# 2022/2023
# Benefit Enrollment Guide

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Ventura - Fair Haven - Union

**Networks:**

Physicians: PHCS Practitioner Only

Hospital: elap services

American Plan Administrators

# Medical Insurance

| | Gold Plan | Silver Plan | Bronze Plan |
|---|---|---|---|
| | **In-Network** | **In-Network** | **In-Network** |
| Maximum Annual Benefits | Unlimited | None | None |
| Annual Deductible (Single/Family) | $2,500/$5,000 | $5,000/$10,000 | $5,000/$10,000 |
| Coinsurance | The plan pays 70% and you Pay 30% | None | The plan pays 80% You pay 20% |
| Maximum Out-Of- Pocket *100% after limit* (Single/Family) | $6,000/12,000 | $6,850/$13,700 | $6,850/$13,700 |
| **Inpatient Services** | | | |
| ***Semi-private room and Board**<br>**All drugs and medications**<br>**Anesthesia**<br>***Intensive Care & Coronary Units** | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* |
| ***Maternity** | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* |
| ***Routine Nursery Care** | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* |
| ***Skilled Nursing Facility Care** | Subject to Deductible & Coinsurance<br>Maximum of 120 days per Calendar year | Subject to Deductible<br>*Maximum of 120 days per Calendar year* | Subject to Deductible & Coinsurance<br>*Maximum of 120 days per Calendar year* |
| ***Hospice Care** (in-patient/in-home) | Subject to Deductible & Coinsurance<br>*Maximum of 60 days per Calendar year* | Subject to Deductible<br>*Maximum of 60 days per Calendar year* | Subject to Deductible & Coinsurance<br>*Maximum of 60 days per Calendar year* |
| ***Inpatient Admission for Medical Rehabilitation** (i.e., Physical Therapy, Physical Medicine and Rehabilitation) | Subject to Deductible & Coinsurance<br>*Maximum of 60 days per Calendar year* | Subject to Deductible<br>*Maximum of 60 days per Calendar year* | Subject to Deductible & Coinsurance<br>*Maximum of 60 days per Calendar year* |
| ***Organ Transplants** | Subject to Deductible & Coinsurance<br>*Base coverage 90 days Single Hospital confinement* | Subject to Deductible<br>*Transplants performed at our approved facilities are covered and no co-insurance is applied. Transplants performed at other network facilities additional co-insurance of 50% applies.* | Subject to Deductible & Coinsurance<br>*Base coverage 90 days Single Hospital confinement*<br>*Transplants performed at our approved facilities are covered and no co-insurance is applied. Transplants performed at other network facilities additional co-insurance of 50% applies.* |
| **Outpatient Services** | | | |
| **Pre-Admission Testing** | Subject to Deductible & Coinsurance | Subject to Deductible | Subject to Deductible & Coinsurance |
| ***Ambulatory Surgery** | Subject to Deductible & Coinsurance | Subject to Deductible | Subject to Deductible & Coinsurance |
| ***Outpatient Dialysis** | Subject to Deductible & Coinsurance<br>*Maximum of 156 visits per calendar year* | Subject to Deductible | Subject to Deductible & Coinsurance |
| ***Home Health Care Services**<br>*(4 hours = 1 visit)* | Subject to Deductible & Coinsurance<br>*Maximum of 60 visits per calendar year* | $20 Copay after deductible<br>*Maximum of 60 visits per calendar year* | *$20 Copay after deductible*<br>*Maximum of 60 visits per calendar year* |

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| | Gold Plan | Silver Plan | Bronze Plan |
|---|---|---|---|
| | In-Network | In-Network | In-Network |
| **Medical** | | | |
| **Home, Office and I/P hospital physician visits** | $40 Copay | $30 Copay | $30 Copay |
| **Prenatal and post-natal care** | $40 Copay | $30 Copay | $30 Copay |
| **Routine Adult Physical** (one per year) | No Charge | No Charge | No Charge |
| **Preventive Mammography and Pap Smear Screening** | No Charge | No Charge | No Charge |
| **Preventive Prostate Screening** | No Charge | No Charge | No Charge |
| **Well Baby and Well Child Care up to age 19 Includes:** *Routine physical examinations, laboratory tests, vision & hearing Screening and routine immunizations* | No Charge | No Charge | No Charge |
| **Specialist office visits** | $80 Copay | $60 Copay | $60 Copay |
| **Surgery and Anesthesia – in Office** | -- | Subject to Deductible | Subject to Deductible & Coinsurance |
| **Allergy Care** | $40 Copay *Maximum of 36 visits per calendar year* | $30 Copay *Maximum of 36 visits per calendar year* | $30 Copay after deductible *Maximum of 36 visits per calendar year* |
| **Chiropractic Care** | $40 Copay *Maximum of 20 visits per calendar year* | $30 Copay after deductible *Maximum of 20 visits per calendar year* | *$30 Copay Maximum of 20 visits per calendar year* |
| **Physical Therapy, Osteopathic Manipulation, Occupational Therapy** | $40 Copay *Maximum of 30 combined visits per calendar year* | $30 Copay *Maximum of 30 visits per calendar year* | $30 Copay *Maximum of 30 visits per calendar year* |
| **Speech Therapy** | $40 Copay *Maximum of 20 visits per calendar year* | $30 Copay *Maximum of 20 visits per calendar year* | $30 Copay *Maximum of 20 visits per calendar year* |
| **Lab & Radiology** | | | |
| **Diagnostic Lab Tests, X rays** | No Charge | No Charge | No Charge |
| ***High Tech Radiology (e.g., CT Scan, MRI)** | $200 Copay | $300 Copay | $300 Copay |
| **Emergency Coverage** | | | |
| **Emergency Care** | $500 Copay | $400 Copay | $400 Copay |
| **Freestanding Urgent Care Facility** | $100 Copay | $100 Copay | $100 Copay after deductible |
| **Non-Urgent Emergency Room Visits** | Not Covered | Not Covered | Not Covered |
| **Ambulance (Emergency ground transportation only)** | Subject to Deductible & Coinsurance | Subject to Deductible | Subject to Deductible & Coinsurance |
| **ER professional charges** | Subject to Deductible & Coinsurance | Subject to Deductible | Subject to Deductible & Coinsurance |
| **Other Services** | | | |
| ***Prosthetic Devices and Durable Medical Equipment** | Subject to Deductible & Coinsurance | Subject to Deductible | Subject to Deductible & Coinsurance |
| **Routine Vision** | Not Covered | Not Covered | Not Covered |
| ***Home Infusion Therapy** | Subject to Deductible & Coinsurance *Maximum of 60 visits per calendar year* | Subject to Deductible *Maximum of 60 visits per calendar year* | Subject to Deductible & Coinsurance *Maximum of 60 visits per calendar year* |

