

NORTHAMPTON COUNTY PUBLIC SCHOOLS

September 1, 2025 - August 30, 2026

BENEFITS GUIDE



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Employee Benefits Center (EBC)

NCPS Finance Office
757.678.5151 x2201

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This guide contains a summary of the benefits offered by your employer. If there is a conflict between the terms of this outline of benefits and the actual contracts, the terms of the contracts will prevail.



ATTENTION EMPLOYEES: **IMPORTANT DEADLINES**

- THE PREFERRED DEADLINE FOR MAKING CHANGES TO PRE-TAX BENEFITS IS:

Thursday, July 31, 2025

(Pre-tax benefits include flexible spending accounts, cancer, heart/stroke, accident, and critical illness policies, including supplemental health options.)

Changes may still be made to pre-tax benefits until Friday, August 29, 2025.

Changes may be made after August 29, 2025 **only** if a qualifying event has occurred.

Please contact FFGA with questions regarding qualifying events, such as:
marriage, birth of a child, death, divorce, and loss of coverage.

- CHANGES TO YOUR OTHER BENEFITS ARE
ALLOWED YEAR-ROUND.

(Other benefits include disability, life insurance, long-term care, 403(b) and 457 plans.)

If you have any questions or need to make changes, please contact:
Michael Shelly, our Account Manager, at Michael.Shelly@ffga.com

Employee Benefits Center

A guide to your benefits!

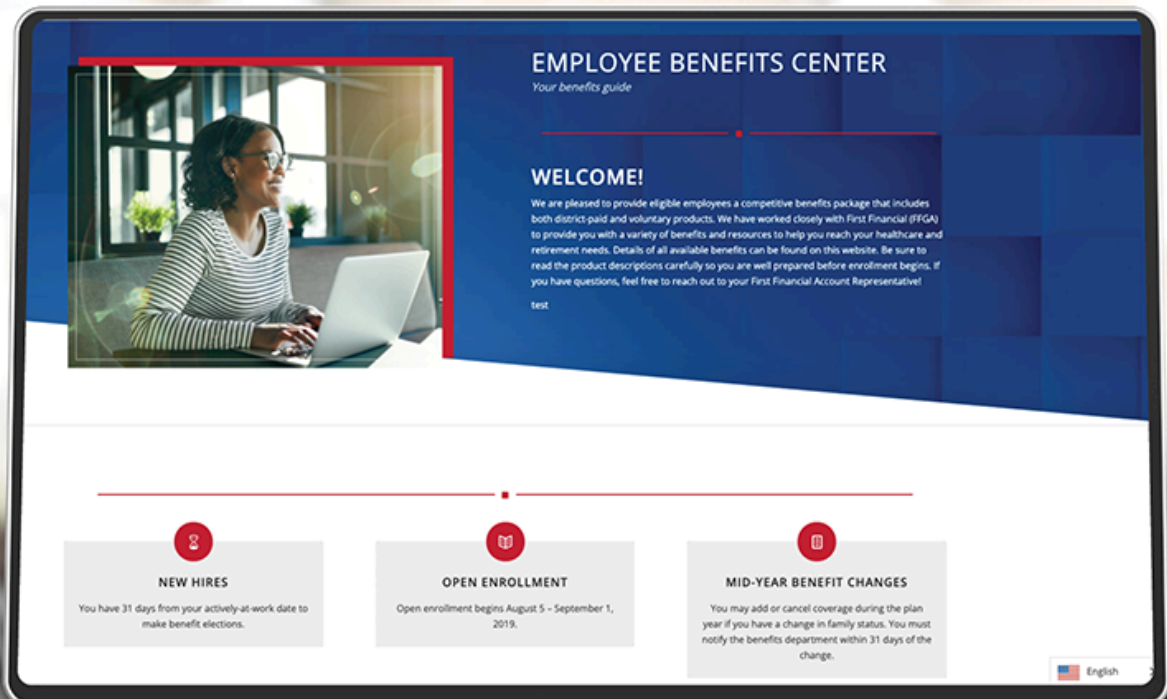
Northampton County Public Schools and FFGA are excited to provide you with a custom website filled with information about your benefits. Visit the Employee Benefits Center to see current benefit options for your employer as well as find claim forms, important phone numbers and enrollment information.

There's no need to register for site access. Simply type the URL below into your browser and you will be directed to your Employee Benefits Center.



Scan the QR code or click the link below this box to learn more about the plans that are available this plan year!

[NCPS Employee Benefits Center](#)



How to Enroll

Benefits Enrollment

Open Enrollment: On-Site

When it's time to enroll in your benefits, your FFGA Account Representative will be on-site to assist you with making your elections. Visit your EBC to view the on-site enrollment schedule.

Open Enrollment: Phone Appointment

Visit northamptonoe2025.timetap.com to schedule an enrollment phone appointment. An FFGA Representative will call you at the phone number you provide at the time of your appointment.

Open Enrollment: Online Self-Enroll

To begin online enrollment, visit <https://ffga.benselect.com/Enroll/login.aspx>.

