ACCOLADE
HEALTHCARE

2023/2024 Benefit Enrollment Guide

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Welcome!

As a new Accolade Healthcare employee, I want to welcome you to a new career with our company. You can take pride in the fact that you are now a team member of a premier provider of skilled health care services. Accolade Healthcare strives to provide excellent care for our residents and will help you attain excellence in your career with us.

An important part of your compensation package is the employee benefits made available to all eligible employees the first of the month following 60 days of employment. This guide will give you an overview of all the available insurance benefit choices. Our H.R./ Benefits Team has worked hard to provide you with a broad choice of insurance benefits to protect you and your family in time of need. Please take the time to review the important information in this guide so you can make informed choices when selecting your benefits.

Please note, it is your decision whether to participate in any of the benefits offered.
It is mandatory to go through the benefit offering interview to hear about your benefit choices. You can then enroll or decline any or all of the offerings.

To make the interview process as easy as possible, we have a dedicated enrollment firm with counselors who are available to help you understand how each benefit can work for you. During the month prior to your benefit eligibility, you must find a time to call the enrollment center at 866-544-4177. The call center is open 8 AM -5 PM Central Time.
You can have your benefit interview at that time if a counselor is available, or schedule an appointment for a future time. It's that simple.

Please contact your Director of Human Resources, Diana Tolley with any question or concerns regarding your benefits.

Again, welcome aboard! Wishing you much success!

Sincerely,

Moe Freedman,
President

ClaimDOC®
Fair Payment Solutions for Health Plans

Medical Insurance

	Base Plan	High Plan
Plan Deductible (single/fammily)	$5,000/$10,000	$2,000/$6,000
Plan Out-of-Pocket Maximum	$7,350/$14,700	$7,350/$14,700
Covered Benefits		
Physician Services - Office Visits		
Primary care visit to treat an injury or illness	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Specialist Visit	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Preventative care/screening/immunization	Plan pays 100%	Plan pays 100%
Inpatient		
Inpatient Hospital Facility Services, Inpatient Physician's Visit/Consultation	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Inpatient Professional Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient		
Outpatient Facility and Professional Services	$25 Copay -Plan pays 70%	$25 Copay -Plan pays 80%
Emergency Services		
Emergency Room Care	$500 copay, and plan pays 70%	$500 copay, and plan pays 80%
Urgent Care Facility	$50 copay, and plan pays 70%	$50 copay, and plan pays 80%
Emergency medical transportation	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities	Subject to Deductible and Coinsurance Annual Limit: 60 days	Subject to Deductible and Coinsurance Annual Limit: 60 days
Laboratory Services		
Physician's Services/Office Visit	$50 copay	$50 copay
Independent Lab	$50 copay	$50 copay
Hospital	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Radiology Services		
Physician's Services/Office Visit	$100 Copay	$100 Copay
Hospital	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Advanced Radiological Imaging (ARI)	Outpatient Facility: $100 copay Hospital: Subject to Deductible and Coinsurance	Outpatient Facility: $100 copay Hospital: Subject to Deductible and Coinsurance

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	Base	High Plan
Outpatient Therapy Services		
Outpatient Physical Therapy	$25 copay Annual Limits: Physical Therapy – 20 visits Limits are not applicable to mental health conditions.	$25 copay Annual Limits: Physical Therapy – 20 visits Limits are not applicable to mental health conditions.
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy	$25 copay Annual Limits: Speech, Hearing and Occupational Therapies – 20 visits	$25 copay Annual Limits: Speech, Hearing and Occupational Therapies – 20 visits
Chiropractic Care	$25 Copay Annual Limit: 25 visits	$25 Copay Annual Limit: 25 visits
Hospice		
Inpatient Facilities and Outpatient Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Other Health Care Facilities/Services		
Home Health Care	Subject to Deductible and Coinsurance Annual Limit: 60 visits	Subject to Deductible and Coinsurance Annual Limit: 60 visits
Organ Transplants	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Durable Medical Equipment and External Prosthetic Appliances	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Breast Feeding Equipment and Supplies	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Mental Health and Substance Use Disorder		
Inpatient mental health	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsuranc
Outpatient mental health – Physician's Office	$25 Copay	$25 Copay
Outpatient mental health – all other services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsuranc
Inpatient substance use disorder	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsuranc
Outpatient substance use disorder – Physician's Office	$25 Copay	$25 Copay
Outpatient substance use disorder – all other services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsuranc
Prescription Drugs		
Generic	$10 Copay	$10 Copay
Brand	$65 Copay	$35 Copay
Non-Brand	$100 Copay	$65 Copay
Specialty Drugs	Not Covered	Not Covered