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| | Gold Plan | Silver Plan | Bronze Plan |
|---|---|---|---|
| | In-Network | In-Network | In-Network |
| **Mental Health & Chemical Dependency** | | | |
| ***Inpatient Mental Health** | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible<br>*Base coverage 90 days*<br>*Single Hospital confinement* | Subject to Deductible & Coinsurance<br>*Base coverage 90 days*<br>*Single Hospital confinement* |
| ***Outpatient Mental Health** | $80 Copay | $60 Copay | $60 Copay |
| ***Inpatient Chemical Dependency treatment** | | | |
| **Detoxification** | Subject to Deductible & Coinsurance<br>*Maximum of 7 days per Calendar year* | Subject to Deductible | Subject to Deductible & Coinsurance |
| **Rehabilitation** | Subject to Deductible & Coinsurance<br>*Maximum of 30 days per Calendar year* | Subject to Deductible | Subject to Deductible & Coinsurance |
| ***Outpatient Chemical Dependency treatment** | $80 Copay | $60 Copay | $60 Copay |
| **Prescription Drugs** | | | |
| | Retail – 30 day supply | Retail – 30 day supply | Retail – 30 day supply |
| **Generic** | $20 copay | $20 Copay | $20 Copay |
| **Preferred Brand** | $50 Copay | $50 Copay | $50 Copay |
| **Non-preferred Brand** | $80 Copay | $80 Copay | $80 Copay |
| **Specialty drugs** | Not Covered | Not Covered | Not Covered |
| | Mail Order – 90 day supply<br>*Required for maintenance drugs after filling three times at a retail pharmacy* | Mail Order – 90 day supply | Mail Order – 90 day supply |
| **Generic** | $20 Copay | $20 Copay | $20 Copay |
| **Preferred Brand** | $125 Copay | $125 Copay | $125 Copay |
| **Non-preferred Brand** | $200 Copay | $200 Copay | $200 Copay |
| **Specialty drugs** | Not Covered | Not Covered | Not Covered |

***These services require precertification.**

The maximums listed above are the total for Network & Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year Maximum is 60 days total, which may be split between Network & Non-Network providers.

Dependent children are covered to age 26.
Refer to your Summary Plan Description for a more complete listing of all benefits, limitations and exclusions.

**General Exclusions**
You are not covered for physical exams for employment, insurance, school, premarital requirement or summer camp (unless substituted for a normal well visit/physical exam); prescription drugs prescribed for a non-covered service; dental services; hearing aid appliances; routine foot care; cosmetic or reconstructive surgery, unless medically necessary; custodial services; weight-reduction programs and Bariatric surgery for any reason; marriage counseling; long-term psychiatric treatment, Infertility Treatment, Autism (NY Autism Mandate), Bariatric Surgery, Cosmetic Surgery, Non-Emergency Care When Traveling outside the U.S., Private-Duty Nursing, Specialty Medications.

See your Plan Documents for a full listing of covered and excluded services.

| | Gap Low Plan | Gap High Plan |
|---|---|---|
| **Inpatient Hospital Benefits -** Inpatient hospital stays, outpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determined your calendar year maximum benefit (multiplied by three for an insured family) | **$5,500** | **$8,000** |
| **Outpatient Hospital Benefits**<br>• Radiological testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility<br>• Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment<br>• Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office<br>• MRIs. CT scans, PET scans, diagnostic ultrasounds, electrocardiogram (EKG) tests performed in a physician's office (x-rays and lab fees are not included)<br>• Cardiac cauterizations and stress tests<br>• Accident, injury, or emergency condition treatment in a hospital ER or urgent care center | **$5,500** | **$8,000** |
| **Accident-Only Ambulance Benefits -** Payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident. Ambulance transportation must be within 72 hours of the accident and must be provided by a licenced professional ambulance company | **$1,000** | **$1,000** |