Enroll Now

Login

- Login: Your Employee ID or Social Security Number (no dashes)
- PIN (first login only): The last four digits of your Social Security Number and the last two digits of the year you were born (six digits total)
- New PIN: The first time you log in you will be required to change to a new PIN. Please note your new PIN because you will use the new PIN from that point forward.

View Current Benefits

After logging in, you will arrive at the welcome screen. Your current benefits and premium deductions will be listed on this screen.

View/Add Dependents

Click next to view your dependents. It is very important to make sure the social security numbers and birth dates listed are correct. If you plan to add dependents, you will need to enter their legal name, social security numbers and birth dates.

Begin Elections

Click next again to begin making your benefit elections. Remember, no changes to your elections can be made during the plan year unless you have either a qualified mid-year change under Section 125 or a special enrollment event.

Enrollment Assistance Center Instructions

Call 855-765-4473 and follow the prompts to be connected to your local FFGA branch office. Hours of operation are 8 a.m. to 5 p.m. (local time) Monday through Friday. There is an option to leave a voice message for a representative to call you back. Phone calls will be returned as soon as possible or the next business day if it is after hours.

Benefit Eligibility & Coverage

Employee Coverage

Eligibility

Eligible employees must be actively at work on the plan effective date for new benefits to be effective.

New Employees

You have 31 days from your actively-at-work date to make benefit elections. See your employer for new hire enrollment details.

Existing Employees

When it's time to enroll in your benefits, your FFGA Account Representative will be available to assist you with making your elections. Your elections can be made anytime during annual enrollment online from your work or home computer. Before enrollment, take time to educate yourself on the available benefits and what options would work best for you and your family by visiting the Employee Benefits Center.

Mid-year Benefit Changes

You may add or cancel coverage during the plan year if you have a change in family status. You must notify the benefits department within 31 days of the change.

Qualifying Life Events Include:

- Changes in household, including marriage, divorce, legal separation, annulment, death of a spouse, birth, adoption, placement for adoption or death of a dependent child
- Loss of health coverage, attributable to your spouse's employment, losing existing health coverage including job-based, individual and student plans, losing eligibility for Medicare, Medicaid, or CHIP, turning 26 and losing coverage through a parent's plan

Declining Coverage

If you are eligible for benefits, but wish to DECLINE coverage, please complete the online enrollment either on your work or home computer. Under each option, you will need to select "waive." **You must still complete the beneficiary information.**

Section 125 Plans

Section 125 Plan Information & Rules

A Section 125 Plan provides a tax-saving way to pay for eligible medical or dependent care expenses. The funds are automatically deducted from your paycheck on a pre-tax basis.

Here’s How It Works

A Section 125 Plan reduces your taxes and increases your spendable income by allowing you to deduct the cost of eligible benefits from your earnings before tax. Plus, the plan is available to you at no cost, and you’re already eligible – all you must do is enroll.

Is It Right For Me?

The savings you may experience with a Section 125 Plan are outlined in the example below. For instance, you could potentially take home about \$70 more each month if you participated in your employer’s Section 125 Plan – that’s a savings of \$840 a year!

You cannot change your benefit elections for the plan year unless the benefits office receives notification in writing within 31 days of the status change. If the benefits office is not notified within 31 days of the status change, no benefit change can be made until the next annual open enrollment.

- IRS specified changes in family status include:
- Change in legal married status
 - Change in number of dependents
 - Termination or commencement of employment
 - Dependent satisfies or ceases to satisfy dependent eligibility requirements
 - Change in residence or worksite that affects eligibility for coverage

Section 125 Plan Sample Paycheck		
	Without S125	With S125
Monthly Salary	\$2,000	\$2,000
Less Medical Deductions	-N/A	-\$250
Tax Gross Income	\$2,000	\$1,750
Less Taxes (Fed/State at 20%)	-\$400	-\$350
Less Estimated FICA (7.65%)	-\$153	-\$133
Less Medical Deductions	-\$250	-N/A
Take Home Pay	\$1,197	\$1,267

You could save \$70 per month in taxes by paying for your benefits on a pre-tax basis!

**The figures in the sample paycheck above are for illustrative purposes only.*

Vision Insurance

Ameritas | www.ameritas.com | 800.487.5553

Proper vision care is essential to your overall well-being. Regular eye exams at any age will help prevent eye disease and keep your vision strong for years to come.

Your employer provides you with a vision plan to take care of you and your family's needs. You must enroll in the vision plan each plan year and premiums are typically paid through payroll deduction. Here are just a few of the areas where you will save money with your plan:

- Eye Exams
- Eyeglasses
- Contact lenses
- Eye surgeries
- Vision correction





Maximize Your Ameritas Vision Benefits

Select the vision provider that's right for you. Keep in mind your out-of-pocket cost will be lower when you see a network provider.



86% of VSP doctors offer early morning, evening or weekend hours.

The VSP Choice Network

- More than 86,000 provider access points nationwide
- VSP offers the nation's largest network of independent doctors. Find your local providers at vsp.com



- Over 8,000 retail locations plus an online option



- Use your out-of-network benefits at Walmart or Sam's Club. They'll file your claim; however, your benefit will be lower compared to an in-network VSP provider.
- No claim forms for in-network services. When you visit a VSP provider, your claim is submitted for you.

