision	
	In-Network	Out-of-Network (Reimbursement)
Exams	Covered in full after \$10 copay	Up to \$40 allowance
Lenses		
Single Bifocal Trifocal Lenticular	Covered	Up to \$40 allowance Up to \$60 allowance Up to \$80 allowance Up to \$100 allowance
Contact Lenses		
Medically-Necessary Elective*	Covered Up to \$175 allowance + 15% off balance over allowance	Up to \$225 allowance Up to \$105 allowance
Frames*	Up to \$175 allowance + 20% off balance over allowance	Up to \$65 allowance
Laser Benefit**	\$200 One-time/lifetime allowance	
Service Frequency		
Exams Lenses and Contact Lenses Frames		Once every 12 months Once every 12 months Once every 12 months

* Contact lenses are in lieu of eyeglass lenses and frames benefit and frames are in lieu of contact lenses and contact lens benefit. Additional discounts not applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions. Discounts are available on additional pairs of eyewear and contact lenses.

** Applicable both in- and out-of-network. Additional discounts apply in-network.

Vision Semi-Monthly	Vision
Employee	\$4.29
Employee + 1	\$6.44
Family	\$8.57

Seeing the world in a whole new way!



Voluntary Benefits

VOLUNTARY GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS



More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.¹

CAMERON COUNTY

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.



To learn more about Life and AD&D insurance, visit www.thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit ² : Increments of \$10,000 Maximum: the lesser of 5x earnings or \$500,000	AD&D: Included
Spouse	Benefit ² : Increments of \$5,000 Maximum: the lesser of 100% of your supplemental coverage or \$250,000	AD&D: Included
Child(ren)	Benefit: Increments of \$2,000 Maximum: \$10,000	AD&D: Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	COVERAGE
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

³Your benefit will reduce by 35% at age 70 and by 50% at age 75. Reductions will be applied to the original amount.

PREMIUMS

See the Life Premium Worksheet.³

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

If you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$300,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.

If you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$75,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.

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

AD&D is available without having to provide information about your or your family's health.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided on the Life Premium Worksheet. You have a choice of coverage amounts. You may elect insurance for you only, or for you and your dependent(s).

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

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 dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, 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 and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion is not available for AD&D coverage. Portability may be available for AD&D coverage.

¹LIMRA, Facts About Life 2020: <https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf>, as viewed on October 14, 2020.

³Rates and/or benefits may be changed on a class basis. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

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The Hartford[®] is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability. © 2020 The Hartford.

The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding The Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

5962a and 5962b NS 07/21

LIMITATIONS & EXCLUSIONS



This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Exclusions: (Applicable to all benefits except the Life Insurance Benefit and the Accelerated Benefit) What is not covered under The Policy?
- The Policy does not cover any loss caused or contributed to by:
 - anaphylactic shock;
 - any form of auto-erotic asphyxiation;
 - failure to wear a Seat Belt while driving or riding as a passenger in a Motor Vehicle;
 - intentionally self-inflicted Injury;
 - stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis or aneurysm;
 - suicide or attempted suicide, whether sane or insane;
 - war or act of war, whether declared or not;
 - injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority except Reserve or National Guard Service;
 - injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
 - injury sustained while On any aircraft:
 - as a pilot, crewmember or student pilot;
 - as a flight instructor or examiner;
 - if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy; or
 - being used for tests, experimental purposes, stunt flying, racing or endurance tests;
 - injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician
 - injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
 - injury sustained while committing or attempting to commit a felony;
 - injury sustained while Intoxicated;
 - injury sustained while driving while Intoxicated;
 - injury sustained by illegal fireworks or the use of any legal fireworks when not following the manufacturer's lighting instructions;
 - driving and violating any applicable cellular device use or distracted driving laws; or
 - failure to wear a helmet while On or riding as a passenger On a motorcycle, bicycle, all-terrain vehicle (ATV) or any other type of motor bike.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

5962c NS 05/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

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ADDITIONAL SERVICES



CAMERON COUNTY

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Life	Ability Assist Counseling Services Health Champion Bereavement Services Funeral Planning Services Will Prep Services Travel Assistance and Identity Theft Support Services

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist^{®1} Counseling Services provides access to Master's degreed clinicians for 24/7 assistance if you're enrolled in coverage. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist[®] Counseling Services:
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS BEREAVEMENT SERVICES?

Bereavement Services⁴ provide a personalized bereavement solution built to help families deal with the many challenges that loss can bring. Empathy provides high-quality, complimentary, on-demand support for every group life beneficiary anticipating or dealing with loss, so that they and their families have everything they need during this difficult time. This includes grief support services, Estate and Probate service, helpful planning tools, digital App, document storage, after-loss support, and access to online content designed to assist with the grieving process.

For more information on Bereavement Services:
Landing Page: empathy.com/partner/hartford
Registration Page: join.empathy.com/hartford
Email Address: hartford@empathy.com
Access Code: **EMP-HART**
For questions, call: 270-681-1364

Additional **Insured and Beneficiary Assist³ Services** that provide compassionate expertise to help employees or their loved ones cope with emotional, financial and legal issues that arise before or after a loss. Includes unlimited phone contact with professionals, as well as five face-to-face sessions*. Additionally, health care support services are available for employees that are terminally ill.

*California residents are limited to three prepaid behavior health counseling sessions in any six-month period. Except for acute emergencies and other special circumstances, additional sessions for California employees are available on a fee-for-service basis.

WHAT IS FUNERAL PLANNING SERVICES?

Funeral Planning Services⁴ provides detailed instructions and on-demand assistance finding a funeral home, identifying vendors, planning events, arranging all details, writing and sending invitations, and negotiating costs on behalf of the insureds, beneficiary and their family. They are given access to a wide range of funeral resources including guides and tailor-made, step-by-step checklists. In addition, a team of experts are available for beneficiaries to call in, chat, email for any funeral, burial, or cremation questions.

For [Bereaved](#), for more information on Funeral Planning Services:
Landing Page: empathy.com/partner/hartford
Registration Page: join.empathy.com/hartford
Email Address: hartford@empathy.com
Access Code: **EMP-HART**
For questions, call: 270-681-1364

For Insureds, for more information on Funeral Planning Services:

Visit: empathy.com/partner/hartfordcare

Registration Page: join.empathy.com/hartfordcare

Email Address: hartfordcare@empathy.com

For questions, call: 229-544-2332

WHAT IS WILL PREP SERVICES?

Will Prep Services⁴ provide online will preparation services alongside step-by-step guidance.

For Bereaved, for more information on Will Prep Services:

Landing Page: empathy.com/partner/hartford

Registration Page: join.empathy.com/hartford

Email Address: hartford@empathy.com

Access Code: **EMP-HART**

For questions, call: 270-681-1364

For Insureds, for more information on Will Prep Services:

Visit: empathy.com/partner/hartfordcare

Registration Page: join.empathy.com/hartfordcare

Email Address: hartfordcare@empathy.com

For questions, call: 229-544-2332

WHAT IS HEALTHCHAMPION?

HealthChampion^{SM5} offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and insurance claims concerns if you're enrolled in coverage. Service includes: claim and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

For more information on HealthChampionSM Services

Call 1-800-964-3577

Visit www.guidanceresources.com

Company name: **Abili** Company ID: **HLF902**

WHAT IS TRAVEL ASSISTANCE AND IDENTITY THEFT SUPPORT SERVICES?

Travel Assistance⁶ is available when traveling more than 100 miles from home and for 90 days or less. Services include but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses.
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains.
- Pre-trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services⁶ provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs. Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

For more information on Travel Assistance or Identity Theft Support Services:

- Call from U.S. and Canada: 800-243-6108 (toll-free)
- Call from Outside U.S.: 202-828-5885
- Or email: assist@imglobal.com

In the event of a life-threatening travel emergency, call local emergency authorities first for immediate assistance before contacting our Travel Assistance partner.

¹AbilityAssist® services are offered through The Hartford by ComPsych®. 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. Services may not be available in all states. Visit <https://www.thehartford.com/employee-benefits/value-added-services> for more information.

³Insured and Beneficiary Assist® services are provided through The Hartford by ComPsych®, the largest provider of employee assistance programs, managed behavioral health, work/life and crisis intervention services. For more information on ComPsych, visit www.compsych.com. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

⁴Bereavement Services, Funeral Planning Services and Will Prep Services are provided through The Hartford by Empathy, a personalized bereavement solution built to help families deal with the many challenges loss can bring. For more information on Empathy, visit www.empathy.com. Empathy is not affiliated with The Hartford and is not a provider of insurance services.

⁵HealthChampionSM services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford doesn't provide basic hospital, basic medical, or major medical insurance. HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment. 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. Health Champion is a service mark of ComPsych. Services may not be available in all states.

Visit <https://www.thehartford.com/employee-benefits/value-added-services> for more information.

⁶Travel Assistance and Identity Theft Support services are offered through a vendor which is not affiliated with The Hartford. These services are not insurance. The Hartford is not responsible and

assumes no liability for the goods and services described in these materials and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states.

Visit <https://www.thehartford.com/employee-benefits/value-added-services> for more information.

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Premium Worksheet



Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE												
Monthly Premium Amount (Cost per Pay Period – 12/Year)												
Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	\$0.46	\$0.46	\$0.52	\$0.59	\$0.87	\$1.46	\$2.28	\$3.55	\$5.50	\$9.72	\$17.33	\$28.51
\$20,000	\$0.92	\$0.92	\$1.04	\$1.18	\$1.74	\$2.92	\$4.56	\$7.10	\$11.00	\$19.44	\$34.66	\$57.02
\$30,000	\$1.38	\$1.38	\$1.56	\$1.77	\$2.61	\$4.38	\$6.84	\$10.65	\$16.50	\$29.16	\$51.99	\$85.53
\$40,000	\$1.84	\$1.84	\$2.08	\$2.36	\$3.48	\$5.84	\$9.12	\$14.20	\$22.00	\$38.88	\$69.32	\$114.04
\$50,000	\$2.30	\$2.30	\$2.60	\$2.95	\$4.35	\$7.30	\$11.40	\$17.75	\$27.50	\$48.60	\$86.65	\$142.55
\$60,000	\$2.76	\$2.76	\$3.12	\$3.54	\$5.22	\$8.76	\$13.68	\$21.30	\$33.00	\$58.32	\$103.98	\$171.06
\$70,000	\$3.22	\$3.22	\$3.64	\$4.13	\$6.09	\$10.22	\$15.96	\$24.85	\$38.50	\$68.04	\$121.31	\$199.57
\$80,000	\$3.68	\$3.68	\$4.16	\$4.72	\$6.96	\$11.68	\$18.24	\$28.40	\$44.00	\$77.76	\$138.64	\$228.08
\$90,000	\$4.14	\$4.14	\$4.68	\$5.31	\$7.83	\$13.14	\$20.52	\$31.95	\$49.50	\$87.48	\$155.97	\$256.59
\$100,000	\$4.60	\$4.60	\$5.20	\$5.90	\$8.70	\$14.60	\$22.80	\$35.50	\$55.00	\$97.20	\$173.30	\$285.10
\$110,000	\$5.06	\$5.06	\$5.72	\$6.49	\$9.57	\$16.06	\$25.08	\$39.05	\$60.50	\$106.92	\$190.63	\$313.61
\$120,000	\$5.52	\$5.52	\$6.24	\$7.08	\$10.44	\$17.52	\$27.36	\$42.60	\$66.00	\$116.64	\$207.96	\$342.12
\$130,000	\$5.98	\$5.98	\$6.76	\$7.67	\$11.31	\$18.98	\$29.64	\$46.15	\$71.50	\$126.36	\$225.29	\$370.63
\$140,000	\$6.44	\$6.44	\$7.28	\$8.26	\$12.18	\$20.44	\$31.92	\$49.70	\$77.00	\$136.08	\$242.62	\$399.14
\$150,000	\$6.90	\$6.90	\$7.80	\$8.85	\$13.05	\$21.90	\$34.20	\$53.25	\$82.50	\$145.80	\$259.95	\$427.65
\$160,000	\$7.36	\$7.36	\$8.32	\$9.44	\$13.92	\$23.36	\$36.48	\$56.80	\$88.00	\$155.52	\$277.28	\$456.16
\$170,000	\$7.82	\$7.82	\$8.84	\$10.03	\$14.79	\$24.82	\$38.76	\$60.35	\$93.50	\$165.24	\$294.61	\$484.67
\$180,000	\$8.28	\$8.28	\$9.36	\$10.62	\$15.66	\$26.28	\$41.04	\$63.90	\$99.00	\$174.96	\$311.94	\$513.18
\$190,000	\$8.74	\$8.74	\$9.88	\$11.21	\$16.53	\$27.74	\$43.32	\$67.45	\$104.50	\$184.68	\$329.27	\$541.69
\$200,000	\$9.20	\$9.20	\$10.40	\$11.80	\$17.40	\$29.20	\$45.60	\$71.00	\$110.00	\$194.40	\$346.60	\$570.20
\$210,000	\$9.66	\$9.66	\$10.92	\$12.39	\$18.27	\$30.66	\$47.88	\$74.55	\$115.50	\$204.12	\$363.93	\$598.71
\$220,000	\$10.12	\$10.12	\$11.44	\$12.98	\$19.14	\$32.12	\$50.16	\$78.10	\$121.00	\$213.84	\$381.26	\$627.22
\$230,000	\$10.58	\$10.58	\$11.96	\$13.57	\$20.01	\$33.58	\$52.44	\$81.65	\$126.50	\$223.56	\$398.59	\$655.73
\$240,000	\$11.04	\$11.04	\$12.48	\$14.16	\$20.88	\$35.04	\$54.72	\$85.20	\$132.00	\$233.28	\$415.92	\$684.24
\$250,000	\$11.50	\$11.50	\$13.00	\$14.75	\$21.75	\$36.50	\$57.00	\$88.75	\$137.50	\$243.00	\$433.25	\$712.75
\$260,000	\$11.96	\$11.96	\$13.52	\$15.34	\$22.62	\$37.96	\$59.28	\$92.30	\$143.00	\$252.72	\$450.58	\$741.26
\$270,000	\$12.42	\$12.42	\$14.04	\$15.93	\$23.49	\$39.42	\$61.56	\$95.85	\$148.50	\$262.44	\$467.91	\$769.77
\$280,000	\$12.88	\$12.88	\$14.56	\$16.52	\$24.36	\$40.88	\$63.84	\$99.40	\$154.00	\$272.16	\$485.24	\$798.28
\$290,000	\$13.34	\$13.34	\$15.08	\$17.11	\$25.23	\$42.34	\$66.12	\$102.95	\$159.50	\$281.88	\$502.57	\$826.79
\$300,000	\$13.80	\$13.80	\$15.60	\$17.70	\$26.10	\$43.80	\$68.40	\$106.50	\$165.00	\$291.60	\$519.90	\$855.30
\$310,000	\$14.26	\$14.26	\$16.12	\$18.29	\$26.97	\$45.26	\$70.68	\$110.05	\$170.50	\$301.32	\$537.23	\$883.81
\$320,000	\$14.72	\$14.72	\$16.64	\$18.88	\$27.84	\$46.72	\$72.96	\$113.60	\$176.00	\$311.04	\$554.56	\$912.32
\$330,000	\$15.18	\$15.18	\$17.16	\$19.47	\$28.71	\$48.18	\$75.24	\$117.15	\$181.50	\$320.76	\$571.89	\$940.83
\$340,000	\$15.64	\$15.64	\$17.68	\$20.06	\$29.58	\$49.64	\$77.52	\$120.70	\$187.00	\$330.48	\$589.22	\$969.34
\$350,000	\$16.10	\$16.10	\$18.20	\$20.65	\$30.45	\$51.10	\$79.80	\$124.25	\$192.50	\$340.20	\$606.55	\$997.85
\$360,000	\$16.56	\$16.56	\$18.72	\$21.24	\$31.32	\$52.56	\$82.08	\$127.80	\$198.00	\$349.92	\$623.88	\$1,026.36
\$370,000	\$17.02	\$17.02	\$19.24	\$21.83	\$32.19	\$54.02	\$84.36	\$131.35	\$203.50	\$359.64	\$641.21	\$1,054.87
\$380,000	\$17.48	\$17.48	\$19.76	\$22.42	\$33.06	\$55.48	\$86.64	\$134.90	\$209.00	\$369.36	\$658.54	\$1,083.38
\$390,000	\$17.94	\$17.94	\$20.28	\$23.01	\$33.93	\$56.94	\$88.92	\$138.45	\$214.50	\$379.08	\$675.87	\$1,111.89
\$400,000	\$18.40	\$18.40	\$20.80	\$23.60	\$34.80	\$58.40	\$91.20	\$142.00	\$220.00	\$388.80	\$693.20	\$1,140.40
\$410,000	\$18.86	\$18.86	\$21.32	\$24.19	\$35.67	\$59.86	\$93.48	\$145.55	\$225.50	\$398.52	\$710.53	\$1,168.91
\$420,000	\$19.32	\$19.32	\$21.84	\$24.78	\$36.54	\$61.32	\$95.76	\$149.10	\$231.00	\$408.24	\$727.86	\$1,197.42
\$430,000	\$19.78	\$19.78	\$22.36	\$25.37	\$37.41	\$62.78	\$98.04	\$152.65	\$236.50	\$417.96	\$745.19	\$1,225.93
\$440,000	\$20.24	\$20.24	\$22.88	\$25.96	\$38.28	\$64.24	\$100.32	\$156.20	\$242.00	\$427.68	\$762.52	\$1,254.44

\$450,000	\$20.70	\$20.70	\$23.40	\$26.55	\$39.15	\$65.70	\$102.60	\$159.75	\$247.50	\$437.40	\$779.85	\$1,282.95
\$460,000	\$21.16	\$21.16	\$23.92	\$27.14	\$40.02	\$67.16	\$104.88	\$163.30	\$253.00	\$447.12	\$797.18	\$1,311.46
\$470,000	\$21.62	\$21.62	\$24.44	\$27.73	\$40.89	\$68.62	\$107.16	\$166.85	\$258.50	\$456.84	\$814.51	\$1,339.97
\$480,000	\$22.08	\$22.08	\$24.96	\$28.32	\$41.76	\$70.08	\$109.44	\$170.40	\$264.00	\$466.56	\$831.84	\$1,368.48
\$490,000	\$22.54	\$22.54	\$25.48	\$28.91	\$42.63	\$71.54	\$111.72	\$173.95	\$269.50	\$476.28	\$849.17	\$1,396.99
\$500,000	\$23.00	\$23.00	\$26.00	\$29.50	\$43.50	\$73.00	\$114.00	\$177.50	\$275.00	\$486.00	\$866.50	\$1,425.50