EQUITABLE

# Dental Insurance

| | Medium Plan | | High Plan | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Reimbursement** | Contracted Allowances | 95th percentile R&C | Contracted Allowances | 95th percentile R&C |
| **Coinsurance** | 100/80/50 | 100/80/50 | 100/90/60 | 100/80/50 |
| Annual Individual Deductible | $50 Calendar Year | $50 Calendar Year | $50 Calendar Year | $50 Calendar Year |
| Annual Family Deductible | $150 | $150 | $150 | $150 |
| Deductible Waived for Preventive | Yes | Yes | Yes | Yes |
| Annual Individual Maximum Benefit | $2,000 Calendar Year | $2,000 Calendar Year | $3,000 Calendar Year | $3,000 Calendar Year |
| Missing Tooth Clause | Applies | Applies | Applies | Applies |
| **Orthodontia** | | | | |
| Child Orthodontia Individual Deductible | $0 | $0 | $0 | $0 |
| Child Orthodontia Lifetime Maximum Benefit | $2,000 | $2,000 | $3,000 | $3,000 |
| Child Orthodontia covered to age | 26 | 26 | 26 | 26 |
| **Prior Coverage Deductible Credit** | No | No | No | No |
| **Preventive Services** | | | | |
| **Periodic and Comprehensive Oral Evaluations**<br>*2 per 12 consecutive months inclusive of Limited Evaluations and Office Visits After Regularly Scheduled Hours.* | 100% | 100% | 100% | 100% |
| **Limited Evaluations**<br>*2 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations and Office Visits After Regularly Scheduled Hours.* | 100% | 100% | 100% | 100% |
| **Professional Consultations**<br>*1 per 12 consecutive months per specialty and no more than 2 for all specialties within this period, inclusive of Office Visit for Observation During Regularly Scheduled Hours- No Other Services Performed.* | 100% | 100% | 100% | 100% |
| **Professional Office Visits**<br>*1 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations, Limited Evaluations and Professional Consultations.* | 100% | 100% | 100% | 100% |
| **Treatments** | | | | |
| **Routine Dental Prophylaxis**<br>*2 per 12 consecutive months including periodontal cleanings and full mouth debridement* | 100% | 100% | 100% | 100% |
| **Fluoride Treatment**<br>*2 per 12 consecutive months to age 16* | 100% | 100% | 100% | 100% |
| **Sealants - child**<br>*Covered for a child up to age13 Limited to one per tooth per 36 months for non-restored first and second permanent molars.* | 100% | 100% | 100% | 100% |
| **Bitewing X-Rays**<br>*2 sets per 12 consecutive months* | 100% | 100% | 100% | 100% |
| **Complete Series or Panoramic X-Rays**<br>*Once per 36 consecutive months* | 100% | 100% | 100% | 100% |
| **Labs and Tests** | | | | |
| **Tests - Brush Biopsy, Adjunctive Pre-Diagnostic, HBA1c and Pulp Vitality**<br>*1 per 12 consecutive months* | 100% | 100% | 100% | 100% |
| **Labs - Accession of Tissue and Laboratory Accession of Sample**<br>*1 per 12 consecutive months* | 100% | 100% | 100% | 100% |

EQUITABLE

| | Medium Plan | | High Plan | |
|---|---|---|---|---|
| **Basic Services**<br>**Waiting Period: None for New Hires Only** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Periapicals and Other X-Rays**<br>*Once per 36 consecutive months* | 80% | 80% | 90% | 80% |
| **Emergency Palliative Treatment**<br>*Eligible only when no other procedure is performed on the same day except for Diagnostic procedures.* | 80% | 80% | 90% | 80% |
| **Basic Restorative Services** (amalgam fillings on all teeth, resin based composite fillings on anterior teeth)<br>*1 per tooth surface per 12 consecutive months* | 80% | 80% | 90% | 80% |
| **Basic Restorative Services** (resin based composite fillings on posterior teeth)<br>*1 per tooth surface per 12 consecutive months* | 80% | 80% | 90% | 80% |
| **Space Maintainers and Recementation of Space Maintainers**<br>*Once per every 60 consecutive months for Children under age 16. Benefit includes all adjustments within 6 months of installation* | 80% | 80% | 90% | 80% |
| **Simple Extractions**<br>*Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services* | 80% | 80% | 90% | 80% |
| **Surgical Extractions and Removal of Impacted Teeth**<br>*Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services* | 80% | 80% | 90% | 80% |
| **Oral Surgery**<br>*Limited to 1 unique site per 36 months* | 80% | 80% | 90% | 80% |
| **Surgical Endodontics**<br>*1 per 36 consecutive months* | 80% | 80% | 90% | 80% |
| **Non-Surgical Endodontics**<br>*Root Canal Treatment and Miscellaneous Services-*<br>*1 per tooth per lifetime*<br>*Root Canal Retreatment*<br>*1 per tooth per 12 consecutive months* | 80% | 80% | 90% | 80% |
| **Periodontal Maintenance**<br>*Only where periodontal treatment has been performed, limited to 4 per 12 consecutive months less the number of teeth cleanings and debridements received during such benefit period* | 80% | 80% | 90% | 80% |
| **Non-Surgical Periodontics**<br>*Full Mouth Debridement -*<br>*1 per 5 years when Dentally Necessary to enable comprehensive evaluation and diagnosis. Counted towards Periodontal Maintenance and regular Cleanings.*<br>*Scaling in Presence of Generalized Gingival Inflammation-*<br>*1 per full mouth per 24 consecutive months.*<br>*Other Non-Surgical procedures-*<br>*1 per 36 consecutive months* | 80% | 80% | 90% | 80% |
| **Surgical Periodontics**<br>*1 per quadrant per 36 consecutive months* | 80% | 80% | 90% | 80% |
| **Anesthesia**<br>*General Anesthesia covered when medically or dentally necessary in conjunction with covered dental services. Local anesthesia is included in the fee for procedure being performed.* | 80% | 80% | 90% | 80% |