Savings

Take advantage of VSP provider discounts, plus visit vsp.com for other exclusive member extras.



20% off remaining frame balance



20% off additional noncovered complete prescription glasses



20-25% off noncovered lens options, such as UV coating and polycarbonate lenses



Extra \$20-\$40 to spend on featured frame brands (vsp.com/specialoffers)



LASIK or PRK laser vision correction at an average of 15% off the usual price, or 5% off a promotional price, through VSP and a contracted laser surgery center

Based on applicable laws, reduced costs may vary by doctor location.

Shop Online

Browse and buy online at eyeconic.com. It's in the VSP network, and your vision benefits will be applied directly to your online order. Create an account there to connect your vision benefits, and get the newest deals on eyewear.

LASIK or PRK

Have you always dreamed of better vision without glasses or contacts? Make your dream a reality by using your VSP laser vision correction discount. To get started, visit your VSP provider for a screening to see if you are a candidate for the procedure.

Using Your Vision Benefit Is Easy Once You Enroll



Find a VSP network provider who's right for you at vsp.com, or call 800-877-7195



Schedule an appointment with the vision care provider of your choice. Be sure to confirm they accept VSP.



If you are visiting a VSP network provider*, simply tell them you have VSP through Ameritas. No ID card is necessary.



That's it. Your VSP provider will handle the rest, and even submit your claim for you.

*For out-of-network eye care providers, you'll need to pay the provider, get an itemized receipt, and submit it along with a VSP Vision Out-of-Network Claim Form. This form is located at ameritas.com/vision, Forms, Claim Forms. Send a copy of the itemized bill and completed claim form to: VSP, P.O. Box 385018, Birmingham, AL 35238-5018.



VSP
800-877-7195
www.vsp.com
Mon-Fri 5am-8pm
Sat 7am-8pm
Sun 7am-7pm (PST)



Ameritas
800-659-2223
www.ameritas.com/vision
Mon-Thu 7am-7pm
Fri 7am-5:30pm (CST)

This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Group dental, vision and hearing care products (9000 Rev. 03-16, dates may vary by state) and individual dental and vision products (Indiv. 9000 Rev. 07-16) are issued by Ameritas Life. Ameritas, the bison design, "fulfilling life" and product names designated with SM or ® are service marks or registered service marks of Ameritas Life, affiliate Ameritas Holding Company or Ameritas Mutual Holding Company. All other brands are property of their respective owners. © 2018 Ameritas Mutual Holding Company.

Vision Plan Benefits

	VSP Signature Network	Out-of-Network
Annual Eye Exam	Covered in full	Up to \$45
Single Vision Lenses	Covered in full	Up to \$35
Bifocal Lenses	Covered in full	Up to \$50
Trifocal Lenses	Covered in full	Up to \$70
Lenticular Lenses	Covered in full	Up to \$90
Progressive Lenses	See lens options	NA
Frames	\$120	\$50
Contacts (elective)	Up to \$105	Up to \$105
Contacts (medically necessary)	Covered in full	Up to \$ 210

Deductible

Annual Eye Exam	\$15	\$15
Eyeglass Lenses or Frames	\$15	\$15

Benefit Frequencies (months)

Based on Date of Service

Exam/Lens/Frame	12/12/24
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Member cost for lens options (May vary by prescription, options chosen and retail location)

Progressive Lenses	Up to provider's contracted fee for lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the progressive lens charge.	Up to Lined Trifocal allowance
Std. Polycarbonate	Covered in full for dependent children \$25 adults	No benefit
Solid Plastic Dye	\$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	\$15	No benefit
Scratch Resistant Coating	\$15-\$29	No benefit
Anti-Reflective Coating	\$39-\$75	No benefit
Ultraviolet Coating	\$14	No benefit

Monthly Rates

Employee only	\$9.70
Employee & Dependents	\$23.76

NORTHAMPTON COUNTY PUBLIC SCHOOLS

Policy #: 010-35426



VSP Network

With access to the largest network of independent doctors, VSP members receive services at rates well below walk-in prices at more than 36,000 doctors nationwide. Find a provider at <https://www.vsp.com>

VSP offers the nation's largest network of independent doctors.

Retail chains accepting VSP include:



Browse and buy eyewear online with in-network benefits applied directly to your order.

[eyeconic](https://www.eyeconic.com)

86% of VSP doctors offer early morning or evening appointments and access to 24-hour emergency care



86%

Get an extra **\$20-\$40** to spend on select featured frame brands



No claim forms to complete when you see a VSP doctor



Online In-network Options

[Eyeconic.com](https://www.eyeconic.com) is in-network online eyewear store - which means you won't have to pay the full price now, then wait to be reimbursed later. Your vision benefits will be applied directly to your online order. Eyeconic FAQ:

<https://www.vsp.com/eyewear-question.html>

Customer Service

VSP 800-877-7195 www.vsp.com

Mon-Fri 5am-8pm, Sat 7am-8pm, Sun 7am-7pm (PST)

Additional Savings

Find More VSP exclusive member savings offers at <https://www.vsp.com/optical-discounts.html>

When you visit a VSP network provider you'll save:



20% off remaining frame balance



20% off non-covered complete prescription glasses and non-prescription sunglasses



15% off LASIK and PRK laser surgery retail price or
5% off promotion price



Find more savings at [vsp.com/specialoffers](https://www.vsp.com/specialoffers)

Based on applicable laws, reduced costs may vary by doctor location.