SPOUSE/PARTNER VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$5,000	\$0.23	\$0.23	\$0.26	\$0.30	\$0.44	\$0.73	\$1.14	\$1.78	\$2.75	\$4.86	\$8.67	\$14.26
\$10,000	\$0.46	\$0.46	\$0.52	\$0.59	\$0.87	\$1.46	\$2.28	\$3.55	\$5.50	\$9.72	\$17.33	\$28.51
\$15,000	\$0.69	\$0.69	\$0.78	\$0.89	\$1.31	\$2.19	\$3.42	\$5.33	\$8.25	\$14.58	\$26.00	\$42.77
\$20,000	\$0.92	\$0.92	\$1.04	\$1.18	\$1.74	\$2.92	\$4.56	\$7.10	\$11.00	\$19.44	\$34.66	\$57.02
\$25,000	\$1.15	\$1.15	\$1.30	\$1.48	\$2.18	\$3.65	\$5.70	\$8.88	\$13.75	\$24.30	\$43.33	\$71.28
\$30,000	\$1.38	\$1.38	\$1.56	\$1.77	\$2.61	\$4.38	\$6.84	\$10.65	\$16.50	\$29.16	\$51.99	\$85.53
\$35,000	\$1.61	\$1.61	\$1.82	\$2.07	\$3.05	\$5.11	\$7.98	\$12.43	\$19.25	\$34.02	\$60.66	\$99.79
\$40,000	\$1.84	\$1.84	\$2.08	\$2.36	\$3.48	\$5.84	\$9.12	\$14.20	\$22.00	\$38.88	\$69.32	\$114.04
\$45,000	\$2.07	\$2.07	\$2.34	\$2.66	\$3.92	\$6.57	\$10.26	\$15.98	\$24.75	\$43.74	\$77.99	\$128.30
\$50,000	\$2.30	\$2.30	\$2.60	\$2.95	\$4.35	\$7.30	\$11.40	\$17.75	\$27.50	\$48.60	\$86.65	\$142.55
\$55,000	\$2.53	\$2.53	\$2.86	\$3.25	\$4.79	\$8.03	\$12.54	\$19.53	\$30.25	\$53.46	\$95.32	\$156.81
\$60,000	\$2.76	\$2.76	\$3.12	\$3.54	\$5.22	\$8.76	\$13.68	\$21.30	\$33.00	\$58.32	\$103.98	\$171.06
\$65,000	\$2.99	\$2.99	\$3.38	\$3.84	\$5.66	\$9.49	\$14.82	\$23.08	\$35.75	\$63.18	\$112.65	\$185.32
\$70,000	\$3.22	\$3.22	\$3.64	\$4.13	\$6.09	\$10.22	\$15.96	\$24.85	\$38.50	\$68.04	\$121.31	\$199.57
\$75,000	\$3.45	\$3.45	\$3.90	\$4.43	\$6.53	\$10.95	\$17.10	\$26.63	\$41.25	\$72.90	\$129.98	\$213.83
\$80,000	\$3.68	\$3.68	\$4.16	\$4.72	\$6.96	\$11.68	\$18.24	\$28.40	\$44.00	\$77.76	\$138.64	\$228.08
\$85,000	\$3.91	\$3.91	\$4.42	\$5.02	\$7.40	\$12.41	\$19.38	\$30.18	\$46.75	\$82.62	\$147.31	\$242.34
\$90,000	\$4.14	\$4.14	\$4.68	\$5.31	\$7.83	\$13.14	\$20.52	\$31.95	\$49.50	\$87.48	\$155.97	\$256.59
\$95,000	\$4.37	\$4.37	\$4.94	\$5.61	\$8.27	\$13.87	\$21.66	\$33.73	\$52.25	\$92.34	\$164.64	\$270.85
\$100,000	\$4.60	\$4.60	\$5.20	\$5.90	\$8.70	\$14.60	\$22.80	\$35.50	\$55.00	\$97.20	\$173.30	\$285.10
\$105,000	\$4.83	\$4.83	\$5.46	\$6.20	\$9.14	\$15.33	\$23.94	\$37.28	\$57.75	\$102.06	\$181.97	\$299.36
\$110,000	\$5.06	\$5.06	\$5.72	\$6.49	\$9.57	\$16.06	\$25.08	\$39.05	\$60.50	\$106.92	\$190.63	\$313.61
\$115,000	\$5.29	\$5.29	\$5.98	\$6.79	\$10.01	\$16.79	\$26.22	\$40.83	\$63.25	\$111.78	\$199.30	\$327.87
\$120,000	\$5.52	\$5.52	\$6.24	\$7.08	\$10.44	\$17.52	\$27.36	\$42.60	\$66.00	\$116.64	\$207.96	\$342.12
\$125,000	\$5.75	\$5.75	\$6.50	\$7.38	\$10.88	\$18.25	\$28.50	\$44.38	\$68.75	\$121.50	\$216.63	\$356.38
\$130,000	\$5.98	\$5.98	\$6.76	\$7.67	\$11.31	\$18.98	\$29.64	\$46.15	\$71.50	\$126.36	\$225.29	\$370.63
\$135,000	\$6.21	\$6.21	\$7.02	\$7.97	\$11.75	\$19.71	\$30.78	\$47.93	\$74.25	\$131.22	\$233.96	\$384.89
\$140,000	\$6.44	\$6.44	\$7.28	\$8.26	\$12.18	\$20.44	\$31.92	\$49.70	\$77.00	\$136.08	\$242.62	\$399.14
\$145,000	\$6.67	\$6.67	\$7.54	\$8.56	\$12.62	\$21.17	\$33.06	\$51.48	\$79.75	\$140.94	\$251.29	\$413.40
\$150,000	\$6.90	\$6.90	\$7.80	\$8.85	\$13.05	\$21.90	\$34.20	\$53.25	\$82.50	\$145.80	\$259.95	\$427.65
\$155,000	\$7.13	\$7.13	\$8.06	\$9.15	\$13.49	\$22.63	\$35.34	\$55.03	\$85.25	\$150.66	\$268.62	\$441.91
\$160,000	\$7.36	\$7.36	\$8.32	\$9.44	\$13.92	\$23.36	\$36.48	\$56.80	\$88.00	\$155.52	\$277.28	\$456.16
\$165,000	\$7.59	\$7.59	\$8.58	\$9.74	\$14.36	\$24.09	\$37.62	\$58.58	\$90.75	\$160.38	\$285.95	\$470.42
\$170,000	\$7.82	\$7.82	\$8.84	\$10.03	\$14.79	\$24.82	\$38.76	\$60.35	\$93.50	\$165.24	\$294.61	\$484.67
\$175,000	\$8.05	\$8.05	\$9.10	\$10.33	\$15.23	\$25.55	\$39.90	\$62.13	\$96.25	\$170.10	\$303.28	\$498.93
\$180,000	\$8.28	\$8.28	\$9.36	\$10.62	\$15.66	\$26.28	\$41.04	\$63.90	\$99.00	\$174.96	\$311.94	\$513.18
\$185,000	\$8.51	\$8.51	\$9.62	\$10.92	\$16.10	\$27.01	\$42.18	\$65.68	\$101.75	\$179.82	\$320.61	\$527.44
\$190,000	\$8.74	\$8.74	\$9.88	\$11.21	\$16.53	\$27.74	\$43.32	\$67.45	\$104.50	\$184.68	\$329.27	\$541.69
\$195,000	\$8.97	\$8.97	\$10.14	\$11.51	\$16.97	\$28.47	\$44.46	\$69.23	\$107.25	\$189.54	\$337.94	\$555.95
\$200,000	\$9.20	\$9.20	\$10.40	\$11.80	\$17.40	\$29.20	\$45.60	\$71.00	\$110.00	\$194.40	\$346.60	\$570.20
\$205,000	\$9.43	\$9.43	\$10.66	\$12.10	\$17.84	\$29.93	\$46.74	\$72.78	\$112.75	\$199.26	\$355.27	\$584.46
\$210,000	\$9.66	\$9.66	\$10.92	\$12.39	\$18.27	\$30.66	\$47.88	\$74.55	\$115.50	\$204.12	\$363.93	\$598.71
\$215,000	\$9.89	\$9.89	\$11.18	\$12.69	\$18.71	\$31.39	\$49.02	\$76.33	\$118.25	\$208.98	\$372.60	\$612.97
\$220,000	\$10.12	\$10.12	\$11.44	\$12.98	\$19.14	\$32.12	\$50.16	\$78.10	\$121.00	\$213.84	\$381.26	\$627.22
\$225,000	\$10.35	\$10.35	\$11.70	\$13.28	\$19.58	\$32.85	\$51.30	\$79.88	\$123.75	\$218.70	\$389.93	\$641.48
\$230,000	\$10.58	\$10.58	\$11.96	\$13.57	\$20.01	\$33.58	\$52.44	\$81.65	\$126.50	\$223.56	\$398.59	\$655.73
\$235,000	\$10.81	\$10.81	\$12.22	\$13.87	\$20.45	\$34.31	\$53.58	\$83.43	\$129.25	\$228.42	\$407.26	\$669.99
\$240,000	\$11.04	\$11.04	\$12.48	\$14.16	\$20.88	\$35.04	\$54.72	\$85.20	\$132.00	\$233.28	\$415.92	\$684.24

\$245,000	\$11.27	\$11.27	\$12.74	\$14.46	\$21.32	\$35.77	\$55.86	\$86.98	\$134.75	\$238.14	\$424.59	\$698.50
\$250,000	\$11.50	\$11.50	\$13.00	\$14.75	\$21.75	\$36.50	\$57.00	\$88.75	\$137.50	\$243.00	\$433.25	\$712.75

CHILD(REN) VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE											
Monthly Premium Amount (Cost per Pay Period – 12/Year)											
Benefit Amount	Cost For Each Child	x	Number of Covered Children	=	Cost For All Children	Benefit Amount	Cost For Each Child	x	Number of Covered Children	=	Cost For All Children
\$2,000	\$0.08	x		=		\$8,000	\$0.31	x		=	
\$4,000	\$0.16	x		=		\$10,000	\$0.39	x		=	
\$6,000	\$0.23	x		=							

5962a NS 07/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

The Buck's Got Your Back®

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Fire Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. © 2020 The Hartford.

This document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

Aflac Group Disability Advantage

INSURANCE PLAN — NON-OCCUPATIONAL

A disabling illness or injury
may be unpredictable.

We'll help make sure they don't
affect your financial plans, too.



THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.



AFLAC GROUP DISABILITY INSURANCE PLAN

Policy Form C50100.1TX

DI^G

Aflac can help you protect one of your most important assets. Your income.

All too often when we hear the words disability and insurance together, it conjures up an image of a catastrophic condition that has left an individual in an incapacitated state. Be it an accident or a sickness, that's the stereotype of a disabling injury that most of us have come to expect.

What most of us don't realize is that in addition to accidental injuries, conditions such as arthritis, heart disease, diabetes, and even pregnancy are some of the leading causes of disability that can keep you out of work and affect your income.

That's where Aflac group disability insurance can help.

Our Aflac group disability plan can help protect your income by offering disability benefits to help you make ends meet when you are out of work. Our plan was created with you in mind and includes:

- **Off-job only coverage.**
- **Benefits that help you maintain your standard of living.**

What you need, when you need it.

Group disability insurance pays cash benefits that you can use any way you see fit.



Here's why the Aflac group disability plan is right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our group disability plan is just another innovative way to help make sure you're well protected.

But it doesn't stop there, having group short-term disability insurance from Aflac means that you will have added financial resources to help with medical costs or ongoing living expenses such as rent, mortgage or car payments.

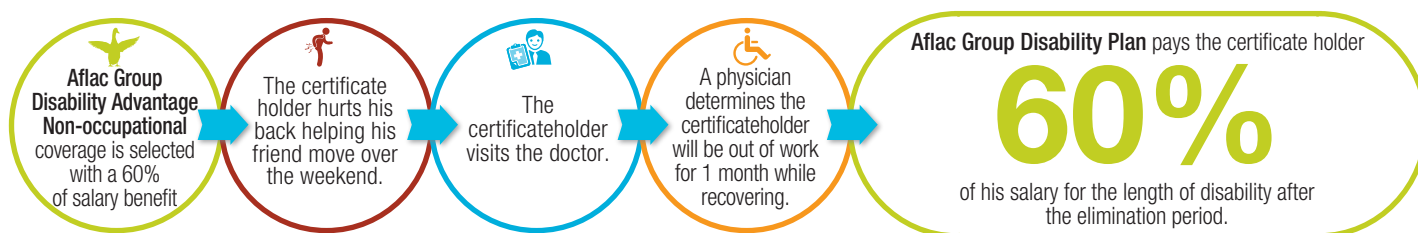
The Aflac group disability plan benefits:

- **Benefits are paid when you are sick or hurt and unable to work, up to 60 percent of your salary (up to 40% in states with state disability).**
- **Minimum and Maximum Total Monthly Benefit – \$300 to \$6,000.**
- **Premium payments are waived after 90 days of total disability (not available on 3 month benefit period).**
- **Partial Disability Benefit.**

Features:

- **Benefits are paid directly to you unless otherwise assigned.**
- **Coverage may be continued. That means you can take it with you if you change jobs (with certain stipulations).**
- **Payroll Deduction – Premiums are paid through convenient payroll deduction.**

How it works



The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

TOTAL DISABILITY

This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. Total disability benefits will be payable monthly once the elimination period has been satisfied.

PARTIAL DISABILITY

The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If you remain partially disabled and are only able to work earning less than 80 percent of your pre-disability income at any job, this plan will still pay you 50 percent of your selected monthly benefit for up to the maximum partial disability benefit period of 3 months after the elimination period. You do not have to have received the Total Disability benefit to receive the Partial Disability benefit.

WAIVER OF PREMIUM

Premiums are waived after 90 days of Total Disability. After Total Disability benefits end, any premiums which become due must be paid in order to keep your insurance in force. This benefit is not available on plans with a 3-month benefit period.

CONTINUATION OF COVERAGE

If you cease employment with your employer, you may elect to continue your coverage. In order to continue your coverage you must meet all of the requirements listed below.

- You must work full-time for another employer.
- You must make a written application and pay the required premium to us within 31 days after the date your insurance would otherwise terminate.
- You must continue to pay any required premiums.

The coverage you may continue is that which you had on the date your employment terminated. If you qualify for this continuation of coverage as described, then the same benefits, plan provisions, and premium rate shown in your certificate as previously issued will apply. Coverage may not be continued if you fail to pay any required premium or if the master policy terminates. Instructions for continuing coverage will be provided within your certificate of coverage.

LIMITATIONS AND EXCLUSIONS

DISABILITY INSURANCE

WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW

If this coverage will replace any existing individual policy please be aware that it may be in your best interest to maintain their individual guaranteed-renewable policy.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for loss caused by Pre-Existing Conditions (except as stated in the provision below).

We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits whenever fraud is committed in making a claim under this coverage.

We will not pay benefits for a Disability that is caused by or occurs as a result of: 1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot; 2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve; 3. An intentionally self-inflicted Injury; 4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated; 5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft; 6. Mental Illness as defined; 7. Alcoholism or drug addiction; 8. An Injury that arises from any employment; 9. Injury or Sickness that is covered by Worker's Compensation.

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the Effective Date. For a condition to have been Pre-existing a Doctor must have advised, diagnosed, or treated the covered employee, or must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment. Treatment or Medical Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

We will not pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability began within the 12-month period after the Effective Date. This limitation does not apply to a loss incurred or a disability beginning after the end of 12 consecutive months, beginning on the insured's effective date of coverage, during which the insured has not received medical advice or treatment in connection with the pre-existing condition.

PREGNANCY LIMITATION

Within the first nine months of the Effective Date of coverage, we will not pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth will be payable. The maximum Period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

TERMS YOU NEED TO KNOW

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Benefit Period is the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of disability. Each new Benefit Period is subject to a new Elimination Period.

Complications of Pregnancy refers to:

Conditions requiring Medical Treatment that comes before or comes after

the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are: 1. Acute nephritis; 2. Nephrosis; 3. Cardiac decompensation; 4. Missed abortion; 5. Disease of the vascular, hemopoietic, nervous, or endocrine systems; and 6. Similar medical and surgical conditions of comparable severity.

Further Complications of Pregnancy include:

1. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement; 2. Ectopic pregnancy that is terminated; and 3. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include the following conditions:

1. Multiple gestation pregnancy; 2. false labor; 3. occasional spotting; and 4. morning sickness.

Complications of pregnancy do not include other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Elective cesarean deliveries are not considered complications of pregnancy.

Effective Date is the date shown on the Certificate Schedule, provided you are actively at work, or if not, it is the date you are actively at work as an eligible employee

Elimination Period is the number of continuous days at the beginning of your Period of Disability for which no benefits are payable. Each new Benefit Period is subject to a new Elimination Period.

Injury refers to a bodily injury not otherwise excluded that is directly caused by a covered accident, is not caused by Sickness, disease, bodily infirmity, or any other cause, and occurs while coverage is in force.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illnesses and Emotional Disorders includes but are not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders or other condition usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Partial Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job. To qualify as Partial Disability, you are able to work at any job earning less than 80 percent of the Annual Income of your Full-Time Job at the time you became disabled.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition that is not caused by an Injury, first manifested and first treated after the Effective Date of coverage, and occurs while coverage is in force.

Termination Coverage will terminate on the earliest of: (1) the date the master policy is terminated, (2) the 31st day after the premium due date if the required premium has not been paid, (3) the date you cease to meet the definition of an employee as defined in the master policy, (4) the date you no longer belong to an eligible class.

Total Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job. To qualify as Total Disability, you may not be working at any job.

You and Your refers to an employee as defined in the Plan.

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

Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center. This brochure is subject to the terms, conditions, and limitations of Policy Form Series C50100.1TX.

Group Short-Term Disability Insurance

Plan Description

The Aflac Group Disability Advantage insurance plan provides for payment of a monthly disability benefit when a covered employee is disabled and unable to work due to an injury or sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit period.