EQUITABLE

| | Medium Plan | | High Plan | |
|---|---|---|---|---|
| **Major Services**<br>**Waiting Period: 12 Months for New Hires Only** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Inlays/Onlays/Crowns**<br>*1 replacement per tooth per 60 consecutive months. Covered when medically or dentally necessary.* | 50% | 50% | 60% | 50% |
| **Dentures - Complete, partial, overdenture,** (upper and lower)<br>*1 replacement per 60 consecutive months. Covered when medically or dentally necessary.* | 50% | 50% | 60% | 50% |
| **Implants**<br>*1 per tooth per lifetime. Covered when medically or dentally necessary.* | 50% | 50% | 60% | 50% |
| **Bridges**<br>*1 replacement per 60 consecutive months. Covered when medically or dentally necessary.* | 50% | 50% | 60% | 50% |
| **Other Dental Prosthetics**<br>*Overdentures 1 replacement per arch per 60 consecutive months against Dentures.*<br>*Tissue Conditioning*<br>*1 per arch per 12 consecutive months.* | 50% | 50% | 60% | 50% |
| **Adjustments, Repairs, Reline and Rebase of Dentures**<br>*Adjustments limited to after 6 months of installation if performed by the same dentist* | 50% | 50% | 60% | 50% |
| **Standard Services Not Covered** | | | | |
| **Occlusal Guards** | 0% | 0% | 0% | 0% |
| **Orthodontic Services**<br>**Waiting Period: 12 Months for New Hires Only** | | | | |
| **Child Orthodontic Services**<br>*Covered for dependent children only* | 50% | 50% | 50% | 50% |

EQUITABLE

# Dental DMO plan

| | |
|---|---|
| Lifetime Ortho Maximum | $1,950 |
| Office Visit Copay | $0 |
| | |
| Periodic Oral Exam | $0 |
| X-Rays, Complete Series | $0 |
| 2 Bitewing X-Rays | $0 |
| Adult Prophylaxis (cleaning) | $0 |
| 2 Surface Filling | $40 |
| 1 Surface Comp. Resin Filling (anterior teeth) | $20 |
| Porcelain/Gold Crown | $80-$350 |
| Anterior Root Canal | $100 |
| Scalings & Root Planing (Quad) | $36 |
| Complete Upper Denture | $210 |
| Retainer Crown | $195 |
| Single Extraction | $10-$45 |
| Limited Orthodontics (child and adult) | $1000-$1350 |
| Comprehensive Orthodontics (child and adult) | $1800-$1950 |

# Vision Insurance

| Vision care services | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Exam** | | |
| *Use your Exam coverage once every rolling 12 months* | | |
| **Routine/Comprehensive Eye Exam** | $10 Copay | $25 Reimbursement |
| **Standard Contact lens Fit/Follow up** | Member pays discounted fee of $40 | Not covered |
| **Premium Contact Lens Fit/Follow-Up** | Member pays 90% of retail | Not covered |
| **Eyeglass Lenses /Lens options** | | |
| *Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses* | | |
| **Standard Plastic Single Vision Lenses** | $25 Copay | $10 Reimbursement |
| **Standard Plastic Bifocal Vision Lenses** | $25 Copay | $25 Reimbursement |
| **Standard Plastic Trifocal Vision Lenses** | $25 Copay | $55 Reimbursement |
| **Standard Plastic Lenticular Vision Lenses** | $25 Copay | $55 Reimbursement |
| **Standard Progessive Vision lenses** | $90 Copay | $25 Reimbursement |
| **Premium Progressive Vision lenses**[1] | 20% Discount off retail<br>minus $120 plan allowance<br>plus $90 Copay = member out-of-pocket | $25 Reimbursement |
| **UV Treatment** | Member pays discounted fee of $15 | Not Covered |
| **Tint (Solid and Gradient)** | Member pays discounted fee of $15 | Not Covered |
| **Standard Plastic Scratch Coating** | $0 Copay | $15 Reimbursement |
| **Standard Polycarbonate Lenses -** Adults | Member pays discounted fee of $40 | Not Covered |
| **Standard Polycarbonate Lenses -**<br>Children until age 19 | $0 Copay | $35 Reimbursement |
| **Standard Anti-Reflective Coating** | Member pays discounted fee of $45 | Not Covered |
| **Polarized And Other Lens Add Ons** | Member pays 80% of Retail | Not covered |
| **Contact Lenses** | | |
| *Use your Contact Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses* | | |
| **Conventional contact lenses** | $105 Allowance**<br>Additional 15% off balance<br>over the allowance | $75 Reimbursement |
| **Disposable contact lenses** | $105 Allowance | $84 Reimbursement |
| **Medically necessary contact lenses** | $0 Copay | $200 Reimbursement |
| **Frames** | | |
| *Use your frame coverage once every rolling 24 months* | | |
| **Any Frame available, including frames for prescription sunglasses** | $130 Allowance**<br>Additional 20% off balance<br>over the Allowance | $65 Reimbursement |
| **In Network Discounts** | | |
| **Additional pairs of eyeglasses or prescription sunglasses**[2] | Up to a 40% Discount | |
| **Non-covered items**[3] | 20% Discount | |
| **Lasik Laser vision correction or PRK from U.S. Laser Network**[4] **only. Call 1-800-422-6600** | 15% discount off retail or 5% discount off the promotional price | |
| **Retinal Imaging**[5] | Member pays a discounted fee up to $39 | |

## Partial list of exclusions and limitations

*Exclusions and limitations for vision include: any charges in excess of the benefits, dollar or supply limits listed above; special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses. Other exclusions and limitations may also apply.*

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111. Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

[1]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.
[2]Additional pair discount applies to purchases made after the plan allowances have been exhausted.
[3]Non covered discounts may not be available in all states.
[4]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
[5]Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care (“EyeMed”), LLC. Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 877-973-3238. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512. 1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). Help for those who speak another language and for the hearing impaired

# Hospital Indemnity Insurance

**Plan Description**
The Aflac Group Hospital Indemnity Plan provides cash benefits directly to you that help pay for some of the costs – medical and nonmedical – associated with a covered hospital stay due to a sickness or accidental injury.