Laser Vision Surgery

Your vision plan provides an average discount of 15% on LASIK and PRK. Your maximum out-of-pocket per eye is \$1,800 for LASIK, \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP Provide must coordinate the procedure. Getting started is simple; just follow the steps at <https://www.vsp.com/lasik.html>

Based on applicable laws, reduced costs may vary by doctor location.

Rx Savings

Save on Prescription medications at 60,000 Pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. Just Present your Rx savings card. To access and print your Rx savings cards, visit [ameritas.com](https://www.ameritas.com), register/sign in to your secure member account and select member savings. This discount is offered at no additional cost and is not insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exduisions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Flexible Spending Accounts

First Financial Administrators, Inc. | www.ffga.com
1.866.853.3539 P.O. Box 161968 | Altamonte Springs, FL 32716

Medical FSA

A Medical Flexible Spending Account (Medical FSA) is an IRS-approved program to help you save taxes and pay for out-of-pocket medical expenses not covered under your medical plan. Your plan includes a grace period option, so you have additional time to incur and claim against unused funds in the new plan year. Keep in mind that remaining balances after the grace period is exhausted will be forfeited under the use-it-or-lose-it rule.

Your maximum contribution amount for 2025 is \$3,300.

Medical FSA Highlights

- Contributions are automatically deducted from your paycheck on a pre-tax basis, which helps reduce your taxable income and increase your spendable income.
- Your full election will be available to you at the beginning of the plan year.
- Be conservative – any money left in your account at the end of the plan year will be forfeited.
- Use your benefits card to pay for qualified expenses upfront without spending money out of pocket.
- Keep all receipts in case you need to substantiate a claim for tax purposes.

NOTE: The IRS requires proof that all expenses are eligible. Keep all receipts in case you need to substantiate a claim for tax purposes. Your receipt must include the date of purchase or service, amount you were required to pay after insurance, description of the product or service, merchant or provider name, and the patient's name.

Dependent Care FSA

With a Dependent Care Flexible Spending Account, you can set aside part of your pay on a pre-tax basis to pay for eligible dependent care expenses like childcare, babysitters, and adult day care.

You may allocate up to \$5,000 per tax year for reimbursement of dependent care services.

If you are married and file a separate tax return, the limit is \$2,500.

Dependent Care FSA Highlights

- Eligible dependents must be claimed as an exemption on your tax return.
- Eligible dependents must be children under age 13 or an adult dependent incapable of self-care.
- Funds become available as contributions are made to your account.
- Keep all receipts in case you need to substantiate a claim for tax purposes.
- Balances will be forfeited at the end of the runoff or grace period.

FSA Resources

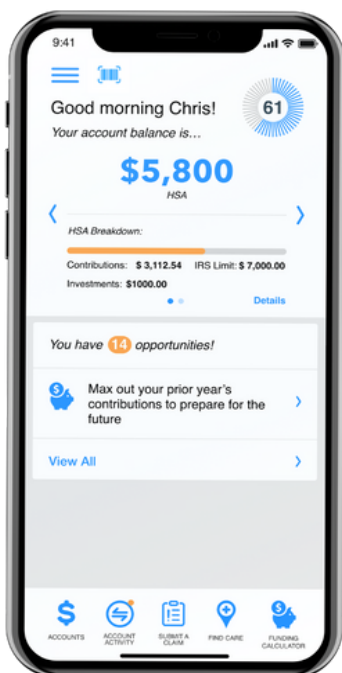
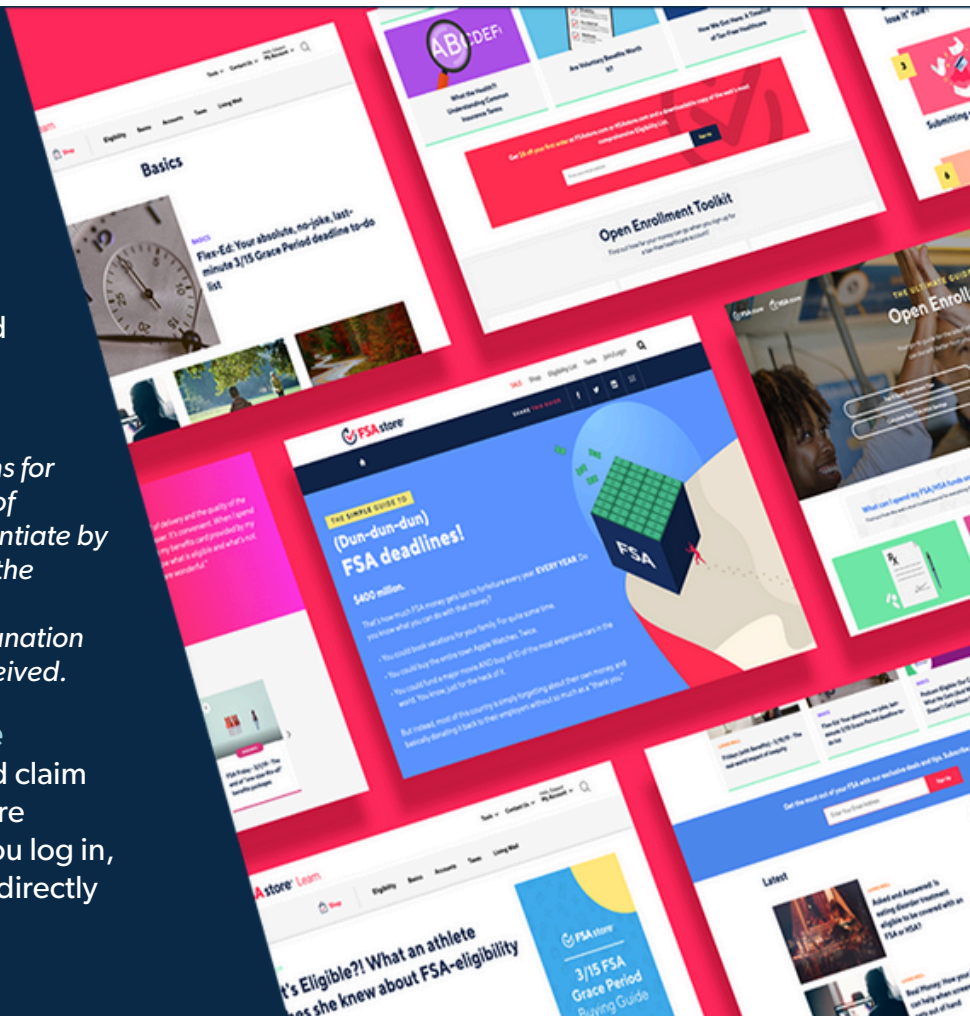
Benefits Card