Features and Plan Provisions (specific benefit provisions may vary by situs state)

Benefit Amounts	\$300 to \$4,000
Coverage	Non-Occupational
Guaranteed Issue Amounts	Monthly benefit of up to \$4,000 Participation Requirement: 0%
Requirement for Group Billing	25 Payors
Payment Method	Payroll Deducted
Maximum Income Replacement	60% of the employee's base annual pay (up to 40% in states with state disability benefits)
Pre-existing Condition Exclusion	12/12
Rate Guarantee	1 Year(s)
Portability/Continuation	Standard Portability (An employee's coverage may be continued when eligibility or employment ends. Coverage will end on the date the group plan is terminated.)
Waiver of Premium	Not Included
Eligibility	Employee must work at least 19 hours per week with a base annual pay of at least \$9,000.
Issue Ages	Employee: 18-74
Termination Age	None

Group Short-Term Disability Insurance

Plan Benefits

(Descriptions of specific provisions may vary by state.)

Benefits	
Benefit Duration	3 Months
Elimination Period	14/14 Days

Total Disability Benefit

Total Disability Benefit

This benefit pays the monthly benefit when a covered employee is totally disabled and unable to work due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Total Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, **or**
- The employee earns 80% or more of pre-disability income working at any job, **or**
- The employee reaches the end of the total disability benefit period.

Partial Disability Benefit

This benefit pays 50% of the monthly benefit when a covered employee is partially disabled and returns to work earning less than 80% of base income due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Partial Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, **or**
- The employee earns 80% or more of pre-disability income working at any job, **or**
- The employee reaches the end of the partial disability benefit period, a maximum of 3 months.

The Partial Disability Benefit has its own benefit period; it is **not** subject to the Total Disability Benefit Period. The employee may be eligible for the Partial Disability Benefit even if he has not received the Total Disability Benefit.

Group Short-Term Disability Insurance

Pre-Existing Conditions

Pre-Existing Condition Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the effective date of coverage.

For a condition to have been pre-existing:

- A doctor must have advised, diagnosed, or treated the covered employee, **or**
- Symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability was diagnosed within the 12-month period after the effective date of coverage.

We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12-months after the effective date of coverage.

Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

Please request a sample policy for full benefit descriptions and definitions.

Separate Periods of Disability

Same or Related Conditions

Separate periods of disability resulting from the **same condition or a related condition** are considered a continuation of the prior disability if they are not separated by 180 days or more.

Once the maximum Disability Benefit has been paid, the covered employee will not be eligible for a new Disability Benefit due to the **same or a related condition for 180 days** after **all** the following conditions are met:

- The employee has been released by a doctor from the prior disability.
- The employee is no longer disabled.
- The employee is no longer qualified to receive any disability benefits under the certificate.

After the disability benefit period, the employee may continue coverage if **all** of the following conditions are met:

- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group master policy is still in force upon return to work.

Unrelated Causes

Separate periods of disability resulting from unrelated causes **are** considered a continuation of the prior disability if they are not separated by the covered employee returning to work at a full-time job for **30 consecutive days**, during which the employee is performing the material and substantial duties of that job.

Once the maximum Disability Benefit has been paid, the employee will not be eligible for a new Benefit for disability due to an unrelated cause, until 30 consecutive days after all the following conditions are met:

- The employee has been released by a doctor from a prior disability.
- The employee is no longer qualified to receive any disability benefits under this certificate.

After the disability benefit period, the employee may continue coverage if all of the following conditions are met:

- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group Policy is still in force upon

Group Short-Term Disability Insurance

Monthly Rates per \$100 of monthly benefit

Age Band	18-49	50-64	65-74
Premium Rate	\$1.41	\$1.53	\$1.73

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000 or more	\$300	\$4.24	\$4.59	\$5.19
\$9,000 to \$9,999	\$400	\$5.65	\$6.11	\$6.92
\$10,000 to \$11,999	\$500	\$7.07	\$7.64	\$8.65
\$12,000 to \$13,999	\$600	\$8.48	\$9.17	\$10.38
\$14,000 to \$15,999	\$700	\$9.89	\$10.70	\$12.11
\$16,000 to \$17,999	\$800	\$11.31	\$12.23	\$13.84
\$18,000 to \$19,999	\$900	\$12.72	\$13.76	\$15.57
\$20,000 to \$21,999	\$1,000	\$14.13	\$15.28	\$17.30
\$22,000 to \$23,999	\$1,100	\$15.55	\$16.81	\$19.03
\$24,000 to \$25,999	\$1,200	\$16.96	\$18.34	\$20.76
\$26,000 to \$27,999	\$1,300	\$18.38	\$19.87	\$22.49
\$28,000 to \$29,999	\$1,400	\$19.79	\$21.40	\$24.22
\$30,000 to \$31,999	\$1,500	\$21.20	\$22.93	\$25.95
\$32,000 to \$33,999	\$1,600	\$22.62	\$24.45	\$27.68
\$34,000 to \$35,999	\$1,700	\$24.03	\$25.98	\$29.41
\$36,000 to \$37,999	\$1,800	\$25.44	\$27.51	\$31.14
\$38,000 to \$39,999	\$1,900	\$26.86	\$29.04	\$32.87
\$40,000 to \$41,999	\$2,000	\$28.27	\$30.57	\$34.60
\$42,000 to \$43,999	\$2,100	\$29.68	\$32.10	\$36.33
\$44,000 to \$45,999	\$2,200	\$31.10	\$33.62	\$38.06
\$46,000 to \$47,999	\$2,300	\$32.51	\$35.15	\$39.79
\$48,000 to \$49,999	\$2,400	\$33.92	\$36.68	\$41.52
\$50,000 to \$51,999	\$2,500	\$35.34	\$38.21	\$43.25
\$52,000 to \$53,999	\$2,600	\$36.75	\$39.74	\$44.98
\$54,000 to \$55,999	\$2,700	\$38.16	\$41.27	\$46.71
\$56,000 to \$57,999	\$2,800	\$39.58	\$42.79	\$48.44
\$58,000 to \$59,999	\$2,900	\$40.99	\$44.32	\$50.17
\$60,000 to \$61,999	\$3,000	\$42.40	\$45.85	\$51.90
\$62,000 to \$63,999	\$3,100	\$43.82	\$47.38	\$53.63
\$64,000 to \$65,999	\$3,200	\$45.23	\$48.91	\$55.36
\$66,000 to \$67,999	\$3,300	\$46.64	\$50.44	\$57.09

Group Short-Term Disability Insurance

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$68,000 to \$69,999	\$3,400	\$48.06	\$51.97	\$58.82
\$70,000 to \$71,999	\$3,500	\$49.47	\$53.49	\$60.55
\$72,000 to \$73,999	\$3,600	\$50.89	\$55.02	\$62.28
\$74,000 to \$75,999	\$3,700	\$52.30	\$56.55	\$64.01
\$76,000 to \$77,999	\$3,800	\$53.71	\$58.08	\$65.74
\$78,000 to \$79,999	\$3,900	\$55.13	\$59.61	\$67.47
\$80,000 or more	\$4,000	\$56.54	\$61.14	\$69.20

This proposal has been generated based on the enrollment technology intended to be used. If there is a change to the enrollment technology the proposal may need to be modified based on the capabilities of the new platform.

The rates shown are for proposal purposes only and should not be used to fulfill enrollment. Upon won notification, Aflac will provide Build Requirements with the final rates to the Policy Administrator and their enrollment technology vendor. Rates enrolled other than the final provided will not be honored.

Group Short-Term Disability Insurance

Plan Description

The Aflac Group Disability Advantage insurance plan provides for payment of a monthly disability benefit when a covered employee is disabled and unable to work due to an injury or sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit period.

Features and Plan Provisions (specific benefit provisions may vary by situs state)

Benefit Amounts	\$300 to \$4,000
Coverage	Non-Occupational
Guaranteed Issue Amounts	Monthly benefit of up to \$4,000 Participation Requirement: 0%
Requirement for Group Billing	25 Payors
Payment Method	Payroll Deducted
Maximum Income Replacement	60% of the employee's base annual pay (up to 40% in states with state disability benefits)
Pre-existing Condition Exclusion	12/12
Rate Guarantee	1 Year(s)
Portability/Continuation	Standard Portability (An employee's coverage may be continued when eligibility or employment ends. Coverage will end on the date the group plan is terminated.)
Waiver of Premium	After 90 consecutive days of disability caused by a covered sickness or injury, for as long as he remains disabled, up to the applicable benefit period.
Eligibility	Employee must work at least 19 hours per week with a base annual pay of at least \$9,000.
Issue Ages	Employee: 18-74
Termination Age	None

Group Short-Term Disability Insurance

Plan Benefits

(Descriptions of specific provisions may vary by state.)

Benefits	
Benefit Duration	6 Months
Elimination Period	14/14 Days

Total Disability Benefit

Total Disability Benefit

This benefit pays the monthly benefit when a covered employee is totally disabled and unable to work due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Total Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, **or**
- The employee earns 80% or more of pre-disability income working at any job, **or**
- The employee reaches the end of the total disability benefit period.

Partial Disability Benefit

This benefit pays 50% of the monthly benefit when a covered employee is partially disabled and returns to work earning less than 80% of base income due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Partial Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, **or**
- The employee earns 80% or more of pre-disability income working at any job, **or**
- The employee reaches the end of the partial disability benefit period, a maximum of 3 months.

The Partial Disability Benefit has its own benefit period; it is **not** subject to the Total Disability Benefit Period. The employee may be eligible for the Partial Disability Benefit even if he has not received the Total Disability Benefit.

Group Short-Term Disability Insurance

Pre-Existing Conditions

Pre-Existing Condition Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the effective date of coverage.

For a condition to have been pre-existing:

- A doctor must have advised, diagnosed, or treated the covered employee, **or**
- Symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability was diagnosed within the 12-month period after the effective date of coverage.

We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12-months after the effective date of coverage.

Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

Please request a sample policy for full benefit descriptions and definitions.

Separate Periods of Disability

Same or Related Conditions

Separate periods of disability resulting from the **same condition or a related condition** are considered a continuation of the prior disability if they are not separated by 180 days or more.

Once the maximum Disability Benefit has been paid, the covered employee will not be eligible for a new Disability Benefit due to the **same or a related condition for 180 days** after **all** the following conditions are met:

- The employee has been released by a doctor from the prior disability.
- The employee is no longer disabled.
- The employee is no longer qualified to receive any disability benefits under the certificate.

After the disability benefit period, the employee may continue coverage if **all** of the following conditions are met:

- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group master policy is still in force upon return to work.

Unrelated Causes

Separate periods of disability resulting from unrelated causes **are** considered a continuation of the prior disability if they are not separated by the covered employee returning to work at a full-time job for **30 consecutive days**, during which the employee is performing the material and substantial duties of that job.

Once the maximum Disability Benefit has been paid, the employee will not be eligible for a new Benefit for disability due to an unrelated cause, until 30 consecutive days after all the following conditions are met:

- The employee has been released by a doctor from a prior disability.
- The employee is no longer qualified to receive any disability benefits under this certificate.

After the disability benefit period, the employee may continue coverage if all of the following conditions are met:

- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group Policy is still in force upon

Group Short-Term Disability Insurance

Monthly Rates per \$100 of monthly benefit

Age Band	18-49	50-64	65-74
Premium Rate	\$2.05	\$2.35	\$2.93

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000 or more	\$300	\$6.16	\$7.04	\$8.80
\$9,000 to \$9,999	\$400	\$8.21	\$9.39	\$11.73
\$10,000 to \$11,999	\$500	\$10.27	\$11.73	\$14.67
\$12,000 to \$13,999	\$600	\$12.32	\$14.08	\$17.60
\$14,000 to \$15,999	\$700	\$14.38	\$16.43	\$20.53
\$16,000 to \$17,999	\$800	\$16.43	\$18.77	\$23.47
\$18,000 to \$19,999	\$900	\$18.48	\$21.12	\$26.40
\$20,000 to \$21,999	\$1,000	\$20.54	\$23.47	\$29.33
\$22,000 to \$23,999	\$1,100	\$22.59	\$25.81	\$32.26
\$24,000 to \$25,999	\$1,200	\$24.64	\$28.16	\$35.20
\$26,000 to \$27,999	\$1,300	\$26.70	\$30.50	\$38.13
\$28,000 to \$29,999	\$1,400	\$28.75	\$32.85	\$41.06
\$30,000 to \$31,999	\$1,500	\$30.80	\$35.20	\$44.00
\$32,000 to \$33,999	\$1,600	\$32.86	\$37.54	\$46.93
\$34,000 to \$35,999	\$1,700	\$34.91	\$39.89	\$49.86
\$36,000 to \$37,999	\$1,800	\$36.96	\$42.24	\$52.80
\$38,000 to \$39,999	\$1,900	\$39.02	\$44.58	\$55.73
\$40,000 to \$41,999	\$2,000	\$41.07	\$46.93	\$58.66
\$42,000 to \$43,999	\$2,100	\$43.13	\$49.28	\$61.60
\$44,000 to \$45,999	\$2,200	\$45.18	\$51.62	\$64.53
\$46,000 to \$47,999	\$2,300	\$47.23	\$53.97	\$67.46
\$48,000 to \$49,999	\$2,400	\$49.29	\$56.32	\$70.40
\$50,000 to \$51,999	\$2,500	\$51.34	\$58.66	\$73.33
\$52,000 to \$53,999	\$2,600	\$53.39	\$61.01	\$76.26
\$54,000 to \$55,999	\$2,700	\$55.45	\$63.36	\$79.19
\$56,000 to \$57,999	\$2,800	\$57.50	\$65.70	\$82.13
\$58,000 to \$59,999	\$2,900	\$59.55	\$68.05	\$85.06
\$60,000 to \$61,999	\$3,000	\$61.61	\$70.40	\$87.99
\$62,000 to \$63,999	\$3,100	\$63.66	\$72.74	\$90.93
\$64,000 to \$65,999	\$3,200	\$65.71	\$75.09	\$93.86
\$66,000 to \$67,999	\$3,300	\$67.77	\$77.43	\$96.79

Group Short-Term Disability Insurance

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$68,000 to \$69,999	\$3,400	\$69.82	\$79.78	\$99.73
\$70,000 to \$71,999	\$3,500	\$71.88	\$82.13	\$102.66
\$72,000 to \$73,999	\$3,600	\$73.93	\$84.47	\$105.59
\$74,000 to \$75,999	\$3,700	\$75.98	\$86.82	\$108.53
\$76,000 to \$77,999	\$3,800	\$78.04	\$89.17	\$111.46
\$78,000 to \$79,999	\$3,900	\$80.09	\$91.51	\$114.39
\$80,000 or more	\$4,000	\$82.14	\$93.86	\$117.33

This proposal has been generated based on the enrollment technology intended to be used. If there is a change to the enrollment technology the proposal may need to be modified based on the capabilities of the new platform.

The rates shown are for proposal purposes only and should not be used to fulfill enrollment. Upon won notification, Aflac will provide Build Requirements with the final rates to the Policy Administrator and their enrollment technology vendor. Rates enrolled other than the final provided will not be honored.

Group Short-Term Disability Insurance

Exclusions and Limitations

We will pay all applicable benefits if the covered employee's disability is caused by a covered sickness or covered injury and if it occurs while this coverage is in force. All benefits are subject to the limitations and exclusions, pre-existing condition limitations, and other plan terms.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one sickness, more than one injury, or a sickness and an injury. We reserve the right to meet with the covered employee while a claim is pending, or to use an independent consultant and doctor's statement to determine whether the covered employee is qualified to receive disability benefits.

The covered employee must be under the care and attendance of a doctor for these benefits to be payable. Benefits will cease on the date of the covered employee's death.

Limitations and Exclusions

- A. We will not pay benefits whenever coverage provided by this plan is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.**
- In Tennessee: this exclusion does not apply
- B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.**
- In Texas: We will not pay benefits whenever fraud is committed in making a claim under this coverage.
- C. We will not pay benefits for disability that is caused by or occurs as a result of:**
- 1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.**
 - In Connecticut: Participation (taking part or sharing) in aggressive conflict of any kind, including any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot (A riot can be defined as a public uproar, disturbance, or outbreak)
 - In Florida: add, War does not include acts of terrorism
 - In Maryland: this exclusion does not apply
 - In North Carolina: Any act of war, declared or undeclared; insurrection; rebellion; or act of active participation in a riot; this does not include terrorism.
 - In Utah: Any act of war, declared or undeclared; voluntary participation in an insurrection or rebellion; or voluntary act of participation in a riot.
 - In Oklahoma: Any act of war, declared or undeclared; while serving in the military: insurrection; rebellion; or act of active participation in a riot.
 - 2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.**
 - 3. An intentionally self-inflicted injury.**
 - 4. A commission of a crime for which the Employee has been convicted; we will not pay a benefit for any period of disability during which the Employee is incarcerated.**
 - In Maryland: Loss to which a contributing cause was the insured's commission of or attempt to commit a felony; and we will not pay a benefit for any period of disability during which the insured is incarcerated.
 - In Nebraska: Commission of or attempt to commit a felony.
 - 5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.**
 - In New Hampshire: Aviation, except as a fare paying passenger in a licensed passenger aircraft
 - 6. Mental illness as defined in the plan.**
 - In California: this exclusion does not apply
 - In Montana: this exclusion does not apply
 - In Vermont: this exclusion does not apply
 - 7. Alcoholism or drug addiction**
 - In California: this exclusion does not apply
 - In Connecticut: Being legally intoxicated or voluntarily using any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his physician for the insured. (Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
 - In Maryland: The insured's being intoxicated or under the influence of any narcotic.
 - In Michigan: This exclusion does not apply

Group Short-Term Disability Insurance

- In Minnesota: Loss occurred while the insured is driving or operating a motor vehicle and is determined to have a blood alcohol level exceeding the legal limit as defined by state law; and loss sustained or contracted in consequence of the insured being under the influence of any narcotic unless administered on the advice of a physician.
- In South Dakota: Treatment of alcoholism or drug addiction, or complications due to an addiction
- In Vermont: this exclusion does not apply.

For off-job coverage, the following limitations and exclusions will apply:

8. An injury that arises from any employment.

- In California: this exclusion does not apply
- In South Dakota: An injury arising from any employment. (An injury which occurs on the job that is denied Workers' Compensation benefits for any reason permissible by Title 58 of South Dakota's Insurance Related Law is not considered to be an "injury arising from any employment.")

9. Injury or sickness that is covered by Worker's Compensation.

- In California: An Injury or Sickness that is covered by Worker's Compensation or that arises from any employment as determined by the California Workers Compensation Appeals Board
- In North Carolina: Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- In South Dakota: Injury or Sickness paid by Worker's Compensation.

Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the effective date of coverage.