Generic drugs for a 30 day supply may be obtained at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

ClaimDOC® Fair Payment Solutions for Health Plans

Medical Insurance

	High Dedutible Health Plan - HSA Eligible
Plan Deductible (single/fammily)	In Network: $6,000/$12,000 Out of Network: $12,000/$24,000
Plan Out-of-Pocket Maximum	In Network: $6,000/$12,000 Out of Network: $12,000/$24,000
Covered Benefits	
Physician Services - Office Visits	
Primary care visit to treat an injury or illness	No charge after deductible
Specialist Visit	No charge after deductible
Preventative care/screening/immunization	No charge; deductible does not apply
If you have a test	
Diagnostic test (x-ray, blood work)	No charge after deductible* *preauthorization may be required*
Imaging (CT/PET scans, MRIs)	No charge after deductible* *preauthorization may be required*
Prescription Drugs	
Preferred generic drugs	No charge after deductible*
Non-preferred generic drugs	No charge after deductible*
Preferred brand drugs	No charge after deductible*
Non-preferred brand drugs	No charge after deductible*
Preferred specialty drugs	No charge after deductible*
Non-preferred specialty drugs	No charge after deductible*
* Out of Network-Retail: No Charge after deductible More information about prescription drug coverage is available at www.bcbsil.com/member/prescription-drug-planinformation/drug-lists	
Outpatient Surgery	
Facility fee (e.g. ambulatory surgery center)	No charge after deductible* *Preauthorization may be required*
Physician/surgeon fees	No charge after deductible* *Preauthorization may be required*
Emergency Services	
Emergency Room Care	No charge after deductible
Urgent Care Facility	No charge after deductible
Emergency medical transportation	No charge after deductible *Preauthorization may be required for non-emergency transportation*
Hospital stay	
Facility fee (e.g. hospital room)	No charge after deductible *preauthorization required*
Physician/surgeon fees	No charge after deductible *preauthorization required. Preuthorization penalty: $1,000 or 50% of the eligible charge.*
Mental Health, Behavioral Health, Substance Abuse Services	
Inpatient and Outpatient services	No charge after deductible *preauthorization may be required*
Pregnancy	
Office Visits	No charge after deductible
Childbirth/delivery professional services	No charge after deductible
Outpatient Facility	No charge after deductible
Childbirth/delivery facility services	No charge after deductible
Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound).	
Recovery or Other Special Health Needs	
Home Health Care, Rehabilitation services, Habilitation services, Skilled nursing care, Hospital Services	No charge after deductible *preauthorization may be required*
Durable medical equipment *Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).*	No charge after deductible