The FFGA Benefits Card is available to all employees that participate in a Medical FSA and/or a Dependent Care FSA. The Benefits Card gives you immediate access to your money at the point of purchase. Cards are available for participating employees, their spouse and any eligible dependents who are at least 18 years old.

The IRS requires validation of most transactions for FSAs. You must submit receipts for validation of expenses when requested. If you fail to substantiate by providing a receipt to FFGA within 60 days of the purchase or date of service your card will be suspended until the necessary receipt or explanation of benefits from your insurance provider is received.

View Your Account Details Online

Sign up to view your account balance, find claim forms and check claims status on our secure website. Log in at www.ffga.com. After you log in, you may sign up to have reimbursements directly deposited to your bank account.



FF Mobile Account App

With the FF Mobile Account App, you can submit claims, view account balance and history, check claims status, view alerts, upload receipts and documentation and more! The FF Mobile Account App is available for Apple® and Android™ devices on either the App Store or Google Play Store.

FSA Store

FFGA has partnered with the FSA Store to bring you an easy-to-use online store to better understand and manage your account. You can shop for eligible medical items like bandages and contact solution, browse for products and services using the Eligibility List and visit the Learning Center to find answers to commonly asked questions. Visit the store at <http://www.ffga.com/individuals/#stores> for more details and special deals.



Texas Life

Permanent Life



www.TexasLife.com | 800.283.9233

Texas Life Insurance - Permanent, Portable Life Insurance

The peace of mind voluntary, permanent life insurance provides is unmatched. It is a solid companion to your group life insurance plan. Texas Life provides life insurance that you can keep for a lifetime. The plan is easy to purchase, pay for, and keep through the convenience of payroll deduction. Coverage is affordable and dependable. Plus, Texas Life has over a century of experience protecting families and giving the peace of mind only permanent life insurance can provide.

Texas Life - Permanent Life Highlights

- You own the policy, even if you change jobs or retire.
- The policy remains in force until you die or up to age 121 if you pay the necessary premium on time.
- It is a permanent, universal life policy which means you can rest easy knowing your loved ones will be well taken care of when you're gone.



WOW!

LIFE INSURANCE YOU CAN KEEP!

LIFE INSURANCE HIGHLIGHTS

For the employee

PURELIFE-PLUS



**YOU OWN IT.
COST IS REASONABLE**



**YOU CAN COVER YOUR SPOUSE, CHILDREN
AND GRANDCHILDREN, TOO²**



**YOU PAY FOR IT THROUGH CONVENIENT
PAYROLL DEDUCTIONS: NO CHECKS TO
WRITE OR LINKS TO CLICK**



**YOU CAN QUALIFY BY ANSWERING JUST
3 QUESTIONS - NO EXAM OR NEEDLES⁵**



**YOU CAN TAKE IT WITH
YOU WHEN YOU CHANGE
JOBS OR RETIRE¹**



**YOU CAN GET A LIVING BENEFIT IF YOU
BECOME TERMINALLY ILL³**



**YOU CAN GET CASH TO COVER
LIVING EXPENSES IF YOU BECOME
CHRONICALLY ILL⁴**



TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

- ¹ As long as the necessary premiums are paid.
- ² Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
- ³ Conditions apply. Accelerated Death Benefit Due to Terminal Illness Rider Form ICC07-ULABR-07 or Form Series ULABR-07
- ⁴ Chronic Illness Rider available for an additional cost for employees and their spouses. Conditions apply. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15. Payment of this rider terminates the contract and any obligations under other riders, endorsements and supplemental benefits as if the insured had died.
- ⁵ Issuance of coverage depends on answers to these questions.