| Hospitalization Benefits | Benefit Amount |
|---|---|
| **Hospital Admission (per confinement)**<br>*once per covered sickness or accident per calendar year for each insured*<br><br>Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury or because of a covered sickness. Not payable for confinement to an observation unit, or for emergency room treatment or outpatient treatment. | $1,000 |
| **Hospital Confinement (per day)**<br>*maximum of 31 days per confinement for each covered sickness or accident for each insured*<br><br>Payable for each day that an insured is confined to a hospital as an inpatient as the result of a covered accidental injury or because of a covered sickness.If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness. | $150 |
| **Hospital Intensive Care (per day)**<br>*maximum of 10 days per confinement for each covered sickness or accident for each insured*<br><br>Payable for each day that an insured is confined in a hospital intensive care unit because of a covered accidental injury or because of a covered sickness. We will pay benefits for only one confinement in a hospital's intensive care unit at a time, even if it is caused by more than one covered accidental injury, more than one covered sickness or a covered accidental injury and a covered sickness. If we pay benefits for confinement in a hospital's intensive care unit and an insured becomes confined to a hospital's intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.<br><br>***This benefit is payable in addition to the Hospital Confinement Benefit.*** | $150 |
| **Intermediate Intensive Care Step-Down Unit (per day)**<br>*maximum of 10 days per confinement for each covered sickness or accident for each insured*<br><br>Payable for each day when an insured is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time.<br><br>Once benefits are paid, if an insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.<br><br>***This benefit is payable in addition to the Hospital Confinement Benefit.*** | $75 |
| *In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident.* | |

| Health Screening Benefit | | Benefit Amount |
|---|---|---|
| The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.<br>This benefit is payable for each insured. | | |
| • Blood test for triglycerides<br>• Bone marrow testing<br>• Breast ultrasound<br>• CA 15-3 (blood test for breast cancer)<br>• CA 125 (blood test for ovarian cancer)<br>• CEA (blood test for colon cancer)<br>• Chest X-ray<br>• Colonoscopy<br>• DNA stool analysis<br>• Fasting blood glucose test<br>• Flexible sigmoidoscopy<br>• Non-diagnostic vascular screening | • Immunization<br>• Hemoccult stool analysis<br>• Mammography<br>• Pap smear<br>• PSA (blood test for prostate cancer)<br>• Serum cholesterol test to determine level of HDL and LDL<br>• Serum protein electrophoresis (blood test for myeloma)<br>• Spiral CT screening for lung cancer<br>• Stress test on a bicycle or treadmill<br>• Thermography<br>• Urinalysis<br>• Vision screening | $50<br>per calendar year |

# Accident Insurance

Accident insurance is designed to help you meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Indemnity lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The accident plan is guaranteed issue, so no health questions are required.

| Initial Accident Treatment Benefit | Benefit Amount |
|---|---|
| **INITIAL TREATMENT** (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following: | |
| **Hospital emergency room with X-Ray / without X-Ray** | $200/$150 |
| **Urgent care facility with X-Ray / without X-Ray** | $200/$150 |
| **Doctor's office or facility** (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray | $100/$75 |
| **AMBULANCE** (once per day, within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury. | $300 Ground<br>$900 Air |
| **MAJOR DIAGNOSTIC TESTING** (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center. | $150 |
| **EMERGENCY ROOM OBSERVATION** (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury. | $70<br>For each 24 hour period<br>$35<br>For less than 24 hours, but at least 4 hours |
| **PRESCRIPTIONS** (2 times per accident, within 6 months after the accident) Payable for a prescription filled that - due to a covered accidental injury - is ordered by a doctor, dispensed by a licensed pharmacist and medically necessary for the care and treatment of the insured.<br>This benefit is not payable for therapeutic devices or appliances; experimental drugs; drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or immunization agents, biological sera, blood or blood plasma.<br>This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available). | $5 |
| **BLOOD/PLASMA/PLATELETS** (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury. | $200 |
| **PAIN MANAGEMENT** (once per accident, within 6 months after the accident) Payable when an insured, due to a covered accidental injury, is prescribed and receives a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is only payable for pain management techniques (as shown above) that are administered in a hospital or doctor's office. This benefit is not payable for an epidural administered during a surgical procedure. | $75 |
| **CONCUSSION** (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident. | $350 |
| **TRAUMATIC BRAIN INJURY** (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a covered accident. To qualify as TBI, the neurological deficit must require treatment by a neurologist and a prescribed course of physical, speech and/or occupational therapy under the direction of a neurologist. | $3,500 |
| **COMA** (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident. | $7,500 |
| **EMERGENCY DENTAL WORK** (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident. | $30<br>Extraction<br>$120<br>Repair with a crown |
| **BURNS** (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered. | |
| **Second Degree** | |
| Less than 10% | $75 |
| At least 10% but less than 25% | $150 |
| At least 25% but less than 35% | $375 |
| 35% or more | $750 |
| **Third Degree** | |
| Less than 10% | $750 |
| At least 10% but less than 25% | $3,750 |
| At least 25% but less than 35% | $7,500 |
| 35% or more | $15,000 |

| Initial Accident Treatment Benefit *(continued)* | |
|---|---|
| **EYE INJURIES** Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia. | $175 |
| **FRACTURES** (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures. | Up to $3,000 based on a schedule |
| **DISLOCATIONS** (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint. | Up to $2,250 based on a schedule |
| **LACERATIONS** (once per accident, within 7 days after the accident) Payable when an insured receives a laceration in a covered accident and the laceration is repaired by a doctor. For multiple lacerations, we will pay a maximum of 200% of the benefit for the largest single laceration requiring stitches. Lacerations requiring stitches (including liquid skin adhesive): | |
| Over 15 centimeters | $600 |
| 5-15 centimeters | $300 |
| Under 5 centimeters | $75 |
| Lacerations not requiring stitches | $37.50 |
| **OUTPATIENT SURGERY AND ANESTHESIA** (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount. | $300 |
| **FACILITIES FEE FOR OUTPATIENT SURGERY** (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center). | $75 |
| **OUTPATIENT SURGERY AND ANESTHESIA** (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident)<br>Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount. | $35 |
| **INPATIENT SURGERY AND ANESTHESIA** (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount. | $750 |
| **TRANSPORTATION** (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident)<br>Payable for transportation if, because of a covered accident, an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city. | $350 Plane<br>$150 Any ground transportation |
| *Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.* | |
| **Hospitalization Benefit** | |
| **HOSPITAL ADMISSION** (once per accident, within 6 months after the accident)<br>Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury.<br>This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment. | $900 per confinement |
| **HOSPITAL CONFINEMENT** (maximum of 365 days per accident, within 6 months after the accident)<br>Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury.<br>If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement.<br>This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility. | $225 per day |
| **HOSPITAL INTENSIVE CARE** (maximum of 30 days per accident, within 6 months after the accident)<br>Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury.<br>We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury.<br>If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement.<br>This benefit is payable in addition to the Hospital Confinement Benefit. | $300 per day |