- In Georgia: Pre-existing Condition is the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within 12 months preceding the effective date of coverage of the insured.
- In Indiana: Pre-existing Condition is a disease or physical condition of the insured that existed within the 12-month period before the insured's effective date.
- In Massachusetts: 6 month-period
- In New Mexico: 6 month-period
- In North Carolina: Pre-existing Condition is a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 12-month period immediately preceding the effective date of coverage of the insured person.
- In North Dakota: Pre-existing Condition is a disease or physical condition that existed within the 12-month period before the insured's effective date.
- In Pennsylvania: 90-day period
- In Utah: Pre-existing Condition refers to the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12-month period preceding the insured's effective date, or a condition for which medical advice or treatment was recommended by or received from a physician within the 12-month period before the insured's effective date.
- In New Jersey: Added the following language: (1) immediately prior to becoming covered under this group policy, the insured was enrolled as a member under another group disability income policy issued by us; and (2) benefits were paid by us for the condition under the group disability income policy under which the insured was previously insured.

For a condition to have been pre-existing, a doctor must have advised, diagnosed, or treated the covered employee, or symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

- In Georgia: this statement does not apply
- In Montana: For a condition to have been pre-existing, a doctor must have advised, diagnosed, or treated the insured.
- In North Carolina: this statement does not apply
- In North Dakota: For a condition to have been pre-existing, medical advice or treatment must have been received by the insured during the 12 months before the effective date of coverage.
- In Texas: For a condition to have been pre-existing, a doctor must have advised, diagnosed, or treated the insured, or it must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment.
- In Utah: this statement does not apply
- In New Jersey: the following does not apply, "or symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment".

We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability was diagnosed within the 12-month period after the effective date of coverage.

- In Massachusetts: 6 month-period

Group Short-Term Disability Insurance

- In New Mexico: 6 month-period
- In South Dakota: We will not pay benefits for any disability resulting from or affected by a pre-existing condition during the 12-month period after the insured's effective date.
- In Texas: We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability began within the 12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12 months after the effective date of coverage.

- In Maryland: Added the following statements: An illness, disease, infection, disorder, or injury will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date. The Pre-existing Condition Limitation does not apply to a condition the insured revealed in the application for coverage, unless the condition was excluded by a signed waiver rider attached to the certificate.
- In New Mexico: 6 months
- In North Carolina: Added the following statement: If the prospective insured's medical history is not obtained in the application process, the insurer may not deny a claim for disabilities that commence more than 24 months after the effective date of coverage on the grounds the disability is caused by a pre-existing condition.
- In South Dakota: We will not reduce or deny a claim for benefits for any disability that was incurred more than 12 months following the insured's effective date due to a pre-existing condition.
- In Texas: This limitation does not apply to a loss incurred or a disability beginning after the end of 12 consecutive months, beginning on the insured's effective date of coverage, during which the insured has not received medical advice or treatment in connection with the pre-existing condition.

Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

- In Kansas: Replaced first sentence with: We will not pay benefits for a disability that is caused by, or occurs as a result of, the insured's pregnancy or childbirth if conception was prior to the effective date of coverage.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

- In Idaho: The pregnancy limitation does not apply
- In Kansas: Replaced first sentence with: Disability benefits for complications of pregnancy where conception was after the effective date of coverage, will be payable.
- In Maryland: Added the following statement: The pregnancy limitation does not apply to a condition revealed in the application for coverage, unless the condition was excluded by a signed waiver rider attached to the contract.
- In Montana: The pregnancy limitation does not apply.
- In New Hampshire: The pregnancy limitation does apply.

Group Short-Term Disability Insurance

Notices

This proposal is a brief description of coverage, not a contract. Read your policy and riders (as applicable) carefully for exact plan language, terms, and conditions.

If this coverage will replace any existing individual policy, please be aware that it may be in your employees' best interest to maintain their individual guaranteed-renewable policy.

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

For Texas: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

For Wyoming: The Policy does not contain comprehensive adult wellness benefits as defined by law.

Group Accident Insurance



How does it work?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

Accident Insurance can pay you money for covered accidental injuries and their treatment.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

Since our founding in 1848, Unum has been a leader in the employee benefits business.

Innovation, integrity and an unwavering commitment to our customers has helped us become a global leader in financial protection benefits.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

How much does it cost?

Your monthly premium	Option 1
You	\$9.94
You and your spouse	\$17.65
You and your children	\$30.44
Family	\$38.15

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	\$50,000
Spouse	\$25,000
Children	\$12,500
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	\$50,000
Spouse	\$25,000
Children	\$12,500
Dismemberment	
Both Feet	\$50,000
Both Hands	\$50,000
One Foot	\$25,000
One Hand	\$25,000
Thumb and Index Finger of the same Hand	\$12,500
Coma	
Coma	\$10,000
Loss of Use	
Hearing	\$12,500
Sight of one Eye	\$25,000
Sight of both Eyes	\$50,000
Speech	\$25,000
Paralysis	
Uniplegia	\$12,500
Hemi/Paraplegia	\$25,000
Triplegia	\$37,500
Quadriplegia	\$50,000

Hospitalization

Admission	\$1,500
Admission – Hospital ICU (added to Admission)	\$1,500
Daily Stay (365 days)	\$300
Daily Stay – Hospital ICU (added to Daily Stay)	\$600
Short Stay	\$200

Injury

Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	\$500
2nd Degree Burns - 20% or greater of skin surface	\$1,000
3rd Degree Burns - Less than 5% of skin surface	\$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	\$5,000

Injury

3rd Degree Burns - 20% or greater of skin surface	\$10,000
Concussion	
Concussion	\$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	\$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	\$150
Dislocations	
Knee joint (other than patella)	\$1,650
Ankle bone or bones of the foot (other than toes)	\$2,000
Hip joint	\$3,375
Collarbone (sternoclavicular)	\$825
Elbow joint	\$500
Hand (other than Fingers)	\$500
Lower jaw	\$500
Shoulder	\$600
Wrist joint	\$600
Collarbone (acromioclavicular and separation)	\$325
Finger or Toe (Digit)	\$150
Kneecap (patella)	\$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	\$200
Fractures	
Skull (except bones of Face or Nose), Depressed	\$4,500
Hip or Thigh (femur)	\$3,375
Skull (except bones of Face or Nose), Non-depressed	\$2,250
Vertebrae, body of (other than Vertebral Processes)	\$1,350
Leg (mid to upper tibia or fibula)	\$1,650
Pelvis	\$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	\$675
Upper Arm between Elbow and Shoulder (humerus)	\$675
Upper Jaw, Maxilla (other than alveolar process)	\$675
Ankle (lower tibia or fibula)	\$550

Injury

Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	\$550
Foot or Heel (other than Toes)	\$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	\$550
Kneecap (patella)	\$450
Lower Jaw, Mandible (other than alveolar process)	\$450
Vertebral Processes	\$450
Rib	\$450
Tailbone (coccyx), Sacrum	\$450
Finger or Toe (Digit)	\$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	\$200
Lacerations	
No Repair	\$50
Repair Less than 2 inches	\$150
Repair At least 2 inches but less than 6 inches	\$300
Repair 6 inches or greater	\$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	\$750
One Digit (a Thumb or Big Toe)	\$1,125
Two or more Digits	\$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	\$150
Ruptured or Herniated Disc	
One Disc	\$180
Two or more Discs	\$300
Recovery	
Acquired Brain Injury	\$25
At-Home Care	\$100
Physician Follow-Up Visits	\$75
Physician Follow-Up Maximum Visits	2
Prescription Benefit Incidence per covered accident	N/A
Rehabilitation or Subacute Rehabilitation Unit	\$100
Telehealth Service	\$25
Telemedicine Medical Service	\$25

SCHEDULE OF BENEFITS

Recovery

Therapy Services (chiro, speech, PT, occ)	\$25
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Therapy Services Maximum Days	15
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Surgery

Dislocations	
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Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
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Anesthesia	
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Epidural or Regional Anesthesia	\$100
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General Anesthesia	\$250
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Connective Tissue	
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Exploratory without Repair	\$100
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Repair for One Connective Tissue	\$800
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Repair for Two or more Connective Tissues	\$1,200
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Eye Surgery	
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Eye Surgery, Requiring Anesthesia	\$300
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Fractures	
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Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
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Surgical Repair same bone maximum incurred per accident	1 Fracture
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Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
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General Surgery	
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Abdominal, Thoracic, or Cranial	\$1,500
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Exploratory	\$150
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Incidence per covered accident	1 Per Insured
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Hernia Surgery	
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Hernia Surgery	\$150
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Knee Cartilage	
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Knee Cartilage (Meniscus) Exploratory without Repair	\$150
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Knee Cartilage (Meniscus) with Repair	\$750
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Outpatient Surgical Facility	
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Outpatient Surgical Facility	\$300
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Ruptured or Herniated Disc Surgery	
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Exploratory without Repair	\$125
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One Disc	\$675
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Two or more Discs	\$1,000
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Treatment

Ambulance	
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Treatment

Air	\$1,500
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Ground	\$300
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Durable Medical Equipment	
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Tier 1 (arm sling, cane, medical ring cushion)	\$50
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Tier 2 (bedside commode, cold therapy system, crutches)	\$100
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Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	\$200
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Emergency Dental Repair	
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Dental Crown	\$350
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Dental Extraction	\$115
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Filling or Chip Repair	\$90
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Imaging	
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Tier 1: X-rays or Ultrasound	\$50
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Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	\$100
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Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
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Lodging	
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Lodging (per night)	\$150
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Prosthetic Device	
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One Device or Limb	\$750
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Two or more Devices or Limbs	\$1,500
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Skin Grafts	
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For Burns - Payable as a % of the applicable Burn benefit	50%
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Not Burns - Less than 20% of skin surface	\$250
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Not Burns - 20% or greater of skin surface	\$500
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Treatment	
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Emergency Room Treatment	\$200
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Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	\$50
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Pain Management Injections (epidural, cortisone, steroid)	\$100
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Transfusions	\$400
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Transportation (per trip)	\$100
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Treatment in a Physician's Office or Urgent Care Facility (initial)	\$125
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Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 31 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at

<https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as the result any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undecared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of trauma, infection, or other diseases;
- an occupational injury;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- Infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;#practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
 - voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, intoxicant, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician
- Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of Coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:

- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue

- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

THIS IS A LIMITED BENEFITS POLICY

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to certificate form GAC16-1 et al. and GAC16-2 and Policy Form GAP16-1 et al. in all states or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

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El Seguro de Accidentes



¿Cómo funciona?

El Seguro de Accidentes provee un pago de beneficio fijo basado en el tipo de lesión sufrida o el tipo de tratamiento que necesite. Cubre los accidentes que sucedan fuera del trabajo. Además, incluye una variedad de incidentes, desde lesiones comunes hasta eventos más graves.

¿Por qué es tan valiosa esta cobertura?

Puede ayudarle con los gastos por cuenta propia que no cubra su plan médico, tales como los copagos y deducibles. Se le garantiza recibir cobertura base, sin tener que responder un cuestionario médico. El costo se paga mediante cómodas deducciones de su cheque de sueldo. Puede conservar su cobertura si cambia de trabajo o se jubila. Se le facturará directamente a usted.

¿Quién puede obtener esta cobertura?

Usted	Si tiene una relación laboral activa*
Su cónyuge	Los cónyuges pueden obtener cobertura siempre que usted haya comprado la cobertura para usted mismo.
Sus hijos	Hijos dependientes desde su nacimiento hasta los 26 años independientemente de su estado civil o de que sean o no estudiantes.

*Los empleados deben estar legalmente autorizados para trabajar en los Estados Unidos y estar trabajando activamente en un establecimiento en los Estados Unidos para recibir cobertura. Consulte el Programa de beneficios para obtener una lista completa de lo que está cubierto.

¿Cuánto costará?

Su prima mensual	Opción 1
Usted	\$9.94
Usted y su cónyuge	\$17.65
Usted y sus hijos	\$30.44
Familia	\$38.15

El Seguro de Accidentes puede pagarle dinero por las lesiones accidentales cubiertas y su tratamiento.



Desde nuestra fundación en 1848, Unum ha sido líder en los beneficios empresariales para los empleados.

La innovación, la integridad y un compromiso inquebrantable con nuestros clientes nos han ayudado a convertirnos en un líder mundial en beneficios de protección financiera.

Muerte Accidental y Desmembramiento

AD&D	
Empleado	\$50,000
Cónyuge	\$25,000
Hijos	\$12,500

Transporte público
El beneficio se paga si la persona asegurada sufre una lesión al ser un pasajero que paga un pasaje en un transporte público (p. ej., trenes, colectivos y aviones de transporte masivo)

Empleado	\$50,000
Cónyuge	\$25,000
Hijos	\$12,500

Desmembramiento

Ambos pies	\$50,000
Ambas manos	\$50,000
Un pie	\$25,000
Una mano	\$25,000
Pulgar y dedo índice de la misma mano	\$12,500

Coma	
Coma	\$10,000

Pérdida de uso	
Audición	\$12,500

Vista de un ojo	\$25,000
Vista de ambos ojos	\$50,000

Habla	\$25,000
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Parálisis	
Monoplejía	\$12,500

Paraplejía/hemiplejía	\$25,000
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Triplejía	\$37,500
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Cuadriplejía	\$50,000
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Hospitalización

Ingreso	\$1,500
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Ingreso: UCI del Hospital (añadido a la admisión)	\$1,500
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Estadía diaria (365 días)	\$300
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Estadía diaria: UCI del Hospital (añadido a Estancia Diaria)	\$600
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Estadía breve	\$200
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Lesión

Quemaduras de tercer grado: un 5% como mínimo, pero menos del 20% de la superficie de la piel	\$5,000
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Quemaduras de tercer grado: un 20% o más de la superficie de la piel	\$10,000
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Concusión	
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Concusión	\$200
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Daño en tejido conectivo	
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Un tejido conectivo (tendón, ligamento, manguito rotador, músculo)	\$90
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Dos o más tejidos conectivos (tendón, ligamento, manguito rotador, músculo)	\$150
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Dislocaciones	
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Articulación de la rodilla (excepto la rótula)	\$1,650
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Hueso del tobillo o huesos del pie (excepto los dedos)	\$2,000
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Articulación de la cadera	\$3,375
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Clavícula (esternoclavicular)	\$825
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Articulación del codo	\$500
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Mano (excepto los dedos)	\$500
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Mandíbula inferior	\$500
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Hombro	\$600
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Articulación de la muñeca	\$600
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Clavícula (acromioclavícula y separación)	\$325
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Dedo de la mano o el pie	\$150
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Rótula	\$500
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Dislocación incompleta: pagadero como un % del beneficio de dislocación aplicable	25%
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Lesión ocular	
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Lesión ocular	\$200
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Fracturas	
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Cráneo (excepto huesos del rostro o la nariz), deprimido	\$4,500
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Cadera o muslo (fémur)	\$3,375
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Cráneo (excepto huesos del rostro o la nariz), no deprimido	\$2,250
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Vértebra, cuerpo de (excepto procesos vertebrales)	\$1,350
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Pierna (mitad a parte superior de tibia o peroné)	\$1,650
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Pelvis	\$1,350
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Huesos del rostro o la nariz (excepto mandíbula inferior, mandíbula superior)	\$675
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Lesión

Parte superior del brazo entre el codo y el hombro (húmero)	\$675
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Mandíbula superior (excepto proceso alveolar)	\$675
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Tobillo (parte inferior de la tibia o peroné)	\$550
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Clavícula (clavícula y esternón) u omóplato (escápula)	\$550
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Pie o talón (excepto los dedos del pie)	\$450
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Antebrazo (olécranon, radio, o cúbito), mano, o muñeca (excepto los dedos de la mano)	\$550
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Rótula	\$450
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Mandíbula inferior (excepto proceso alveolar)	\$450
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Procesos vertebrales	\$450
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Costilla	\$450
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Cóxis, sacro	\$450
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Dedo de la mano o el pie	\$225
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Fractura conminuta: pagadero como un % del beneficio de fracturas aplicable	25%
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Mismo máximo por huesos incurrido por accidente	1 Fractura
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Multiplicador pagadero máximo por huesos múltiples	2 Veces
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Lesiones internas	
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Lesiones internas	\$200
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Laceraciones	
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Sin reparación	\$50
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Reparación de menos de 2 pulgadas	\$150
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Reparación de entre 2 pulgadas y 6 pulgadas	\$300
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Reparación de 6 pulgadas o más	\$600
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Pérdida de un dedo	
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Un dedo (que no sea un pulgar o dedo gordo)	\$750
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Un dedo (un pulgar o dedo gordo)	\$1,125
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Dos o más dedos	\$1,500
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Cartilago de la rodilla	
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Lesión en el cartilago de la rodilla (menisco)	\$150
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Ruptura o hernia de disco	
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Un disco	\$180
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Dos o más discos	\$300
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Recuperación

Visitas máximas de seguimiento del médico	2
Incidencia de beneficio de recetas por accidente cubierto	N/D
Unidad de rehabilitación o rehabilitación de subagudos	\$100
Servicio de telesalud	\$25
Servicio Médico de Telemedicina	\$25
Servicios terapéuticos (quiropática, habla, kinesiología)	\$25
Días máximos de servicios terapéuticos	15

Cirugía

Dislocaciones	
Dislocación, reparación quirúrgica: pagadero como un % del beneficio de lesión aplicable	100%
Anestesia	
Anestesia	\$100
Anestesia general	\$250
Tejido conectivo	
Exploración sin reparación	\$100
Reparación de un tejido conectivo	\$800
Reparación de dos o más tejidos conectivos	\$1,200
Cirugía ocular	
Cirugía ocular que requiera anestesia	\$300
Fracturas	
Fracturas, reparación quirúrgica: pagadero como un % del beneficio de lesión aplicable	100%
Reparación quirúrgica del mismo máximo por huesos incurrido por accidente	1 Fractura
Reparación quirúrgica multiplicadores máximos pagables para múltiples huesos	2 Veces
Cirugía general	
Abdominal, torácica o craneal	\$1,500
Exploratoria	\$150
Incidencia por accidente cubierto	1 Por Asegurado
Cirugía de hernia	
Cirugía de hernia	\$150
Cartílago de la rodilla	
Cartílago de la rodilla (menisco) - exploratoria sin reparación	\$150
Cartílago de la rodilla (menisco) - con reparación	\$750

Cirugía

Instalación quirúrgica ambulatoria	
Instalación quirúrgica ambulatoria	\$300
Cirugía de ruptura o hernia de disco	
Exploración sin reparación	\$125
Un disco	\$675
Dos o más discos	\$1,000

Tratamiento

Ambulancia	
Aérea	\$1,500
Terrestre	\$300
Equipo médico duradero	
Nivel 1 (cabestrillo, bastón, cojín médico en forma de anillo)	\$50
Nivel 2 (cajonera junto a la cama, sistema de terapia fría, muletas)	\$100
Nivel 3 (corset lumbar, corset ortopédico, movimiento pasivo continuo, carrito eléctrico)	\$200
Reparación odontológica de emergencia	
Corona dental	\$350
Extracción dental	\$115
Relleno o reparación de diente astillado	\$90
Imágenes	
Nivel 1: Radiografías o ultrasonido	\$50
Nivel 2: Escaneo Óseo, TAC, TC, EEG, RM, ARM, IRM	\$100
Asignación por incidencia de imágenes médicas cubiertas por accidente por nivel	1 Por Asegurado Por Nivel
Hospedaje	
Hospedaje (por noche)	\$150
Dispositivo prostético	
Un dispositivo o una extremidad	\$750
Dos o más dispositivos o extremidades	\$1,500
Injertos de piel	
Por quemaduras: pagadero como un % del beneficio de quemaduras aplicable	50%
No por quemaduras: menos de un 20% de la superficie de la piel	\$250
No por quemaduras: un 20% o más de la superficie de la piel	\$500
Tratamiento	
Tratamiento en Urgencias	\$200

Tratamiento

Inyección para prevenir o limitar infecciones (tétano, rabia, antisuero, inmunoglobulina)	\$50
Inyección para el manejo del dolor (epidural, cortisona, esteroide)	\$100
Transfusiones	\$400
Transporte (por viaje)	\$100
Tratamiento en el consultorio de un médico o instalación de urgencias (inicial)	\$125

Relación laboral activa

Se considera que tiene una relación laboral activa si, el día en que solicita la cobertura, recibe un pago regular por el mínimo requerido de 30 horas cada semana y realiza las tareas materiales y sustanciales de su ocupación regular. La cobertura del seguro se retrasará si no forma parte de una relación laboral activa debido a una lesión, una enfermedad, un despido temporario o una licencia en la fecha en que hubiera entrado en efecto el seguro. Los nuevos empleados tienen un período de gracia de 31 día/días para ser elegibles para recibir la cobertura. Comuníquese con el administrador de su plan para confirmar su fecha de elegibilidad.