23Mo22-C FFGA 1020 (exp0325) Not for use in CA, FL or NH.

The agent/agency offering this proposal is not affiliated with Texas Life other than to market its products. Claims payments are the responsibility of Texas Life Insurance Company.

PureLife-plus is a Flexible Premium Adjustable Life Insurance to Age 121. As with most life insurance products, Texas Life contracts and riders contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative or see the PureLife-plus brochure for costs and complete details. Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO. Texas Life is licensed to do business in the District of Columbia and every state but New York.



LIFE INSURANCE HIGHLIGHTS

For the employee

PURELIFE-PLUS

Voluntary permanent life insurance can be an ideal complement to the group term and optional term life insurance your employer might provide. This voluntary permanent universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term life insurance may be portable if you change jobs, but even if you can keep them after you retire, they usually cost more and decline in death benefit.

The contract, PURELIFE-PLUS, is underwritten by Texas Life Insurance Company, and it has the following features:

- **High Death Benefit.** Written on a minimal cash-value Universal Life frame, PURELIFE-PLUS features one of the highest death benefits per payroll-deducted dollar offered at the worksite.¹
- **Refund of Premium.** Unique in the workplace, PURELIFE-PLUS offers you a refund of 10 years' premium, should you surrender the contract if initial specified premium paid for ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Due to Terminal Illness Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a \$150 (\$100 in Florida) administrative fee. Included with your contract at no additional cost, this valuable living benefit helps give you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.) (Form ICC07-ULABR-07 or Form Series ULABR-07)*
- **Accelerated Death Benefit for Chronic Illness Rider.** Included on employee and spouse contracts at an additional cost, this rider will be triggered by the loss of two out of six Activities of Daily Living² or severe cognitive impairment for a period of 90 days. It pays the insured up to 92% of the death benefit minus a small administrative fee, should the insured decide to exercise it. This valuable living benefit can help offset the cost of either in-home care or care in a resident facility. *(Conditions apply.) (Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15)*



TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

Additional Features

- **Minimal Cash Value.** Designed to provide a high death benefit at a reasonable premium, PURELIFE-PLUS helps provide peace of mind for you and your beneficiaries while freeing investment dollars to be directed toward such tax-favored retirement plans as 403(b), 457 and 401(k).
- **Long Guarantees.** Enjoy the assurance of a contract that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).³

You may apply for this permanent coverage, not only for yourself, but also for your spouse, children and grandchildren.⁴



3 QUICK QUESTIONS

You can qualify by answering just 3 questions⁵ – no exams or needles.

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

- 1 Been actively at work on a full time basis, performing usual duties?
- 2 Been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days?
- 3 Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation, dialysis treatment, or treatment for alcohol or drug abuse?

Important Note: Texas Life does not offer legal or financial advice. Contact an attorney and a financial advisor in your state for legal and financial information on wills, estates and trusts.

PureLife-plus is a Flexible Premium Adjustable Life Insurance to Age 121. As with most life insurance products, Texas Life contracts and riders contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative or see the Purelife-plus brochure for costs and complete details. Contract Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18.

¹ Voluntary Whole and Universal Life Products, Eastbridge Consulting Group, March 2022

² Six Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that: (1) places the Insured in jeopardy of harming him/herself or others and, therefore, the Insured requires Substantial Supervision by another individual; and (2) is measured by clinical evidence and standardized tests which reliably measure impairment in; (a) short or long-term memory; (b) orientation to people, places or time; and (c) deductive or abstract reasoning.

³ As long as you pay the necessary premium. Guarantees are subject to product terms, limitations, exclusions, and the insurer's claims paying ability and financial strength. 45 years average for all ages based on our actuarial review.

⁴ Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.

⁵ Issuance of coverage will depend on the answer to these questions.