| Hospitalization Benefit *(continued)* | |
|---|---|
| **INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT** (maximum of 30 days per accident, within 6 months after the accident)<br>Payable for each day an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury.<br>We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury.<br>If we pay benefits for confinement in an intermediate intensive care step-down unit and an insured becomes confined to an intermediate intensive care step-down unit again within 6 months because of the same condition, we will treat this confinement as the same period of confinement.<br>This benefit is payable in addition to the Hospital Confinement Benefit. | $150<br>per day |
| **FAMILY MEMBER LODGING** (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident)<br>Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family.<br>For this benefit to be payable:<br>• The insured must be confined to a hospital for treatment of a covered accidental injury;<br>• The hospital and motel/hotel must be more than 100 miles from the insured's residence; and<br>• The treatment must be prescribed by the insured's treating doctor. | $150<br>per day |
| **After Care Benefits** | |
| **APPLIANCES** (within 6 months after the accident)<br>Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion.<br>Cane, Ankle Brace<br>Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar<br>Wheelchair, Knee Scooter, Body Jacket, Back Brace | <br><br>$30<br>$75<br>$300 |
| **ACCIDENT FOLLOW-UP TREATMENT** (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident)<br>Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident.<br>Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment. | $35 |
| **POST-TRAUMATIC STRESS DISORDER (PTSD)** (once per accident, within 6 months after the accident)<br>Payable if the insured is diagnosed with PTSD, a mental health condition triggered by a covered accident. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist. | $150 |
| **REHABILITATION UNIT** (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured)<br>Payable for each day that, due to a covered accidental injury, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement.<br>We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid. We will pay the highest eligible benefit. | $75<br>per day |
| **THERAPY** (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)<br>Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist. | $35 |
| **CHIROPRACTIC OR ALTERNATIVE THERAPY** (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)<br>Payable if because of injuries received in a covered accident, an insured receives acupuncture or chiropractic treatment. | $25 |
| **Life Changing Events Benefits** | |
| **DISMEMBERMENT** (once per accident, within 6 months after the accident)<br>Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident.<br>Dismemberment means:<br>• Loss of a hand -The hand is removed at or above the wrist joint;<br>• Loss of a foot -The foot is removed at or above the ankle;<br>• Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or<br>• Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable).<br>If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit. | |

| Life Changing Events Benefits *(continued)* | |
|---|---|
| **SINGLE LOSS** (the loss of one hand, one foot, or the sight of one eye) | |
| Employee | $6,250 |
| Spouse | $2,500 |
| Child(ren) | $1,250 |
| **DOUBLE LOSS** (the loss of both hands, both feet, the sight of both eyes, or a combination of any two) | |
| Employee | $12,500 |
| Spouse | $5,000 |
| Child(ren) | $2,500 |
| **LOSS OF ONE OR MORE FINGERS OR TOES** | |
| Employee | $625 |
| Spouse | $250 |
| Child(ren) | $125 |
| **PARTIAL DISMEMBERMENT** (includes at least one joint of a finger or a toe) | |
| Employee | $62.50 |
| Spouse | $62.50 |
| Child(ren) | $62.50 |
| **PARALYSIS** (once per accident, diagnosed by a doctor within six months after the accident)<br>Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.<br>Paraplegia<br>Quadriplegia | <br><br><br>$2,500<br>$5,000 |
| **PROSTHESIS** (once per accident, up to 2 prosthetic devices and one replacement per device per insured)*<br>Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury. Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices* and /or joint replacements.<br>* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment. | $1,500 |
| **RESIDENCE/VEHICLE MODIFICATION** (once per accident, within one year after the accident)<br>Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of one of the following, due to a covered accidental injury:<br>• The sight of one eye;<br>• The use of one hand/arm; or<br>• The use of one foot/leg. | $1,000 |
| **Wellness Rider** | |
| **WELLNESS BENEFIT (once per calendar year)**<br>Payable for the following wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.<br>• Annual physical exams<br>• Flexible Sigmoidoscopy<br>• Mammograms<br>• PSA Tests<br>• Pap Smears<br>• Ultrasounds<br>• Eye Examinations<br>• Blood Screening<br>• Immunizations | |
| **THE AMOUNT PAID WILL BE BASED ON WHEN THE WELLNESS TEST WAS PERFORMED:**<br>First year of certificate<br>Second, third and fourth year of certificate<br>Fifth year of certificate and thereafter | <br>$15<br>$30<br>$60 |