Si se inscribe, y es elegible para recibir Medicare (tiene más de 65 años o es discapacitado), la Guía sobre Seguro Médico para Personas con Medicare está disponible en <https://es.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>

Fecha de vigencia de la cobertura

La cobertura entra en vigencia el primer día del mes en que comiencen las deducciones del cheque de nómina.

Exclusiones y limitaciones

No pagaremos beneficios por un reclamo que suceda como resultado de lo siguiente, o por causa de esto, o para el cual lo siguiente haya contribuido:

- cometer o intentar cometer un crimen;
- participar de una actividad u ocupación ilegal;
- lesionarse de manera intencional o intentar o cometer suicidio, se esté o no sano;
- participación activa en un motín, una rebelión o actividad terrorista. Esto no incluye conmociones o desórdenes civiles, lesión por ser un transeúnte inocente o lesión por defensa propia;
- participar en una guerra o cualquier acto de guerra, ya sea declarado o no declarado;
- combatir o entrenar para combate mientras se es parte de las fuerzas armadas de cualquier nación o autoridad, incluida la Guardia Nacional u organizaciones gubernamentales similares;
- una Pérdida Cubierta que sucede mientras un Asegurado es encarcelado legalmente en una institución penal o correccional;
- procedimientos electivos, cirugías cosméticas o reconstructivas, a menos que sean el resultado de una lesión traumática, una infección u otra enfermedad;
- una lesión ocupacional;
- cualquier enfermedad, dolencia corporal u otra enfermedad física anormal, o enfermedad mental o nerviosa, incluidos el diagnóstico, el tratamiento o la cirugía correspondiente;
- Infección. Esta exclusión no aplica cuando la infección se debe directamente a un corte o a una herida sufrida en un Accidente Cubierto
- procedimientos experimentales o de investigación
- operar cualquier vehículo motorizado mientras se está embriagado
- operar, aprender a operar, desempeñarse como miembro del personal de una aeronave o un globo aerostático, incluidos los que no son a motor, a menos que se viaje como pasajero habiendo pagado un pasaje;
- saltar, tirarse en paracaídas o caerse de una aeronave o un globo aerostático, incluidos los que no son a motor;
- viajar o volar en una aeronave o un globo aerostático, incluidos los que no son a motor, si se está usando para pruebas o con fines experimentales, en relación con una autoridad militar, o para viajes más allá de la atmósfera de la tierra;
- practicar para una competencia atlética competitiva profesional o semiprofesional, o entrenar para esta, por la cual se reciba una remuneración o compensación;
- usar o conducir un vehículo aéreo, terrestre o acuático en una carrera o concurso de velocidad o resistencia; y
- participar de ala delta, bungee jumping, planeador de vela, paravela, parapente o salto desde una base.

Los Beneficios por Muerte Accidental y Desmembramiento también están sujetos a las siguientes exclusiones. No pagaremos beneficios por un reclamo que suceda como resultado de lo siguiente, o por causa de esto, o para el cual lo siguiente haya contribuido:

- estar embriagado; y
- uso voluntario o tratamiento por uso voluntario de cualquier fármaco con receta o de venta libre, alcohol, veneno, gas u otra sustancia química a menos que se tome según receta o indicación del Médico del Asegurado.

Asimismo, no se pagará ningún beneficio por una Pérdida Cubierta que ocurra antes de la Fecha Efectiva de la Cobertura.

Fin de la cobertura

Si elige cancelar su cobertura en relación con este certificado, esta finalizará el primer día del mes siguiente en el que le haya proporcionado la notificación a su Empleador. De lo contrario, su cobertura en relación con este certificado finaliza según lo que suceda primero de lo siguiente:

- la fecha en que Unum o su empleador cancele esta póliza;
- la fecha en que deje de pertenecer a un grupo elegible;
- la fecha en que su grupo elegible ya no recaiga dentro de la cobertura;
- la fecha de su muerte;
- el último día del período en que se realiza cualquier contribución de prima requerida;
- el último día de relación laboral activa. No obstante, siempre y cuando la prima se pague como corresponde, la cobertura continuará
- de acuerdo con la disposición Continuación de su Cobertura durante Ausencias; o
- si elige continuar su cobertura para usted, su cónyuge e hijos de acuerdo con la Portabilidad de Seguro de Accidentes. Proporcionaremos cobertura para una Solicitud Pagadera que ocurra mientras esté cubierto por este certificado

ESTO ES UNA PÓLIZA DE BENEFICIOS LIMITADOS

Esta cobertura es un complemento del seguro médico. Esta cobertura es un complemento del seguro de salud. No es un sustituto de los beneficios de salud esenciales o la cobertura esencial mínima según lo definido en la ley federal. Los asegurados en algunos estados deben estar cubiertos por un seguro médico

integral antes de solicitar esta cobertura.

Esta información no tiene la finalidad de describir completamente la cobertura de seguro disponible. Es posible que la póliza o sus provisiones varíen o no estén disponibles en algunos estados. La póliza tiene exclusiones y limitaciones que pueden afectar cualquiera de los beneficios pagaderos. Para conocer los detalles completos de la cobertura y su disponibilidad, consulte el formulario de certificado GAC16-1 et al. and GAC16-2 e formulario de póliza GAP16-1 et al. en todos los estados o comuníquese con su representante de Unum.

Unum cumple con todas las leyes estatales de unión civil de parejas y de parejas de hecho cuando sean aplicables.

Suscrito por: Unum Insurance Company, Portland, Maine

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How to file a claim for Unum benefits

When life gets complicated, we make it simple to access the benefits you need.

Don't worry, we've got you.



Use your MyUnum for Members online account for fastest results!



Register for an account at unum.com/access

- View benefits and file claims
- Upload documents and add/update medical providers
- Update your profile & communication preferences
- View status and payment information



Get the MyUnum for Members mobile app

- Enjoy the convenience of your online account on-the-go by downloading from the applicable app store*
- Easily submit photos of required documents directly from the app

Only your employer can electronically file, or check the status of a Term Life or Accidental Death & Dismemberment (AD&D) claim.

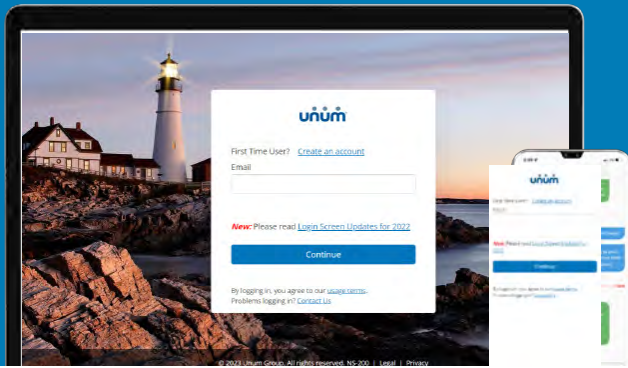
Experience the benefits of filing and managing your claim online

The same tools in your online account are available in the app—giving you a flexible, efficient and transparent experience. You can:

- ✓ Complete one easy-to-use guided form, and we'll check it for completeness *before you submit*—helping minimize delays
- ✓ Choose direct deposit and get approved payments up to a week faster than check
- ✓ Log in to view status 24/7
- ✓ Opt in to receive updates and requests through email or text instead of snail mail
- ✓ Upload required documents any time—even using your phone's camera!
- ✓ Access your policy documents and year-end tax forms



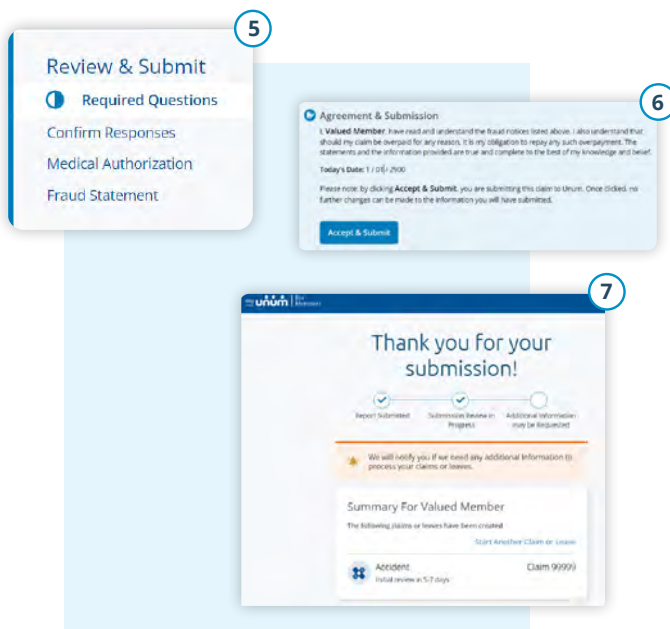
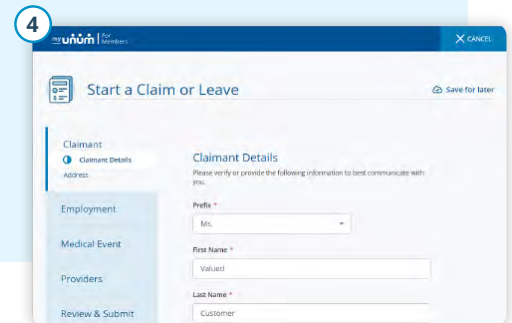
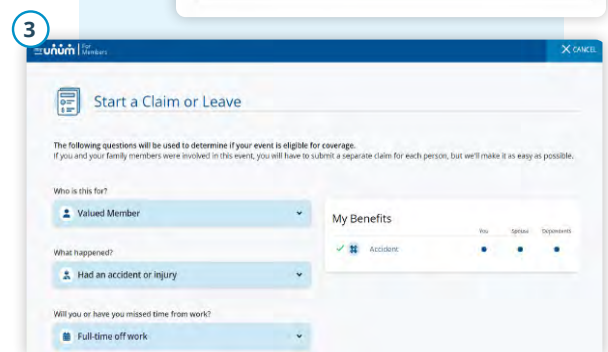
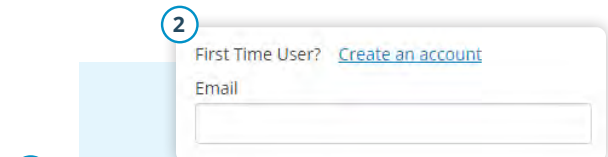
unum.com/access



Instructions for filing your claim

On the web

1. Go to unum.com/access.
2. a. If filing for the first time, click "Create an account." We recommend using a personal email address that is easily accessible when away from work.
b. If you already have an account, enter your email.
3. Once you're logged in, begin with "Start a Claim or Leave" to provide initial details of what happened.
4. Add claimant information as requested, including:
 - a. Your employment information
 - b. Medical care resulting from the event, like surgery
 - c. Medical providers visited—physicians, hospitals, other medical professionals



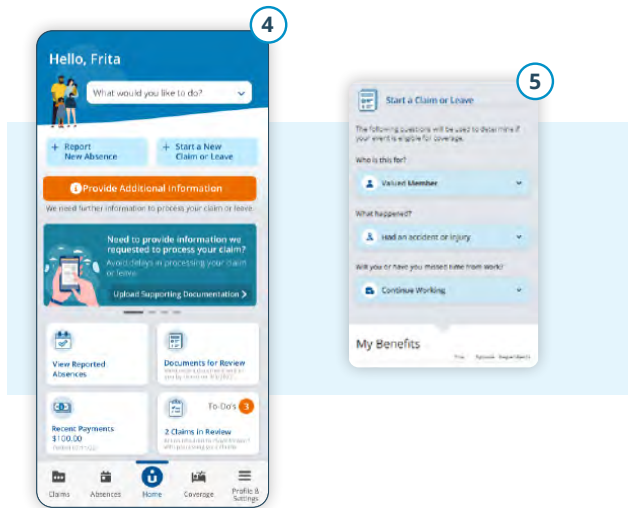
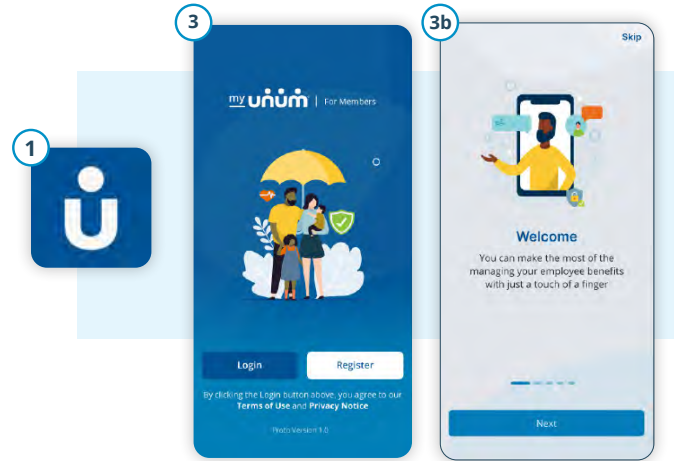
5. Review your information and:
 - a. Confirm responses
 - b. Provide medical authorization
 - c. Review fraud statement

6. Select "Accept" and "Submit."

7. View confirmation screen, see any next tasks and track progress.

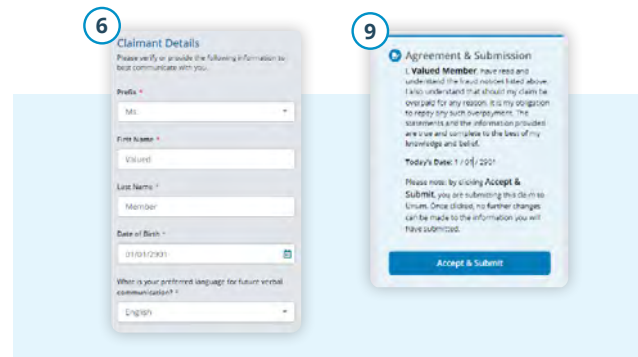
On the app

1. Download the MyUnum for Members app from either Apple® or Google Play™.
2. If you already have an account, you can log in.
3. If you do not have an account, select “register.”
 - a. Read the Terms of Use and select “I understand and accept.”
 - b. If this is your first time registering in the app, you’ll see a series of Welcome screens. Review the featured app highlights or tap “skip” if you prefer.



4. On the main dashboard, click on the “Start new claim or leave” button
5. Provide information about what happened so Unum can identify which coverage applies to your situation.
6. Add information about the following:
 - a. The claimant (you or a family member)
 - b. Your employment
 - c. Medical events resulting from the event, like surgery
 - e. Medical providers visited — physicians, hospitals, other medical professionals

7. Review your information and:
 - a. Confirm responses
 - b. Provide medical authorization
 - c. Review fraud statement
8. Select “Accept” and “Submit.”
9. View confirmation screen, see any next tasks and track progress.



Better benefits
at work.™

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MK-669700-2

FOR EMPLOYEES

(3-22)



Group Critical Illness Insurance

Plan 1

When life takes an unexpected turn due to a critical illness diagnosis, your focus should be on recovery — not finances. Colonial Life’s group critical illness insurance helps provide financial support by providing a lump-sum benefit payable directly to you for your greatest needs.

Coverage amount: _____

Critical illness benefit

COVERED CONDITION ¹	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Benign brain tumor	100%
Coma	100%
End stage renal (kidney) failure	100%
Heart attack (myocardial infarction)	100%
Loss of hearing	100%
Loss of sight	100%
Loss of speech	100%
Major organ failure requiring transplant	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Stroke	100%
Sudden cardiac arrest	100%
Coronary artery disease	25%

An unexpected moment changes life forever

Chris was mowing the lawn when he suffered a stroke. His recovery will be challenging, and he's worried, since his family relies on his income.

HOW CHRIS'S COVERAGE HELPED

The lump-sum payment from his critical illness insurance helped pay for:



Co-payments and hospital bills not covered by his medical insurance



Physical therapy to get back to doing what he loves



Household expenses while he was unable to work

For illustrative purposes only.

KEY BENEFITS

- Available coverage for spouse and eligible dependent children at 50% of your coverage amount
- Cover your eligible dependent children at no additional cost
- Receive coverage regardless of medical history, within specified limits
- Works alongside your health savings account (HSA)
- Benefits payable regardless of other insurance

Subsequent diagnosis of a different critical illness²

If you receive a benefit for a critical illness and are later diagnosed with a different critical illness, 100% of the coverage amount may be payable for that particular critical illness.