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age (ALB)	Semi-Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD
	Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									Age to Which Coverage is Guaranteed at Table Premium
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
17-20		6.53	11.93	17.33	22.73	33.53	44.33	55.13	65.93	75
21-22		6.67	12.20	17.74	23.28	34.35	45.43	56.50	67.58	74
23		6.80	12.48	18.15	23.83	35.18	46.53	57.88	69.23	75
24-25		6.94	12.75	18.57	24.38	36.00	47.63	59.25	70.88	74
26		7.22	13.30	19.39	25.48	37.65	49.83	62.00	74.18	75
27-28		7.35	13.58	19.80	26.03	38.48	50.93	63.38	75.83	74
29		7.49	13.85	20.22	26.58	39.30	52.03	64.75	77.48	74
30-31		7.63	14.13	20.63	27.13	40.13	53.13	66.13	79.13	73
32		8.04	14.95	21.87	28.78	42.60	56.43	70.25	84.08	74
33		8.32	15.50	22.69	29.88	44.25	58.63	73.00	87.38	74
34		8.73	16.33	23.93	31.53	46.73	61.93	77.13	92.33	75
35		9.28	17.43	25.58	33.73	50.03	66.33	82.63	98.93	76
36		9.55	17.98	26.40	34.83	51.68	68.53	85.38	102.23	76
37		9.97	18.80	27.64	36.48	54.15	71.83	89.50	107.18	77
38		10.38	19.63	28.88	38.13	56.63	75.13	93.63	112.13	77
39		11.07	21.00	30.94	40.88	60.75	80.63	100.50	120.38	78
40	5.38	11.75	22.38	33.00	43.63	64.88	86.13	107.38	128.63	79
41	5.76	12.72	24.30	35.89	47.48	70.65	93.83	117.00	140.18	80
42	6.20	13.82	26.50	39.19	51.88	77.25	102.63	128.00	153.38	81
43	6.59	14.78	28.43	42.08	55.73	83.03	110.33	137.63	164.93	82
44	6.97	15.74	30.35	44.97	59.58	88.80	118.03	147.25	176.48	83
45	7.36	16.70	32.28	47.85	63.43	94.58	125.73	156.88	188.03	83
46	7.80	17.80	34.48	51.15	67.83	101.18	134.53	167.88	201.23	84
47	8.18	18.77	36.40	54.04	71.68	106.95	142.23	177.50	212.78	84
48	8.57	19.73	38.33	56.93	75.53	112.73	149.93	187.13	224.33	85
49	9.06	20.97	40.80	60.64	80.48	120.15	159.83	199.50	239.18	85
50	9.61	22.34	43.55	64.77	85.98					86
51	10.27	23.99	46.85	69.72	92.58					87
52	10.99	25.78	50.43	75.08	99.73					88
53	11.54	27.15	53.18	79.20	105.23					88
54	12.09	28.53	55.93	83.33	110.73					88
55	12.69	30.04	58.95	87.87	116.78					89
56	13.24	31.42	61.70	91.99	122.28	CHILDREN AND GRANDCHILDREN (NON-TOBACCO) with Accidental Death Rider Grandchild coverage available through age 18.				89
57	13.90	33.07	65.00	96.94	128.88					89
58	14.51	34.58	68.03	101.48	134.93					89
59	15.17	36.23	71.33	106.43	141.53					89
60	15.59	37.29	73.45	109.62	145.78					90
61	16.31	39.08	77.03	114.98	152.93					90
62	17.19	41.28	81.43	121.58	161.73					90
63	18.07	43.48	85.83	128.18	170.53					90
64	19.00	45.82	90.50	135.19	179.88					90
65	20.05	48.43	95.73	143.03	190.33					90
66	21.20					Issue Age	Premium		Guaranteed Period	90
							\$25,000	\$50,000		90
67	22.47					15D-1	4.63	8.13	81	91
68	23.84					2-4	4.75	8.38	80	91
69	25.22									91
70	26.65					5-8	4.88	8.63	79	91

CHILDREN AND GRANDCHILDREN (NON-TOBACCO)
 with Accidental Death Rider
 Grandchild coverage available through age 18.

Issue Age	Premium		Guaranteed Period
	\$25,000	\$50,000	
15D-1	4.63	8.13	81
2-4	4.75	8.38	80
5-8	4.88	8.63	79
9-10	5.00	8.88	79
11-16	5.13	9.13	77
17-20	6.13	11.13	75
21-22	6.25	11.38	74
23	6.38	11.63	75
24-25	6.50	11.88	74
26	6.75	12.38	75

Indicates
 Spouse
 Coverage
 Available

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO

Accelerated Death Benefit for Chronic Illness Rider Form ICC15-ULABR-CI-15, ULABR-CI-15 or CA-ULABR-CI-18