Dental Insurance

	Low Plan	High Plan	
	Participating Providers	Participating Providers	Non-Participating Providers
Annual Deductible (Individual/family) *applies to Basic & Major services only*	$50/$150	$50/$150	$50/$150
Annual maximum	$1,000	$1,000	$1,000
Office Visit Copay	N/A	N/A	N/A
Orthodontic Services	Not Included	50% *covered only for children (appliance must be placed prior to age 20).*	50%
Orthodontic Deductible	N/A	None	None
Orthodontic Lifetime Maximum	N/A	$1,000	$1,000
Preventive Services			
Oral examinations **	100%	100%	100%
Cleanings (Adult/Child) **	100%	100%	100%
Fluoride **	100%	100%	100%
Sealants (permanent molars only) **	100%	100%	100%
Bitewing Images **	100%	100%	100%
Full mouth series Images **	100%	100%	100%
Space Maintainers	100%	100%	100%
Basic Services			
Root canal therapy	Not Covered	80%	50%
Anterior teeth / Bicuspid teeth	Not Covered	80%	50%
Root canal therapy, molar teeth	Not Covered	80%	50%
Scaling and root planing **	Not Covered	80%	50%
Gingivectomy*	Not Covered	80%	50%
Amalgam (silver) fillings	80%	80%	50%
Composite fillings *(anterior teeth only)*	80%	80%	50%
Stainless steel crowns	80%	80%	50%
Incision and drainage of abscess*	80%	80%	50%
Uncomplicated extractions	80%	80%	50%
Surgical removal of erupted tooth*	80%	80%	50%
Surgical removal of impacted tooth *(soft tissue)**	80%	80%	50%
Osseous surgery * **	Not Covered	80%	50%
Surgical removal of impacted tooth *(partial bony/ full bony)**	Not Covered	80%	50%
General anesthesia/intravenous sedation*	80%	80%	50%
Crown Lengthening	Not Covered	80%	50%
Major Services			
Inlays	Not Covered	50%	50%
Onlays	Not Covered	50%	50%
Crowns	Not Covered	50%	50%
Full & partial dentures	Not Covered	50%	50%
Pontics	Not Covered	50%	50%
Denture repairs	Not Covered	50%	50%
Crown Build-Ups	Not Covered	50%	50%
Implants	Not Covered	50%	50%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
** Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Vision Insurance

Vision care services	Aetna Vision Network	Out of Network
Exam with Dilation as Necessary		
Use your Exam coverage once every rolling 12 months		
Routine/Comprehensive Eye Exam	$10 Copay	$32 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 Progressive Vision Lenses	$90 Copay	$25 Reimbursement
Premium Progressive Vision Lenses[1] *(Member pays bifocal copay plus tier amount based on brand)*	Tier 1 = $85 Copay Tier 2 = $95 Copay Tier 3 = $110 Copay	$25 Reimbursement
Other Premium Progressive Lenses[1]	20% Discount off retail minus $120 plan allowance 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 - Adult	Member pays discounted fee of $40	Not Covered
Standard Polycarbonate Lenses - Children To Age 19	$0 Copay	$35 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Premium Anti-Reflective Coating[1] *(Tier amount based on brand)*	Tier 1 = $57 Copay Tier 2 = $68 Copay Tier 3 = 20% discount off retail	Not Covered
Photochromic/Transitions Plastic	Member pays discounted fee of $75	Not Covered
Polarized And Other Lens Add Ons	Member pays 80% of retail	Not Covered
Contact Lenses		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional Contact Lenses	$130 Allowance** Additional 15% off balance over allowance	$90 Reimbursement
Disposable Contact Lenses	$130 Allowance	$104 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** Additional 20% off balance over allowance	$90 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	

**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.

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 *The maximum income replacement for states with state disability benefits is 40%.*
Waiver of Premium	Premium payments are waived after 90 days of Total Disability.
Portability	This valuable coverage may be continued, even if the covered employee changes employers. The covered employee must apply to continue coverage within 31 days of ending employment with their current employer. The covered employee must be working as a full-time employee with a new employer and pay the required premiums. The coverage continued will include the same benefits, same plan provisions, and same premium rates as previously issued. The coverage may be continued as long as the required premiums are paid and the group master policy issued to the employer remains in force.
Issue Ages	Employee: 18-74
Termination Age	Terminates at age 75

Total Disability Benefit

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 Benefit

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.

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.

Hospital Indemnity Insurance

Plan Description
Chubb Hospital Indemnity is designed to help employees deal with the cost of a hospitalization by providing benefits that can be used to offset out-of-pocket costs associated with hospital admission and confinement.