Subsequent diagnosis of the same critical illness²

If you receive a benefit for a critical illness and are later diagnosed with the same critical illness,³ 25% of the coverage amount may be payable for that critical illness.

Additional covered conditions for dependent children

COVERED CONDITION ¹	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Cerebral palsy	100%
Cleft lip or palate	100%
Cystic fibrosis	100%
Down syndrome	100%
Spina bifida	100%

For more information,
talk with your
benefits counselor.

Preparing for the unexpected is simpler than you think.
With Colonial Life, you'll have the support you need to face
life's toughest challenges.

1. Refer to the certificate for complete definitions of covered conditions.
2. Dates of diagnoses of a covered critical illness must be separated by more than 180 days.
3. Critical illnesses that do not qualify include: coronary artery disease, loss of hearing, loss of sight, loss of speech, and occupational infectious HIV or occupational infectious hepatitis B,C or D.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay the Critical Illness Benefit, Benefits Payable Upon Subsequent Diagnosis of a Critical Illness or Additional Critical Illness Benefit for Dependent Children that occurs as a result of a covered person's: doctor or physician relationship; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

PRE-EXISTING CONDITION LIMITATION

We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person received medical advice or treatment within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy forms GCI6000-P-EE-TX and GCI6000-P-AU-TX and certificate forms GCI6000-C-EE-TX and GCI6000-C-AU-TX. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

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ColonialLife.com

Group Cancer Insurance*

Plan 3



A cancer diagnosis takes life on an unexpected turn. Treatment decisions should not put your finances at risk. Colonial Life's group cancer insurance helps by providing a lump-sum benefit payable directly to you to help cover any expenses.

Coverage amount: _____

Cancer benefits

COVERED CANCER CONDITION ¹	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Invasive cancer (including all breast cancer)	100%
Non-invasive cancer	25%
Skin cancer initial diagnosis	\$400 per lifetime

Reoccurrence of invasive cancer (including all breast cancer)

If you receive a benefit for invasive cancer and are later diagnosed with a reoccurrence of invasive cancer, 25% of the coverage amount is payable if treatment-free for at least 12 months and in complete remission prior to the date of reoccurrence; excludes non-invasive or skin cancer.

BENEFITS STORY

Caring for the caregiver

Kathy is a 45-year-old devoted mother who coaches her son's soccer team and cares for her father, who recently moved in with them. When she was diagnosed with breast cancer, she worried about taking care of everyone.

How Kathy's coverage helped

The lump-sum amount from her cancer benefit helped pay for:



Expenses related to her ongoing treatments



Childcare and an aid to assist with her father



Meals and household expenses



Prescriptions to help with the side effects of her treatments to work

For illustrative purposes only.

Key benefits

- Available coverage for spouse and eligible dependent children at 50% of your coverage amount
- Cover your eligible dependent children at no additional cost
- Receive coverage regardless of medical history, within specified limits
- Works alongside your health savings account (HSA)
- Benefits payable regardless of other insurance

Preparing for the unexpected is simpler than you think. With Colonial Life, you'll have the support you need to face life's toughest challenges.



For more information, talk with your benefits counselor.

BENEFITS STORY

A cancer that struck twice

When Paul was first diagnosed with invasive thyroid cancer he received 100% of his initial coverage amount of \$20,000. Paul recovered and was treatment-free for over 12 months and in complete remission from his cancer.

Unfortunately, Paul was later diagnosed again with invasive thyroid cancer. With the reoccurrence of invasive cancer, Paul received \$5,000, which was 25% of his initial coverage amount.

How Paul's coverage helped

The lump-sum amount from the reoccurrence of invasive cancer helped him pay for:



Rent and other household expenses



Expenses related to his ongoing treatments



Transportation to medical facility

For illustrative purposes only.

1. Please refer to the certificate for complete definitions of covered conditions.

* The filed product name in PA is Group Critical Illness Specified Disease Insurance. In FL and VT, the filed product name is Group Cancer Limited Benefit Insurance.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this insurance.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Invasive Cancer (including all Breast Cancer) Benefit, Non-Invasive Cancer Benefit, Benefit Payable Upon Reoccurrence of Invasive Cancer (including all Breast Cancer) or Skin Cancer Initial Diagnosis Benefit for a covered person's invasive cancer or non-invasive cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having invasive or non-invasive cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while the named insured is covered under the certificate, and who are continuously covered from the date of birth or adoption.

PRE-EXISTING CONDITION LIMITATION

We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

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Group Critical Illness Insurance*

Exclusions and limitations

State-specific exclusions

AK: Alcoholism or Drug Addiction Exclusion does not apply.

CA: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics replaced with Intoxicants or Controlled Substances. Insureds must be covered by comprehensive health insurance before applying for insurance.

CO: Suicide exclusion: whether sane or not replaced with while sane.

CT: Alcoholism or Drug Addiction Exclusion replaced with Intoxication or Drug Addiction; Felonies or Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply.

DC: Alcoholism or Drug Addiction Exclusion does not apply. Insureds must be covered by comprehensive health insurance before applying for insurance.

DE: Alcoholism or Drug Addiction Exclusion does not apply.

GA: Insureds must be covered by comprehensive health insurance before applying for insurance.

IA: Exclusions and Limitations headers renamed to Exclusions and Limitations for Critical Illness Covered Conditions and Critical Illness Cancer Covered Conditions.

ID: War or Armed Conflict Exclusion replaced with War; Felonies and Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse.

IL: Alcoholism or Drug Addiction Exclusion replaced with Alcoholism or Substance Abuse Disorder.

KS: Alcoholism or Drug Addiction Exclusion does not apply.

KY: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion replaced with Intoxicants, Narcotics and Hallucinogenics.

Premium will vary based on the coverage selected and the age of the named insured. For attained age rates, premiums will increase on the account anniversary date once the named insured reaches the next age band. Premium may increase if coverage is ported.

Waiting Period If included, the Wellbeing Assistance Benefit is subject to a 30-day waiting period. Waiting period means the first 30 days following each covered person's effective date during which no benefits are payable.

Termination of the Named Insured's Coverage The coverage on a named insured under the policy will terminate on the earliest of the following dates:

- the date the policy terminates;
- your policyholder cancels the policy and does not offer replacement coverage;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or

- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while you are covered.

LA: Alcoholism or Drug Addiction Exclusion does not apply; Domestic Partner added to Spouse.

MA: Exclusions and Limitations headers renamed to Limitations and Exclusions for critical illness and cancer. Insureds must be covered by comprehensive health insurance before applying for insurance.

MD: Alcoholism or Drug Addiction Exclusion does not apply; Felonies or Illegal Occupations Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply; Prohibited Practitioner Referral added as an additional exclusion for cancer.

MI: Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion does not apply.

MN: Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion does not apply; Felonies and Illegal Occupations Exclusion replaced with Felonies or Illegal Jobs; Intoxicants and Narcotics Exclusion replaced with Narcotic Addiction. Insureds must be covered by comprehensive health insurance before applying for insurance.

MO: Alcoholism or Drug Addiction Exclusion replaced with Drug Addiction; Felonies or Illegal Occupations Exclusion replaced with Illegal Activities.

MS: Alcoholism or Drug Addiction Exclusion does not apply.

ND: Alcoholism or Drug Addiction Exclusion does not apply.

NV: Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse.

PA: Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion: whether sane or not removed.

SD: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply.

TX: Alcoholism or Drug Addiction Exclusion does not apply; Doctor or Physician Relationship added as an additional exclusion.

UT: Alcoholism or Drug Addiction Exclusion replaced with Alcoholism.

VT: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion: whether sane or not removed. Insureds must be covered by comprehensive health insurance before applying for insurance.

WA: Intoxicants and Narcotics Exclusion does not apply.

State-specific pre-existing condition limitations

CA: Pre-existing Condition means a sickness or physical condition for which a covered person was diagnosed or treated within 12 months before the coverage effective date shown on the Certificate Schedule.

FL: Pre-existing is 6/12; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date shown on the Certificate Schedule. Genetic information is not a pre-existing condition in the absence of a diagnosis of the condition related to such information.

GA: Pre-existing Condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received within 12 months preceding the coverage effective date.

ID: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition which caused a covered person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the coverage effective date shown on the Certificate Schedule.

IL: Pre-existing Condition means a sickness or physical condition for which a covered person was diagnosed, treated, had medical testing by a legally qualified physician, received medical advice, produced symptoms or had taken medication within 12 months before the coverage effective date shown on the Schedule of Benefits.

IN: Pre-existing is 6 months/12 months.

MA: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.

MD: Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date shown on the Certificate Schedule. Pre-existing condition does not include a condition revealed on the application unless excluded by a signed waiver rider.

ME: Pre-existing is 6 months/6 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.

MI: Pre-existing is 6 months/6 months.

NC: Pre-existing Condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. If a covered person is 65 or older when this certificate is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated.

NV: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date. Pre-existing Condition does not include genetic information in the absence of a diagnosis of the condition related to such information.

PA: Pre-existing is 90 days/12 months; Pre-existing Condition means a disease or physical condition for which you received medical advice or treatment within 90 days before the coverage effective date shown on the Certificate Schedule.

SD: Pre-existing is 6 months/12 months.

TX: Pre-existing condition means a sickness or physical condition for which a covered person received medical advice or treatment within 12 months before the coverage effective date shown on the Certificate Schedule.

UT: Pre-existing is 6 months/6 months.

WY: Pre-existing is 6 months/12 months.

*The filed product name in IA, PA, and WY is Group Critical Illness Specified Disease Insurance. In FL and VT, the filed product name is Group Critical Illness Limited Benefit Insurance.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this insurance.

This information is not intended to be a complete description of the insurance coverage available. The insurance, its name or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company. This form is not complete without base form 385403, 387100, 387169, 402383, 402558 or 387238, and rider form 387307, 387381, 387452, 387523, 387594, 387665, 402605 or 402671.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

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Group Critical Illness Insurance*

Wellbeing Assistance Benefit

The wellbeing assistance benefit can help reduce the risk of serious illness through early detection of disease or risk factors.

Wellbeing assistance benefit.....\$_____

Maximum of one test per covered person per calendar year; subject to a 30-day waiting period before the benefit is payable. The test must be performed after the waiting period.

- Blood test for triglycerides
- Bone marrow testing
- BRCA1 or BRCA2 testing (genetic test for breast cancer)
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Carotid Doppler
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy



For more information, talk with your Colonial Life benefits counselor.

*Refer to the base plan brochure for state-specific filed product name.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this insurance.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

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Group Critical Illness Insurance

Infectious Diseases Rider



For more information,
talk with your
benefits counselor.

ColonialLife.com

The sudden onset of an infectious or contagious disease can create unexpected circumstances for you or your family. The infectious diseases rider provides a lump sum which can be used toward health care expenses or meeting day-to-day needs. These benefits are for you as well as your covered family members.

Payable for each covered infectious disease once per covered person per lifetime

COVERED INFECTIOUS DISEASE ¹	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Hospital confinement for seven or more consecutive days for treatment of the disease	
Antibiotic resistant bacteria (including MRSA)	50%
Cerebrospinal meningitis (bacterial)	50%
Diphtheria	50%
Encephalitis	50%
Legionnaires' disease	50%
Lyme disease	50%
Malaria	50%
Necrotizing fasciitis	50%
Osteomyelitis	50%
Poliomyelitis	50%
Rabies	50%
Sepsis	50%
Tetanus	50%
Tuberculosis	50%
Hospital confinement for 14 or more consecutive days for treatment of the disease	
Coronavirus disease 2019 (COVID-19)	25%



ColonialLife.com

1. Refer to the certificate for complete definitions of covered diseases.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

EXCLUSIONS AND LIMITATIONS FOR INFECTIOUS DISEASES RIDER

We will not pay benefits for a covered infectious disease that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a covered infectious disease.

PRE-EXISTING CONDITION LIMITATION

We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX) and rider form R-GCI6000-INF. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

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STATE-SPECIFIC EXCLUSIONS

- AK:** Alcoholism or Drug Addiction Exclusion does not apply
- CO:** Suicide exclusion: whether sane or not replaced with while sane
- CT:** Alcoholism or Drug Addiction Exclusion replaced with Intoxication or Drug Addiction; Felonies or Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply
- DE:** Alcoholism or Drug Addiction Exclusion does not apply
- IA:** Exclusions and Limitations headers renamed to Exclusions and Limitations for Critical Illness Covered Conditions and Critical Illness Cancer Covered Conditions
- ID:** War or Armed Conflict Exclusion replaced with War; Felonies and Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse
- IL:** Alcoholism or Drug Addiction Exclusion replaced with Alcoholism or Substance Abuse Disorder
- KS:** Alcoholism or Drug Addiction Exclusion does not apply
- KY:** Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion replaced with Intoxicants, Narcotics and Hallucinogenics.
- LA:** Alcoholism or Drug Addiction Exclusion does not apply; Domestic Partner added to Spouse
- MA:** Exclusions and Limitations headers renamed to Limitations and Exclusions for critical illness and cancer
- MI:** Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion does not apply
- MN:** Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion does not apply; Felonies and Illegal Occupations Exclusion replaced with Felonies or Illegal Jobs; Intoxicants and Narcotics Exclusion replaced with Narcotic Addiction
- MS:** Alcoholism or Drug Addiction Exclusion does not apply
- ND:** Alcoholism or Drug Addiction Exclusion does not apply
- NV:** Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse
- PA:** Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion: whether sane or not removed
- SD:** Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply
- TX:** Alcoholism or Drug Addiction Exclusion does not apply; Doctor or Physician Relationship added as an additional exclusion
- UT:** Alcoholism or Drug Addiction Exclusion replaced with Alcoholism
- VT:** Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion: whether sane or not removed

STATE-SPECIFIC PRE-EXISTING CONDITION LIMITATIONS

- FL:** Pre-existing is 6/12; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date shown on the Certificate Schedule. Genetic information is not a pre-existing condition in the absence of a diagnosis of the condition related to such information.
- GA:** Pre-existing Condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received within 12 months preceding the coverage effective date.
- ID:** Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition which caused a covered person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the coverage effective date shown on the Certificate Schedule.
- IL:** Pre-existing Condition means a sickness or physical condition for which a covered person was diagnosed, treated, had medical testing by a legally qualified physician, received medical advice, produced symptoms or had taken medication within 12 months before the coverage effective date shown on the Schedule of Benefits.
- IN:** Pre-existing is 6 months/12 months
- MA:** Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.
- ME:** Pre-existing is 6 months/6 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.
- MI:** Pre-existing is 6 months/6 months
- NC:** Pre-existing Condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. If a covered person is 65 or older when this certificate is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated.
- NV:** Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date. Pre-existing Condition does not include genetic information in the absence of a diagnosis of the condition related to such information.
- PA:** Pre-existing is 90 days/12 months; Pre-existing Condition means a disease or physical condition for which you received medical advice or treatment within 90 days before the coverage effective date shown on the Certificate Schedule.
- SD:** Pre-existing is 6 months/12 months
- TX:** Pre-existing condition means a sickness or physical condition for which a covered person received medical advice or treatment within 12 months before the coverage effective date shown on the Certificate Schedule.
- UT:** Pre-existing is 6 months/6 months

This information is not intended to be a complete description of the insurance coverage available. The insurance, its name or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company. This form is not complete without base form 385403, 387100, 387169, 402383, 402558 or 387238, and rider form 387307, 387381, 387452, 387523, 387594, 387665, 402605 or 402671. Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

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Help complete your healthcare coverage with Hospital Indemnity Insurance.

Receive benefit payments directly to help prevent financial stress.

Why do I need hospitalization coverage?

Unplanned hospital¹ stays can be expensive. Hospital Indemnity Insurance from MetLife helps by supplementing your medical plan coverage. You'll receive a lump-sum payment² that you can use to pay for things that your medical plan may not cover, such as deductibles, co-pays, out-of-network care, even everyday living expenses. It also provides payment for specialized care; for example, if you need to be in an intensive care unit (ICU).³

Hospital Indemnity Insurance is designed to supplement your healthcare plan.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and eligible members of your household. All you need to do is enroll during the open enrollment period and be actively at work. Some states require the insured to have medical coverage, and dependents may be subject to medical restrictions as outlined in the Certificate.

Q. I have a medical plan at work, so why do I need Hospital Indemnity Insurance?

A. Hospital stays can be pricey and are often unexpected. Even the best medical plans can leave you with extra expenses to pay or with

services that just aren't covered,⁴ such as plan deductibles, co-pays, extra costs for out-of-network care, or non-covered services. Many people aren't prepared to handle these extra costs, so having this extra financial support when the time comes may mean less worry for you and your family.

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your coverage is guaranteed⁵ regardless of your health. You just need to be actively at work. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you first thought.

Q. How much will coverage cost and how do I pay for it?

A. Hospital Indemnity Insurance may cost less than you think. It's designed to be an economical way for you to supplement your healthcare plan. Exact rates can be found in the enrollment materials provided by your employer. **You pay premiums through payroll deductions,** so you don't have to worry about writing any checks or missing payments.

Hospital Indemnity Insurance

Coverage to help pay for expenses related to hospitalization that may not be covered under your medical plan.

Q. When does my coverage begin?

A. Your coverage starts on the effective date. There are no waiting periods for it to begin.

Q. Are benefits paid directly to me or my healthcare provider?

A. Payments go directly to you, not to the doctors, to the hospitals or to any other healthcare providers. And to make things even easier, the check is made payable to you. There's no need to coordinate with any other insurance you may have. The amount you receive will be on top of any other insurance payment you might receive from other plans. You can spend the Hospital Indemnity Insurance payment however you like.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it with you wherever you go so long as you continue paying your premiums.⁶

Q. Is the claims process simple?

A. Yes. Once we've received all the necessary information, claims are generally processed within 10 business days. You only need one claim form per admission or hospital stay, and every claim is reviewed by a professional.⁷

Have other questions?

Please call MetLife and talk with a benefits consultant at:
1 800 GET-MET8

1. Hospital does not include certain facilities, such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Covered services/treatments must be the result of an accident or sickness as defined in the group policy/Certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.
3. The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment. The payment of the admission benefit requires a Confinement. Hospital Confinement requires the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician. Please consult your Certificate for details.
4. There is a pre-existing exclusion for covered sicknesses. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
5. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
6. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.
7. Applies only to "clean" claims. A clean claim is a claim submitted with all the required information necessary to process the claim — no missing information requiring additional follow up with the subscriber. It generally takes 10 business days to process "clean" claims.