# Critical Illness Insurance

**Plan Description**
The Aflac Group Critical Illness Plan provides cash benefits when an insured person is diagnosed with a covered critical illness-and these benefits are paid directly to you. The plan proves a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness

| Covered Critical Illnesses | |
|---|---|
| **Cancer (Internal Or Invasive)** | 100% |
| **Heart Attack (Myocardial Infarction)** | 100% |
| **Stroke (Ischemic Or Hemorrhagic)** | 100% |
| **Major Organ Transplant** | 100% |
| **Kidney Failure (End-Stage Renal Failure)** | 100% |
| **Bone Marrow Transplant (Stem Cell Transplant)** | 100% |
| **Sudden Cardiac Arrest** | 100% |
| **Severe Burn*** | 100% |
| **Paralysis**** | 100% |
| **Coma**** | 100% |
| **Loss of Speech / Sight / Hearing**** | 100% |
| **Non-Invasive Cancer** | 25% |
| **Coronary Artery Bypass Surgery** | 25% |

**This benefit is only payable for a burn due to, caused by, and attributed to, a covered accident.*
***These benefits are payable for loss due to a covered underlying disease or a covered accident.*

## Initial Diagnosis

We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

## Additional Diagnosis

We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months and the new critical illness is not caused or contributed to by a critical illness for which benefits have been paid. Cancer diagnoses are subject to the cancer diagnosis limitation.

## Reoccurrence

We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months and the critical illness is not caused or contributed by a critical illness for which benefits have been paid.
Cancer diagnoses are subject to the cancer diagnosis limitation.

## Child Coverage At No Additional Cost

Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

## Skin Cancer Benefit

We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

## Waiver of Premium

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

## Successor Insured Benefit

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

## Health Screening Benefit (Employee and Spouse only)

We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.
This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse.
**This benefit is not paid for dependent children.**

| Occupational HIV Rider | |
|---|---|
| This benefit pays the applicable maximum benefit amount for the initial positive diagnosis of occupational human immunodeficiency virus (HIV), as a result of a covered injury. This benefit is payable once, and once the benefit is paid, coverage for that individual will terminate.<br>This benefit is paid based on your selected Critical Illness Benefit amount. | 100% |
| **Childhood Conditions Rider** | |
| **Cystic Fibrosis** | 50% |
| **Cerebral Palsy** | 50% |
| **Cleft Lip or Cleft Palate** | 50% |
| **Down Syndrome** | 50% |
| **Phenylalanine Hydroxylase Deficiency Disease (PKU)** | 50% |
| **Spina Bifida** | 50% |
| **Type 1 Diabetes** | 50% |
| *Benefits are payable if a dependent child is diagnosed with one of the conditions listed.* | |

CHUBB®

# Lifetime Benefit Term Life Insurance

## Product Features

- Valuable life insurance protection through age 120!
- LifeTime Benefit Term life insurance up to $250,000 for eligible actively at work employees.
- Life base insurance premiums are guaranteed never to increase through age100.
- No medical exams required. Issuance of coverage depends upon answers to a few health questions.
- Provides paid-up death benefit values after only ten years, so if you decide to stop paying premiums at some time in the future, you are guaranteed paid-up coverage of a reduced amount.
- Flexible! You have the option to: Continue your coverage at the same premium; or Elect paid-up insurance coverage of a reduced amount after 10 years with no further premium payments—Guaranteed!
- Fully portable – you own it and take it with you when you leave your employment.
- Spouse and child coverage is available.
- Based on current interest rate assumptions the death benefit is designed to remain level through age 120 and fully paid up at age 100. In the event of a long term decline in interest rates, your coverage does contain a guarantee ensuring that the initial death benefit will last for the longer of 25 years or to age 70 and thereafter can never be less than 50% of your initial death benefit

## Issue Limits

**Guaranteed Issue Eligibility- Defined Benefit**

Employee Coverage: Issue Ages 19 – 70; Maximum amount allowed is $100,000

Child Term Rider Coverage: Issue ages 15 days to 25 years; 25 units

Child Certificate Coverage: Issue ages 15 days to 25 years; $25,000

**Conditional Guaranteed Issue Eligibility- Defined Benefit**

Employee Coverage: Issue Ages 19 – 70; Maximum amount allowed is $150,000

Spouse Coverage: Issue Ages 19 – 70; Maximum amount allowed is $75,000

**Simplified Eligibility - Defined Benefit**

Employee Coverage: Issue Ages 19 – 70; Maximum amount allowed is $250,000

Spouse Coverage: Issue Ages 19 – 70; Maximum amount allowed is $125,000

Employee Coverage: Issue Ages 71 - 80; Maximum amount allowed is $50,000

The maximum amount of coverage for any one life is limited to the SI maximum limits above even when multiple products are made available.

## Dependent Child Coverage and Eligibility

*Employees may apply for coverage on a Dependent Child in one of the following two ways, but not both:*

- Dependent Child Optional Benefit Rider:
- Available on a Guarantee Issue basis.

Exception: when a child rider is added to an existing employee or spouse LBT contract and the child is not newly eligible, the child is added on a Simplified Issue basis – see below* .

## Dependent Child Individual LBT Certificate:

Available on a Guarantee Issue basis only at the Employee's initial eligibility period.

Employees applying for coverage on a child AFTER their initial eligibility period, may apply for coverage on a Simplified Issue basis – see below*.

Exception: when an Employee adds a newborn child (new step child or newly adopted child) after their initial eligibility period, they may apply for coverage on a Guarantee Issue basis.

**The Employee must answer all the required health questions on the child proposed for coverage on page one and two of the enrollment form which Chubb's Administrative Office will review to determine if the coverage applied for can be issued.*

## Overview of Included Benefit Rider

**Accelerated Death Benefit Rider for Terminal Illness:** Automatically included at no cost. Allows an accelerated payment of 50% of the death benefit not to exceed $100,000 if the insured's death is diagnosed to occur within a 12 month period.