Hospitalization Benefits	Benefit Amount
Hospital Admission (per confinement) Once per calendar year This benefit is for admission to a hospital or hospital sub-acute intensive care unit.	$1,000
Hospital Confinement (per day) Maximum confinement period: 31 days This benefit is for confinement in hospital or hospital sub-acute intensive care unit.	$150
Newborn Nursery Benefit (per day) Maximum Days per Confinement - Normal Delivery: 2 Maximum Days per Confinement - Caesarean Section: 2 This benefit is payable for an insured newborn baby receiving newborn nursery care and who is not confined for treatment of a physical illness, infirmity, disease or injury.	$100
Rehabilitation Unit Confinement Benefit (per day) Maximum confinement period: 10 days This benefit is for confinement in a rehabilitation unit.	$75
Pre-Existing Condition Limitation: None	

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Critical Illness Insurance

Covered Conditions – Pays a percentage of face amount	
Breast Cancer Carcinoma In Situ	25% of Face Amount
Cancer (except skin cancer)	100%
Carcinoma In Situ	25%
Coma	100%
Coronary Artery Obstruction	25%
End Stage Renal Failure	100%
Heart Attack	100%
Loss of Sight, Speech, or Hearing	100%
Major Organ Failure	100%
Paralysis or Dismemberment	100%
Severe Burns	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Skin Cancer Benefit - Payable once per insured per year	$250
Recurrence Benefit	
Benefits are payable for a subsequent diagnosis of Cancer, Coma, Coronary Artery Obstruction, Heart Attack, Major Organ Failure, Severe Burns, Stroke, or Sudden Cardiac Arrest.	100%
Advocacy Package	
Best Doctors Physician Referrals Ask the Expert Hotline provides 24 hour advice from experts about a particular medical condition. In-Depth Medical Review offers a full review of diagnosis and treatment plan.	Yes
Additional Benefits	
Wellness Benefit- Payable once per insured per year	
Basic	$50
Waiting Period	30 days
Benefit Limitations	
Pre-Existing Conditions Limitation	None

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Accident Insurance

Initial Care Benefits	
Emergency Room	$150
Urgent Care	$150
Initial Dr. Visit	$75
Hospital/Facility Benefits	
Standard Hospital Admission	$900
Hospital Confinement (per day, up to 365 days)	$225
ICU Confinement (per day, up to 30 days)	$300
Outpatient Surgery Facility	$75
Rehab Confinement (per day, up to 30 days)	$75
Additional Benefits	
Ambulance (air)	$900
Ambulance (ground)	$300
Appliance	$300
Blood, Plasma, Platelets	$200
Burns	
Level 1	$750
Level 2	$5,000
Level 3	$15,000
Skin Graft	25%
Chiropractic Care (per visit)	$25
Maximum Visits Per Accident	3
Maximum Visits Per Calendar Year	6
Coma	$7,500
Dislocations (up to)	$4,680
Emergency Dental	
Crown	$120
Extraction	$30
Dentures	$120
Implants	$120
Eye Injury	$175
Follow-up Treatment (per visit)	$35

Maximum Visits	6
Fractures (up to)	$6,000
Herniated Disc Surgery	$750
Knee Cartilage - Torn	$750
Lacerations	$38-$600
Lodging (per night, 100 or more miles)	$150
Maximum Nights	30
Loss of hands, feet, sight	$17,500
Loss of fingers or toes	$875
Major Diagnostic Exam (CT, MRI, etc.)	$150
Medicine Benefit	$5
Pain Management	$75
Paralysis	
Two limbs (paraplegia or hemiplegia)	$3,500
Four limbs (quadriplegia)	$7,500
Post – Traumatic Stress Disorder	$150
Maximum Visits	6
Prosthetics	$2,000
Residence/Vehicle Modification	$1,500
Surgery - Abdominal, Cranial, and Thoracic	$750
Hernia	$300
Tendon, Ligament, Rotator Cuff	$750
Therapy – Physical, Occupational, or Speech	$35
Maximum Visits	10
Transportation (per trip, 100 or more miles)	$350
Maximum Trips	3
Traumatic Brain Injury	$350
Wellness (per person, per year)	
Basic	$50
Waiting Period	30 days
X-Ray	$50

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 121 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

**Applies to employee enrollment only during initial eligibility for this coverage*

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: This is a plan sponsor determined benefit rider and, if selected, will be added to all certificates. This rider may be added only to employee or spouse contracts. 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. If death occurs prior to the end of the 25 month period, the remaining amount is paid as a death benefit. Inclusion of the Accelerated Death Benefit for Long Term Care Benefit is determined by the Employer and, if selected, will be inclusive on all Employee certificates.
Restoration of Your Death Benefit 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.