METLIFE'S HOSPITAL INDEMNITY INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. Prior hospital confinement may be required to receive certain benefits. There may be a preexisting condition limitation for hospital sickness benefits. MetLife's Hospital Indemnity Insurance may be subject to benefit reductions that begin at age 65. Like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or GPNP13-HI, GPNP16-HI or GPNP12-AX-PASG or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. In certain states, availability of MetLife's Group Hospital Indemnity Insurance are pending regulatory approval.

Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.



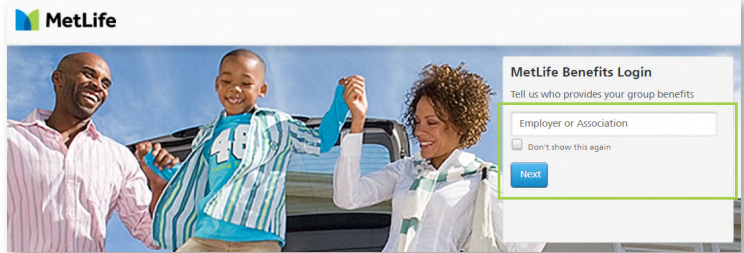
How To Register On MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits by following the steps outlined below:

Registration Process For MyBenefits:

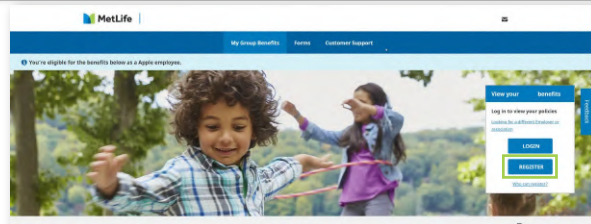
STEP 1 – Provide A Group Name

Access MyBenefits at mybenefits.metlife.com. Enter your employer name, select it in the drop down and select 'Next'. Save this URL to access your MyBenefits account in the future.



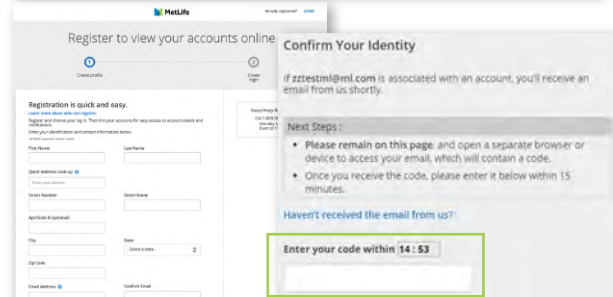
STEP 2 – Register

Once you have selected your employer, from the MyBenefits Home Page you will then select the 'Register' button. Note – Current users will select 'Log In' and enter their username and password.



STEP 3 – Enter Authentication Information

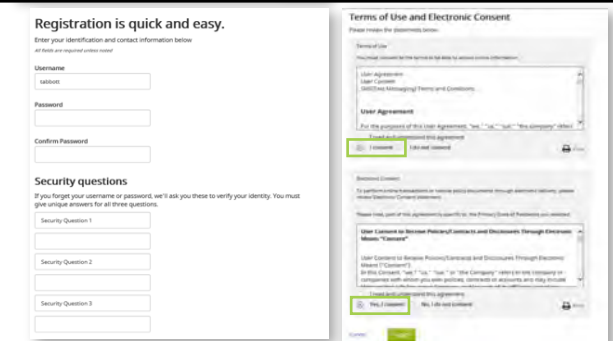
The next screen will begin by entering your name, address, phone number, e-mail (required) and unique security identifiers to confirm your identity. You will then receive a security code, via email or text, that you will need to enter to continue the registration process.



STEP 4 – Establish Account Credentials

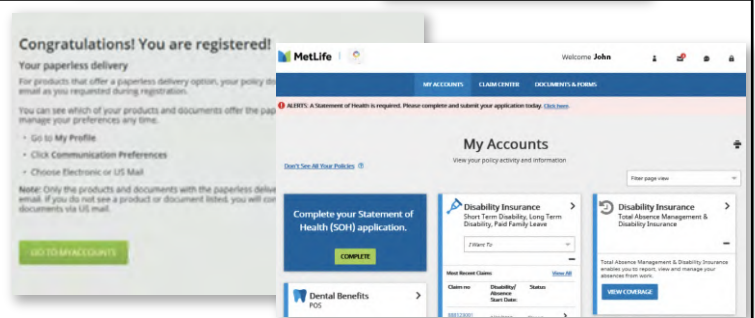
You will then be prompted to create a unique username and password for future access to MyBenefits, as well as choose and answer three identity verification questions that will be used in the event you forget your password.

In addition to reading and agreeing to the Terms of Use, you will be asked to opt into electronic consent.



STEP 5 – Registration Is Complete

Once you have completed the process a 'congratulations' message window will display. You are now registered on MyBenefits! A registration confirmation email will be sent to the email address provided for your registration. You can immediately access your account information by selecting the 'Go To My Account' button within the congratulations window.



Hospital Indemnity Insurance

Cameron County

Coverage to help with unexpected expenses, such as hospitalization expenses that may not be covered under your medical plan.

Hospital Indemnity Insurance Benefits

With MetLife, you'll have a choice of two comprehensive plans (called the "Low Plan" and the "High Plan") which provide lump sum cash payments for covered events regardless of any other payments you may receive from your medical plan. Here are just some of the covered benefits/services^B, when an accident or illness puts you in the hospital.^A

Covered Benefits

Please contact MetLife for detailed definitions and state variations of covered benefits.

Hospital Benefits				
Subcategory	Benefit Limits (Applies to Subcategory)	Benefit	Low Plan	High Plan
Admission Benefit	4 time(s) per calendar year ¹	Admission	\$1,000	\$2,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	\$1,000	\$2,000
Confinement Benefit	15 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 15 of those days	Confinement ⁴	\$200	\$300
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	\$200	\$300
Confinement Benefit for Newborn Nursery Care	2 day(s) per confinement	Confinement Benefit for Newborn Nursery Care ⁵	\$50	\$75

¹ If a covered person is readmitted within 90 days for the same or related sickness/injury for which we paid an Admission Benefit, an additional Admission Benefit is not payable.

⁴ If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.

⁵ Payable for the period of newborn confinement for a newborn child who is not sick or injured.



Hospital Indemnity Insurance

Benefit Payment Example for High Plan

Susan has chest pains at home, and after contacting her doctor, she is instructed to head to her local hospital. Upon arrival, the doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After two days in the Intensive Care Unit, Susan moves to a standard room and spends two additional days recovering in the hospital. Susan was released to her primary care physician for follow-up treatment and observation. Her primary doctor is now keeping a close watch over Susan's overall health. Depending on her health insurance, Susan's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Hospital Indemnity Insurance payments can help cover these unexpected costs or in any other way Susan sees fit.

Covered Benefit	High Benefit Amount
Regular Hospital Admission (1x)	\$2,000
ICU Supplemental Admission (1x)	\$2,000
Regular Hospital Confinement (3 total days)	\$900
ICU Supplemental Confinement (1 day)	\$300
Benefits paid by MetLife Group Hospital Indemnity Insurance	\$5,200

Benefit amount is based on a sample MetLife plan design. Plan design and plan benefits may vary.

Questions & Answers

Q. How do I enroll?

A. Enroll for coverage through your employer.

Q. Who is eligible to enroll for this Hospital Indemnity coverage?

A. You are eligible to enroll yourself and your eligible family members.^C You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective. Dependents to be enrolled may not be subject to a medical restriction as set forth in the Certificate. Some states require the insured to have medical coverage.

Q. How do I pay for my Hospital Indemnity coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer cancels the group policy and offers you similar coverage with a different insurance carrier.^D

Q. What is the coverage effective date?

A. The coverage effective date is October 1, 2022.

Q. Who do I call for assistance?

A. Please call MetLife directly at 1-800-GET-MET8 (1-800-438-6388) and talk with a benefits consultant.



Hospital Indemnity Insurance

Insurance Rates

MetLife offers group rates and payroll deductions, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Hospital Indemnity Insurance

Coverage Options	Low Plan	High Plan
Monthly Cost to You		
Employee	\$19.16	\$35.33
Employee & Spouse	\$41.94	\$77.35
Employee & Child(ren)	\$31.09	\$57.30
Employee & Spouse/Child(ren)	\$53.87	\$99.31

^A Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

^C Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions may apply to dependents serving in the armed forces or living overseas.”

^D Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S HOSPITAL INDEMNITY INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. Prior hospital confinement may be required to receive certain benefits. There may be a preexisting condition limitation for hospital sickness benefits. MetLife's Hospital Indemnity Insurance may be subject to benefit reductions that begin at age 65. Like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX, GPNP13-HI, GPNP16-HI or GPNP12-AX-PASG, or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. In certain states, availability of MetLife's Group Hospital Indemnity Insurance is pending regulatory approval.





Hospital Indemnity Insurance



Cameron County

Group Cancer Quote - Monthly Rates

Effective Date - 10/01/2024

Situs State - TX

Base Policy

Coverage Tier	Low	Mid	High
Employee	\$14.23	\$24.06	\$30.81
Employee + Spouse	\$28.45	\$48.11	\$61.62
Employee + Child(ren)	\$18.12	\$30.58	\$40.83
Family	\$32.33	\$54.63	\$71.63

Variable Benefit Elections

Benefit	Low	Mid	High
Hospital Confinement	\$100 per day	\$200 per day	\$200 per day
Surgical	up to \$1,500	up to \$3,000	up to \$4,500
Radiation/Chemotherapy	\$200 per day	\$500 per day	\$2,500 per month
First Diagnosis	\$5,000	\$7,500	\$10,000
Colony Stimulating Factors	\$500 per month	\$500 per month	\$500 per month
Miscellaneous Diagnostic Services	\$5,000	\$5,000	\$5,000
Self-Administered Drugs	\$1,000 per month	\$1,000 per month	\$1,000 per month
Wellness	\$0	\$0	\$50 per year

Optional Intensive Care Rider (ICR)

Rider amount selection is the choice of the Employee, and is independent of the option selected above

Coverage Tier	\$325 per day	\$625 per day
Employee	\$3.15	\$6.05
Employee + Spouse	\$6.26	\$12.04
Employee + Child(ren)	\$5.14	\$9.89
Family	\$8.26	\$15.88

Residents of most states will be covered by the situs state plan. Residents of certain states will be covered by a state specific certificate of insurance due to these states having extraterritorial laws.

Underwritten by:
Metropolitan Life Insurance Company

Administered by:



**BAY BRIDGE
ADMINISTRATORS**

*"Your solutions begin
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P.O. Box 161690 - Austin, Texas 78716 - (800) 845-7519



**GROUP CANCER AND SPECIFIED DISEASE EXPENSE INSURANCE
GROUP POLICY FORM NO: GP18-BB-SD
GROUP CERTIFICATE FORM NO: GCERT18-BB-SD/CAN**

THE CERTIFICATE OF INSURANCE PROVIDES LIMITED BENEFITS – BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. YOU SHOULD HAVE MEDICAL COVERAGE IN FORCE WHEN YOU ENROLL FOR THIS INSURANCE.

**THE CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT.
IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO
HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM METLIFE.**

RECEIPT OF GROUP CANCER AND SPECIFIED DISEASE EXPENSE INSURANCE BENEFITS MAY AFFECT ELIGIBILITY FOR MEDICAID AND OTHER GOVERNMENTAL BENEFITS AND ENTITLEMENTS. ACCORDINGLY, PERSONS WHO WISH TO MAINTAIN ELIGIBILITY FOR SUCH BENEFITS SHOULD NOT PURCHASE THE COVERAGE MADE AVAILABLE UNDER THE GROUP POLICY.

OUTLINE OF COVERAGE

1) READ YOUR CERTIFICATE CAREFULLY! This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual provisions of the Group Policy and Certificate under which you have coverage will control. The Certificate sets forth in detail the rights and obligations of both you and Metropolitan Life Insurance Company (“MetLife”).

2) CANCER AND SPECIFIED DISEASE INSURANCE COVERAGE. Policies of this category are designed to provide to persons insured, restricted coverage, paying benefits only when certain losses occur as a result of diagnosis of cancer or a specified disease.

3) BENEFITS. The benefits listed in the attached Benefits Summary are primarily payable for certain losses as a result of a diagnosis of cancer or a specified disease covered under the policy. Benefits are payable based on a positive diagnosis of cancer or specified disease made after the covered person’s effective date of insurance.

Please be aware that the Group Policy and Certificate contain specific conditions, definitions, maximums, limitations, exclusions and proof requirements for the benefits described below.

Throughout this outline, “you” and “your” refer to the employee who becomes insured for cancer and specified disease expense insurance. The term “covered person” refers to a person for whom insurance is in effect under the Group Policy.

4) EXCLUSIONS AND LIMITATIONS.

Exceptions and Other Limitations. The Group Policy and Certificate pay benefits only for diagnoses, treatment and services resulting from cancer or specified diseases, as defined in the policy. It does not cover:

- any other disease or sickness;
- injuries;
- unless otherwise defined in the certificate, any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
 - specified disease or specified disease treatment; or
 - cancer or cancer treatment;
 - care and treatment received outside the United States or its territories;
 - care and treatment performed by You, Your Spouse or any member of Your immediate family including Your and/or Your Spouse’s parents, children (natural, step or adopted); siblings; grandparents; or grandchildren; or
 - treatment not prescribed by a physician; or experimental treatment by any program that does not qualify as new and experimental treatment as defined in the policy.

Pre-Existing Condition Limitation. During the first 12 months that coverage under the certificate is in effect for a covered person no benefits will be payable for a loss due to a Pre-Existing Condition.

Pre-Existing Condition - means a disease or physical condition, for which a covered person has received medical advice, treatment, care, services, or for which diagnostic test(s) have been recommended during the 12 months immediately preceding the effective date of insurance for each covered person.

5) TERMINATION DATES. Your insurance under the Group Policy and Certificate will automatically terminate on the earliest of the following dates:

- the date that the policy terminates;
- the date of termination of any section or part of the policy with respect to insurance under such section or part;
- the premium due date that coincides with or next follows the date that you cease to be a member of an eligible class; or
- any premium due date, if premium remains unpaid by the end of the grace period.

The Certificate also sets forth termination provisions for dependents.

6) PORTABILITY. If your insurance ends, you may keep it in force under certain circumstances as described in the Certificate.

7) ADMINISTRATION OF INSURANCE. Some services in connection with this insurance may be performed by our third-party administrator(s). This service arrangement in no way alters Metropolitan Life Insurance Company's obligation to you. Services will not be performed by our third-party administrator(s) if prohibited by mutual agreement with a group customer.

8) PREMIUMS. Premium rates are based on your age on the effective date of coverage and are shown in the enclosed materials. Premium rates are subject to change as stated in the policy.

BENEFITS SUMMARY
Low Plan

The term "Incurred Expense" refers to charges that are solely your responsibility, or expenses that are a combination of insurance reimbursement and your responsibility such as deductibles or co-payments. The fee negotiated between your major medical insurer and medical providers, as reflected on an explanation of benefits from such insurer, would be considered the Incurred Expense.

BENEFIT	BENEFIT AMOUNT
Positive Diagnosis Test	The provider's actual billed charge, up to \$300 per covered person per calendar year
Second and Third Surgical Opinions	The Incurred Expense for the opinion
Non-Local Transportation	(a) The actual billed charges for round trip coach fare on a common carrier; or (b) 50 cents per mile for round-trip personal vehicle transportation for round trips over 60 miles
Adult Companion Lodging and Transportation	(a) For lodging: The actual billed charges up to \$75 per day for a single room in a motel, hotel, or other accommodations, to a maximum stay of 60 days. (b) For transportation: <ul style="list-style-type: none"> • the actual billed charges for a round trip coach fare on a common carrier; or • a personal vehicle allowance of 50 cents per mile for up to 700 miles per hospital stay
Ambulance	The Incurred Expenses for the ambulance service
Donor Benefit Bone Marrow and Stem Cell Transplant	(a) Two times the hospital confinement benefit shown on the Certificate schedule for each day both the covered person and the donor are hospitalized for the transplant (b) For transportation: <ul style="list-style-type: none"> • actual billed charges for round trip coach fare on a common carrier to the city where the transplant is performed; or • personal vehicle allowance of 50 cents per mile up to 700 miles per hospital stay; and (c) actual billed charges for lodging and meals for the donor to remain near hospital up to \$50 per day
Bone Marrow and Peripheral Stem Cell Transplant	The Incurred Expense up to a combined lifetime maximum per covered person of \$15,000
Anesthesia	(a) For anesthesia for skin cancer that is not invasive melanoma: \$100 per covered person. (b) For anesthesia for all other surgery: 25% of the amount paid by us for the surgery
Ambulatory Surgical Center	\$250 per covered person
Drugs and Medicine	\$25 per day per covered person for each day of confinement for a calendar year maximum per covered person of \$600
Outpatient Anti-Nausea Drugs	The actual billed charges, up to \$250 per covered person per calendar year
Miscellaneous Diagnostic Services	The Incurred Expense up to a lifetime maximum of \$5,000 per covered person
Self-Administered Drugs	The Incurred Expense up to \$1,000 per calendar month per covered person
Blood, Plasma, and Platelets	The Incurred Expense up to \$200 per covered person per day

BENEFIT	BENEFIT AMOUNT
Physician's Attendance	\$35 per covered person per day
Private Duty Nursing Services	\$100 per covered person per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit	(a) For the evaluation: The actual billed charges, up to a lifetime maximum per covered person up to \$750 (b) For transportation and lodging: The actual billed charges, up to a lifetime maximum per covered person up to \$350
Breast Prosthesis	The Incurred Expenses
Artificial Limb or Prosthesis	The actual billed charges, up to \$1,500 lifetime maximum per covered person per amputated limb
Physical Therapy or Speech Therapy	\$35 per covered person per day
Extended Benefits	Three times the hospital confinement benefit shown on the Certificate schedule
Extended Care Facility	\$50 per covered person per day, not to exceed the number of days that the hospital confinement benefit was paid
At Home Nursing	\$100 per day per covered person, not to exceed the number of days that the hospital confinement benefit was paid
New and Experimental Treatment	The actual billed charges, up to \$7,500 per covered person per calendar year
Hospice Care	\$50 per covered person per day
Government or Charity Hospital or Outpatient Clinic	\$200 per covered person per day
Hairpiece	The actual billed charges up to the lifetime maximum of \$150 per covered person
Rental or Purchase of Durable Goods	The Incurred Expenses up to \$1,500 per covered person per calendar year
Waiver of Premium	Included
Surgery	Up to \$1,500 per covered person for surgery based on the following: For inpatient surgery: The lesser of: <ul style="list-style-type: none"> • the amount listed on the surgical schedule shown in the Certificate for the applicable surgery; and • the surgeon's actual billed charges for the surgery. For outpatient surgery: 150% of the surgery benefit payable for inpatient surgery. However, we will not pay an amount which exceeds the surgeon's actual billed charges for the surgery.
First Diagnosis Benefit	\$5,000 per covered person
Radiation/Chemotherapy/Immunotherapy	The Incurred Expense up to \$200 per day per covered person
Colony-Stimulating Factors	The Incurred Expense up to \$500 per calendar month per covered person

BENEFIT	BENEFIT AMOUNT
Hospital Confinement	<p>The daily benefit amount \$100 per day per covered person</p> <p>For dependent children under the age of 21 the benefit is two (2) times the daily hospital confinement benefit</p>
BENEFITS PROVIDED BY RIDER	
RIDER	BENEFIT
INTENSIVE CARE UNIT (ICU) BENEFIT RIDER Optional	<p>ICU daily benefit amount (used to determine benefits payable): \$325 or \$625 per covered person per day of confinement.</p> <p>Confinement for treatment of Cancer or Specified Disease pays 2 times the ICU daily benefit amount per day of confinement.</p> <p>Payable for up to 45 days of confinement per period of confinement.</p>

BENEFITS SUMMARY
Mid Plan

The term "Incurred Expense" refers to charges that are solely your responsibility, or expenses that are a combination of insurance reimbursement and your responsibility such as deductibles or co-payments. The fee negotiated between your major medical insurer and medical providers, as reflected on an explanation of benefits from such insurer, would be considered the Incurred Expense.