## Overview of Optional Benefit Riders

*(**Not all riders are available in all states.** See certificate for full explanation and description of terms and benefits.)*

**Dependent Children Term Rider:** Issue ages from 15 days to age 25. One premium covers all eligible children – natural, step, adopted or any under legal guardianship. Coverage lasts to age 26 and may be converted up to 5 times the term amount. Maximum initial term amount is $25,000. Employees may apply for coverage on a Dependent Child in one of the following two ways, but not both: Dependent Child Optional Benefit Rider OR Dependent Child Individual LBT Certificate

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| Overview of Optional Benefit Riders *(continued)* |
| --- |
| **Waiver of Premium Rider:** Available only to employees. Issue ages from 20–55. Waives the base premium and all rider premiums after the 6th month of disability if the insured becomes totally disabled prior to age 60. |
| **Payor Waiver of Premium Rider:** Operates on the same basis as the Waiver of Premium, but waives premiums for any individual certificate of coverage on a spouse or child contract if the payor becomes totally disabled. |
| **Accelerated Death Benefit for Long Term Care (LTC) Rider:**<br>Issue ages are 19–80 for employees and 19-70 for spouses. The insured must be certified as being chronically ill (unable to perform 2 out of 6 activities of daily living or be cognitively impaired) and be confined to a nursing home or assisted living facility, or be receiving home health care or adult day care. The accelerated LTC benefit is 4% of the current death benefit amount payable each month for up to 25 months.<br>If death occurs prior to the end of the 25 month period, the remaining amount is paid as a death benefit. |
| **Restoration of Your Death Benefit**<br>Ordinarily, accelerating your life coverage for Long Term Care benefits can reduce your death benefit to $0. While inforce, this rider restores your life coverage to not less than 50% of the death benefit, up to a maximum of $50,000, on which your LTC benefits were based. This rider assures there will be a death benefit available for your beneficiary up to your insured's age 121. |

# Short-Term Disability Insurance

## Plan Description

The plan provides for payment of a monthly disability benefit when you are disabled and unable to work due to a Non-Occupational Injury or Sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit period.

### Plan Features

| | |
|---|---|
| **Benefit Amounts** | $300 to $6,000 |
| **Maximum Income Replacement** | 60% of the employee's base annual pay<br>*The maximum income replacement for states with state disability benefits is 40%.* |
| **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. |
| **Issue Ages** | Employee: 18-74 |
| **Termination Age** | Terminates at age 75 |

### 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.

### Portability

When you end employment with the employer and your coverage would otherwise terminate, you may elect to continue your coverage under the plan. You may continue the coverage that you had on the date your employment ended, including any in-force Spouse or Dependent Child coverage.

The following conditions must be met for you to keep your certificate in force:

- Within 31 days after the date your insurance would otherwise terminate, you must notify the Company. Notification may be via written notice sent to P.O. Box 427, Columbia, South Carolina, 29202; or by calling the Customer Service number at 800.433.3036; and
- You must pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Insurance will end on the earlier of these dates:

- 31 days after the date you fail to pay any required premium.
- The date the group policy is terminated.

However, coverage may not be continued if:

- You fail to pay any required premium, or
- The Group Policy terminates.

Notification of any changes in the plan will be provided directly to you.

If you qualify for the portability privilege, then we will apply the same benefits, plan provisions, and premium rate as shown in your previously issued coverage.

### 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 symptoms existed 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 was diagnosed within the 12-month period after the 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.

### 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

# Long-Term Disability Insurance

Long-term Disability helps to replace an employee's income due to illness or injury. After the elimination period, the benefit will be 60% of covered monthly earnings up to $5,000 per month.
As long as the employee meets the definition of disability and continues to be disabled, this benefit will be paid to the contract duration. A 3/12 pre-existing condition exclusion clause applies

| Plan Details | |
|---|---|
| **Required Minimum Number of Hours Worked** | 30 hours weekly |
| **Employer Contribution Percentage** | 0% |
| **Elimination Period** | 180 Days |
| **Maximum Benefit Duration** | 5 Years SSFRA |
| **Benefit Percentage** | 60% |
| **Maximum Monthly Benefit** | $5,000 |
| **Pre-Existing Condition Exclusion** | 3/12 |
| **Total Disability Definition** | Regular Occupation; 2 Years |
| **Partial Disability Benefit** | Proportionate Loss |
| **Residual Benefit** | Yes |

**Benefit Features**

- Accumulation of elimination period: 2 times the elimination period
- Continuation of personal insurance under Family Medical leave Act (FMLA)
- Continuation of personal insurance during Leave of Absence, including active military service and temporary layoff
- Gainful occupation: 80% if working/60% if not working
- Individual reinstatement: 30 days
- Mandatory rehabilitation program
- Minimum monthly benefit: $100
- Normal pregnancy and certain complications included in definition of Sickness
- Portability
- Recurrent disability: 6 months
- Return to work benefit: 12 months
- Social security integration method: family
- Survivor benefit: 3 times last gross monthly benefit
- Vocational rehabilitation program
- Waiver of premium
- Workplace modification benefit

# Employer-Paid Life Insurance

Life and Accidental Death and Dismemberment Benefit Summary

| Plan Features | |
|---|---|
| **Class Description:** | All Eligible Full-Time Employees[1] |
| **Required Minimum Number of Hours Worked:** | 24 hours weekly |
| **Amount of Life Insurance:** | $10,000 |
| **Amount of AD&D Insurance:** | Matches Life Amount |
| **Guaranteed Issue Amount:** | $10,000 |

**Reduction Schedule**

Coverage will reduce upon reaching certain ages as follows:

| **Employee's age when reduction occurs** | 65 | 70 | 75 | 80 | 85 | 90 |
|---|---|---|---|---|---|---|
| **Percent of Life Amount Remaining** | 65% | 45% | 30% | 20% | 15% | 10% |

| | |
|---|---|
| **Waiver of Premium Benefit:** | Age 60 w/ 9 month waiting period, terminates at age 65, with a 24-month mental illness/drug & alcohol limitation. |
| **Employer Contribution Percentage:** | 100% |

*This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.*