BENEFIT	BENEFIT AMOUNT
Positive Diagnosis Test	The provider's actual billed charge, up to \$300 per covered person per calendar year
Second and Third Surgical Opinions	The Incurred Expense for the opinion
Non-Local Transportation	(a) The actual billed charges for round trip coach fare on a common carrier; or (b) 50 cents per mile for round-trip personal vehicle transportation for round trips over 60 miles
Adult Companion Lodging and Transportation	(d) For lodging: The actual billed charges up to \$75 per day for a single room in a motel, hotel, or other accommodations, to a maximum stay of 60 days. (e) For transportation: <ul style="list-style-type: none"> • the actual billed charges for a round trip coach fare on a common carrier; or • a personal vehicle allowance of 50 cents per mile for up to 700 miles per hospital stay
Ambulance	The Incurred Expenses for the ambulance service
Donor Benefit Bone Marrow and Stem Cell Transplant	(a) Two times the hospital confinement benefit shown on the Certificate schedule for each day both the covered person and the donor are hospitalized for the transplant (b) For transportation: <ul style="list-style-type: none"> • actual billed charges for round trip coach fare on a common carrier to the city where the transplant is performed; or • personal vehicle allowance of 50 cents per mile up to 700 miles per hospital stay; and (f) actual billed charges for lodging and meals for the donor to remain near hospital up to \$50 per day
Bone Marrow and Peripheral Stem Cell Transplant	The Incurred Expense up to a combined lifetime maximum per covered person of \$15,000
Anesthesia	(c) For anesthesia for skin cancer that is not invasive melanoma: \$100 per covered person. (d) For anesthesia for all other surgery: 25% of the amount paid by us for the surgery
Ambulatory Surgical Center	\$250 per covered person
Drugs and Medicine	\$25 per day per covered person for each day of confinement for a calendar year maximum per covered person of \$600
Outpatient Anti-Nausea Drugs	The actual billed charges, up to \$250 per covered person per calendar year
Miscellaneous Diagnostic Services	The Incurred Expense up to a lifetime maximum of \$5,000 per covered person
Self-Administered Drugs	The Incurred Expense up to \$1,000 per calendar month per covered person
Blood, Plasma, and Platelets	The Incurred Expense up to \$200 per covered person per day

BENEFIT	BENEFIT AMOUNT
Physician's Attendance	\$35 per covered person per day
Private Duty Nursing Services	\$100 per covered person per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit	(c) For the evaluation: The actual billed charges, up to a lifetime maximum per covered person up to \$750 (d) For transportation and lodging: The actual billed charges, up to a lifetime maximum per covered person up to \$350
Breast Prosthesis	The Incurred Expenses
Artificial Limb or Prosthesis	The actual billed charges, up to \$1,500 lifetime maximum per covered person per amputated limb
Physical Therapy or Speech Therapy	\$35 per covered person per day
Extended Benefits	Three times the hospital confinement benefit shown on the Certificate schedule
Extended Care Facility	\$50 per covered person per day, not to exceed the number of days that the hospital confinement benefit was paid
At Home Nursing	\$100 per day per covered person, not to exceed the number of days that the hospital confinement benefit was paid
New and Experimental Treatment	The actual billed charges, up to \$7,500 per covered person per calendar year
Hospice Care	\$50 per covered person per day
Government or Charity Hospital or Outpatient Clinic	\$200 per covered person per day
Hairpiece	The actual billed charges up to the lifetime maximum of \$150 per covered person
Rental or Purchase of Durable Goods	The Incurred Expenses up to \$1,500 per covered person per calendar year
Waiver of Premium	Included
Surgery	Up to \$3,000 per covered person for surgery based on the following: For inpatient surgery: The lesser of: <ul style="list-style-type: none"> • the amount listed on the surgical schedule shown in the Certificate for the applicable surgery; and • the surgeon's actual billed charges for the surgery. For outpatient surgery: 150% of the surgery benefit payable for inpatient surgery. However, we will not pay an amount which exceeds the surgeon's actual billed charges for the surgery.
First Diagnosis Benefit	\$7,500 per covered person
Radiation/Chemotherapy/Immunotherapy	The Incurred Expense up to \$500 per day per covered person
Colony-Stimulating Factors	The Incurred Expense up to \$500 per calendar month per covered person

BENEFIT	BENEFIT AMOUNT
Hospital Confinement	<p>The daily benefit amount \$200 per day per covered person</p> <p>For dependent children under the age of 21 the benefit is two (2) times the daily hospital confinement benefit</p>
BENEFITS PROVIDED BY RIDER	
RIDER	BENEFIT
INTENSIVE CARE UNIT (ICU) BENEFIT RIDER Optional	<p>ICU daily benefit amount (used to determine benefits payable): \$325 or \$625 per covered person per day of confinement.</p> <p>Confinement for treatment of Cancer or Specified Disease pays 2 times the ICU daily benefit amount per day of confinement.</p> <p>Payable for up to 45 days of confinement per period of confinement.</p>

BENEFITS SUMMARY
High Plan

The term "Incurred Expense" refers to charges that are solely your responsibility, or expenses that are a combination of insurance reimbursement and your responsibility such as deductibles or co-payments. The fee negotiated between your major medical insurer and medical providers, as reflected on an explanation of benefits from such insurer, would be considered the Incurred Expense.

BENEFIT	BENEFIT AMOUNT
Positive Diagnosis Test	The provider's actual billed charge, up to \$300 per covered person per calendar year
Second and Third Surgical Opinions	The Incurred Expense for the opinion
Non-Local Transportation	(a) The actual billed charges for round trip coach fare on a common carrier; or (b) 50 cents per mile for round-trip personal vehicle transportation for round trips over 60 miles
Adult Companion Lodging and Transportation	(g) For lodging: The actual billed charges up to \$75 per day for a single room in a motel, hotel, or other accommodations, to a maximum stay of 60 days. (h) For transportation: <ul style="list-style-type: none"> • the actual billed charges for a round trip coach fare on a common carrier; or • a personal vehicle allowance of 50 cents per mile for up to 700 miles per hospital stay
Ambulance	The Incurred Expenses for the ambulance service
Donor Benefit Bone Marrow and Stem Cell Transplant	(a) Two times the hospital confinement benefit shown on the Certificate schedule for each day both the covered person and the donor are hospitalized for the transplant (b) For transportation: <ul style="list-style-type: none"> • actual billed charges for round trip coach fare on a common carrier to the city where the transplant is performed; or • personal vehicle allowance of 50 cents per mile up to 700 miles per hospital stay; and (i) actual billed charges for lodging and meals for the donor to remain near hospital up to \$50 per day
Bone Marrow and Peripheral Stem Cell Transplant	The Incurred Expense up to a combined lifetime maximum per covered person of \$15,000
Anesthesia	(e) For anesthesia for skin cancer that is not invasive melanoma: \$100 per covered person. (f) For anesthesia for all other surgery: 25% of the amount paid by us for the surgery
Ambulatory Surgical Center	\$250 per covered person
Drugs and Medicine	\$25 per day per covered person for each day of confinement for a calendar year maximum per covered person of \$600
Outpatient Anti-Nausea Drugs	The actual billed charges, up to \$250 per covered person per calendar year
Miscellaneous Diagnostic Services	The Incurred Expense up to a lifetime maximum of \$5,000 per covered person
Self-Administered Drugs	The Incurred Expense up to \$1,000 per calendar month per covered person
Blood, Plasma, and Platelets	The Incurred Expense up to \$200 per covered person per day

BENEFIT	BENEFIT AMOUNT
Physician's Attendance	\$35 per covered person per day
Private Duty Nursing Services	\$100 per covered person per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit	(e) For the evaluation: The actual billed charges, up to a lifetime maximum per covered person up to \$750 (f) For transportation and lodging: The actual billed charges, up to a lifetime maximum per covered person up to \$350
Breast Prosthesis	The Incurred Expenses
Artificial Limb or Prosthesis	The actual billed charges, up to \$1,500 lifetime maximum per covered person per amputated limb
Physical Therapy or Speech Therapy	\$35 per covered person per day
Extended Benefits	Three times the hospital confinement benefit shown on the Certificate schedule
Extended Care Facility	\$50 per covered person per day, not to exceed the number of days that the hospital confinement benefit was paid
At Home Nursing	\$100 per day per covered person, not to exceed the number of days that the hospital confinement benefit was paid
New and Experimental Treatment	The actual billed charges, up to \$7,500 per covered person per calendar year
Hospice Care	\$50 per covered person per day
Government or Charity Hospital or Outpatient Clinic	\$200 per covered person per day
Hairpiece	The actual billed charges up to the lifetime maximum of \$150 per covered person
Rental or Purchase of Durable Goods	The Incurred Expenses up to \$1,500 per covered person per calendar year
Waiver of Premium	Included
Surgery	Up to \$4,500 per covered person for surgery based on the following: For inpatient surgery: The lesser of: <ul style="list-style-type: none"> • the amount listed on the surgical schedule shown in the Certificate for the applicable surgery; and • the surgeon's actual billed charges for the surgery. For outpatient surgery: 150% of the surgery benefit payable for inpatient surgery. However, we will not pay an amount which exceeds the surgeon's actual billed charges for the surgery.
First Diagnosis Benefit	\$10,000 per covered person
Radiation/Chemotherapy/Immunotherapy	The Incurred Expense up to \$2,500 per calendar month per covered person
Colony-Stimulating Factors	The Incurred Expense up to \$500 per calendar month per covered person

BENEFIT	BENEFIT AMOUNT
Hospital Confinement	The daily benefit amount \$200 per day per covered person For dependent children under the age of 21 the benefit is two (2) times the daily hospital confinement benefit
Wellness Benefit	\$50 per calendar year per covered person.

BENEFITS PROVIDED BY RIDER	
RIDER	BENEFIT
INTENSIVE CARE UNIT (ICU) BENEFIT RIDER Optional	ICU daily benefit amount (used to determine benefits payable): \$325 or \$625 per covered person per day of confinement. Confinement for treatment of Cancer or Specified Disease pays 2 times the ICU daily benefit amount per day of confinement. Payable for up to 45 days of confinement per period of confinement.

U.S. Business Intermediary and Producer Compensation Notice

Metropolitan Life Insurance Company, Metropolitan Tower Life Insurance Company, MetLife Consumer Services, Inc. and Metropolitan General Insurance Company (collectively herein called "MetLife"), enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related insurance and non-insurance products ("Products") with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products (each an "Intermediary"). MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business (*number of products sold or dollar value of premium*) with MetLife. In addition, supplemental compensation may be payable to your Intermediary for eligible Products. Under MetLife's current supplemental compensation plan (SCP), the amount payable as supplemental compensation may range from 0% to 8% of premium or fees. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period, or other defined period; (2) the amount of eligible new or renewal premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products in force through your Intermediary during a one-year period; (4) the block growth of the products in force through your Intermediary during a one-year period; (5) eligible new or renewal premium or fees growth during a one-year period; or (6) a flat amount, fixed percentage or sliding scale of the premium or fees for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium or fees from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., *insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, participation in an insurer panel, or reinsurance arrangements*).

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Website at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

Non-U.S. Coverage

When providing you with information concerning an eligible group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a MetLife affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MetLife or any other insurer that is not a member of MAXIS GBN. Please note that while MetLife is a member of MAXIS GBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.



DEER OAKS EAP SERVICES

Discover Your EAP + Work-Life Benefit

Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you, your dependents, and household members by your employer. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier, more balanced lives. From stress, addiction, and change management, to locating child care facilities, legal assistance, and financial challenges, our qualified professionals are here to help. These services are completely confidential and can be easily accessed 24/7, offering you around-the-clock assistance for all of life's challenges.

- ✔ **Program Access:** You may access the EAP by calling the toll-free Helpline number, using our iConnectYou App, or instant messaging with a work-life consultant through our online instant messaging system.
- ✔ **Telephonic Assessments & Support:** In-the-moment telephonic support and crisis intervention are available 24/7 along with intake and clinical assessments.
- ✔ **Short-term Counseling:** Counseling sessions with a qualified counselor to assist with issues such as stress, anxiety, grief, marital/family challenges, relationship issues, addiction, etc. Counseling is available via structured telephonic sessions, video, and in-person at local provider offices.
- ✔ **Referrals & Community Resources:** Our team provides referrals to local community resources, member health plans, support groups, legal resources, and child/elder care/daily living resources.
- ✔ **Advantage Legal Assist:** Free 30 minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; and interactive online Simple Will preparation.
- ✔ **Advantage Financial Assist:** Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction, financial planning, and identity theft; supporting educational materials available; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).
- ✔ **Alternate Modes of Support:** Your EAP offers support alternatives in addition to traditional short-term counseling including telephonic life coaching, AWARE stress reduction sessions, and virtual group counseling. During your call with one of our counselors, ask if these programs would be right for you.
- ✔ **Work-life Services:** Our work-life consultants are available to assist you with a wide range of daily living resources such as locating pet sitters, event planners, home repair, tutors, travel planning, and moving services. Simply call the Helpline for resource and referral information.
- ✔ **Child & Elder Care Referrals:** Our child and elder care specialists can help you with your search for licensed child and elder care facilities in your area. They will discuss your needs, provide guidance, resources, and qualified referral packets. Searchable databases and other resources are also available on the Deer Oaks member website.
- ✔ **Take the High Road Ride Reimbursement Program:** Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of \$45.00 (excludes tips).

**CONTACT US:**

Toll-Free: (866) 327-2400

Website: www.deeroakseap.comEmail: eap@deeroaks.com

HEALTH INSURANCE TERMS


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- **Benefits** - The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim** - A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance** - The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment** - An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible** - A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations** - Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Savings Account (HSA)** - An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **Flexible Spending Account (FSA)** - An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP)** - A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network** - Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary** - A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network** - Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum** - The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition** - Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO)** - A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received within the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP)** - A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges** - The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)** - A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

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HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan — whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by **Cameron County** hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duty and privacy practices with respect to your health information.

It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resource Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Plan Administrator.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your

dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility – **Texas - Medicaid**

Website: <https://www.gethipptexas.com>

Phone: 800.440.0493



WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to the medical insurance section of this guide to find the deductible and coinsurance that apply to you. If you would like more information on WHCRA benefits, call the toll free phone number on your medical id card.

NEWBORNS' ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SPECIAL ENROLLMENT RIGHTS

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must enroll within 30 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 30 days after the marriage, birth, or placement for adoption.

To request special enrollment or obtain more information, contact your plan administrator.



YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Cameron County**. About your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **Cameron County** has determined that the prescription drug coverage offered by **Cameron County** medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting **Cameron County** at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current **Cameron County** prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans Visit www.medicare.gov, call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help, or call [800.633.4222](tel:800.633.4222). TTY users should call [877.486.2048](tel:877.486.2048).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at [800.772.1213](tel:800.772.1213). TTY users should call [800.325.0778](tel:800.325.0778).

Date: October 1, 2022

Name of Entity/Sender: Cameron County

Contact Office: Human Services Dept.

Address: Dancy Building, Civil Service Coordinator,
1100 E. Monroe St. #118

Phone Number: (956) 544-0827

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Cameron County		4. Employer Identification Number (EIN) 74-6000420	
5. Employer address Dancy Building, 1100 E Monroe St #118		6. Employer phone number 956-544-0827	
7. City Brownsville	8. State TX	9. ZIP code 78520	
10. Who can we contact about employee health coverage at this job? Jessica Olivares			
11. Phone number (if different from above)		12. Email address jessica.olivares@co.cameron.tx.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

Yes (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
 Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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For any questions or concerns you may have regarding your 2023-2024 Benefits you can contact the following:

MEDICAL

Aetna - P# 143726
(855) 824-5361
www.aetna.com

FSA

Ameriflex
(888) 868-3539
www.myameriflex.com

DENTAL

DELTA (Ortegon) -Group #22541
(800) 521-2651
956) 373-1109 (Ortegon)
www.deltadentalins.com
yvonne@ortegonagency.com

VISION

Davis Vision - P# 505072
(800) 523-2847
www.davisvision.com

VOLUNTARY

Voluntary Life and AD&D -
THE HARTFORD
Short Term Disability - AFLAC
Accident - UNUM
Critical Illness - COLONIAL
956-943-9125
elizabeth.juarez@gefinsurance.com

HOSPITAL BENEFITS

MetLife
(800) GET-MET8
www.metlife.com

MEDICAL - Prescription

CVS Caremark
(888) 792-3862
www.aetna.com

EAP

Deer Oaks
(866) 327-2400
www.deeroakseap.com

CANCER

BAYBRIDGE(Ortegon) -
(956) 373-1109 (Ortegon)
yvonne@ortegonagency.com

BENEFITS SERVICE CENTER:
(956) 943-9137



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