Accidental Death Benefit Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age (ALB)	Semi-Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
17-20		9.28	17.43	25.58	33.73	50.03	66.33	82.63	98.93	71
21-22		9.69	18.25	26.82	35.38	52.50	69.63	86.75	103.88	71
23		10.10	19.08	28.05	37.03	54.98	72.93	90.88	108.83	72
24-25		10.38	19.63	28.88	38.13	56.63	75.13	93.63	112.13	71
26		10.65	20.18	29.70	39.23	58.28	77.33	96.38	115.43	72
27-28		10.93	20.73	30.53	40.33	59.93	79.53	99.13	118.73	71
29		11.07	21.00	30.94	40.88	60.75	80.63	100.50	120.38	71
30-31		12.44	23.75	35.07	46.38	69.00	91.63	114.25	136.88	72
32		12.85	24.58	36.30	48.03	71.48	94.93	118.38	141.83	72
33		12.99	24.85	36.72	48.58	72.30	96.03	119.75	143.48	72
34		13.13	25.13	37.13	49.13	73.13	97.13	121.13	145.13	71
35		14.09	27.05	40.02	52.98	78.90	104.83	130.75	156.68	72
36		14.50	27.88	41.25	54.63	81.38	108.13	134.88	161.63	72
37		15.47	29.80	44.14	58.48	87.15	115.83	144.50	173.18	73
38		15.88	30.63	45.38	60.13	89.63	119.13	148.63	178.13	73
39		16.98	32.83	48.68	64.53	96.23	127.93	159.63	191.33	74
40	8.07	18.49	35.85	53.22	70.58	105.30	140.03	174.75	209.48	76
41	8.57	19.73	38.33	56.93	75.53	112.73	149.93	187.13	224.33	77
42	9.17	21.24	41.35	61.47	81.58	121.80	162.03	202.25	242.48	78
43	9.94	23.17	45.20	67.24	89.28	133.35	177.43	221.50	265.58	80
44	10.33	24.13	47.13	70.13	93.13	139.13	185.13	231.13	277.13	80
45	10.88	25.50	49.88	74.25	98.63	147.38	196.13	244.88	293.63	81
46	11.32	26.60	52.08	77.55	103.03	153.98	204.93	255.88	306.83	81
47	11.87	27.98	54.83	81.68	108.53	162.23	215.93	269.63	323.33	82
48	12.36	29.22	57.30	85.39	113.48	169.65	225.83	282.00	338.18	82
49	13.08	31.00	60.88	90.75	120.63	180.38	240.13	299.88	359.63	83
50	13.68	32.52	63.90	95.29	126.68					83
51	14.29	34.03	66.93	99.83	132.73					83
52	15.17	36.23	71.33	106.43	141.53					84
53	15.94	38.15	75.18	112.20	149.23					85
54	16.65	39.94	78.75	117.57	156.38					85
55	17.42	41.87	82.60	123.34	164.08					85
56	18.30	44.07	87.00	129.94	172.88					85
57	19.18	46.27	91.40	136.54	181.68					86
58	20.12	48.60	96.08	143.55	191.03					86
59	21.05	50.94	100.75	150.57	200.38					86
60	21.64	52.42	103.70	154.99	206.28					86
61	22.91	55.58	110.03	164.48	218.93					86
62	24.12	58.60	116.08	173.55	231.03					87
63	25.33	61.63	122.13	182.63	243.13					87
64	26.54	64.65	128.18	191.70	255.23					87
65	27.86	67.95	134.78	201.60	268.43					87
66	29.29									88
67	30.83									88
68	32.42									88
69	34.13									88
70	35.94									89

CHILDREN AND GRANDCHILDREN (TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO

Accelerated Death Benefit for Chronic Illness Rider Form ICC15-ULABR-CI-15, ULABR-CI-15 or CA-ULABR-CI-18

Accidental Death Benefit Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07

23M014-C-SM FFGA-T 1012 (exp0325)

Issue Age	Premium		Guaranteed Period
	\$25,000	\$50,000	
17-20	8.63	16.13	71
21-22	9.00	16.88	71
23	9.38	17.63	72
24-25	9.63	18.13	71
26	9.88	18.63	72

Indicates
Spouse
Coverage
Available

Disability Insurance

Manhattan Life | www.ManhattanLife.com | 800.669.9030

Why Do I Need Disability Insurance?

Have you ever wondered what would happen to your income if you had an accidental injury, sickness, or pregnancy? That is why you need disability coverage. It replaces a portion of income for the period you are unable to work due to those reasons. You can choose the benefit amount, which is the amount of your income to replace, and the waiting period that you begin receiving payments.

How do you decide if you need disability insurance? Consider these questions when making your decision:

- How much employer leave do you have?
- Do you have savings?
- Do you have other income you can rely on, such as from your spouse or from child support?
- How close are you to retirement?
- Could you go on Social Security Disability or take a Disability Retirement?
- What are your other sources of income?



Disability Income

Supplemental income protection



Protect your financial well-being with Voluntary Disability

A Disability plan will help with day-to-day expenses – housing, food, car payments, even additional medical costs – if you become disabled from an accident or illness. You will not have to worry about using your savings or incurring additional debt to cover these costs and care for your family.

Why do I need Disability coverage?

Most people can't afford to be disabled, even for a short time. Almost 90 percent of disabling accidents and illnesses are not work related, so you can't count on Workers Compensation to be there for you and your loved ones.

National Safety Council, Injury Facts 2008 Ed.

Because you can't know when a disabling illness or injury will impact your ability to bring home a paycheck, you can enroll in Disability coverage from ManhattanLife to help you and your family deal with the unexpected. You will be able to concentrate on your recovery after a sickness or accident and return to your job.

Here's how it works

Benefits from your ManhattanLife plan are paid in addition to any Disability coverage you already have. Your monthly coverage, elimination period, benefit period and any optional benefits will depend on the plan design your employer selects. You will find the plan to be easy and economical – your premiums are conveniently paid through payroll deduction.

Disability Income Coverage

Coverage type	Disability Income Plus provides a monthly disability income benefit as a result of non-occupational accident or sickness.		
Product	Policy Type:	Group	
	Policy Name:	Disability Income Plus	
	Policy Form:	M-8014	
Eligibility	Issue Age:	Employee:	18 – 70
	Criteria:	<ul style="list-style-type: none"> Employee is benefit eligible, actively at work full-time, working at least 20 hours per week. Employee only coverage. 	
	Termination Age:	<ul style="list-style-type: none"> Age 70 unless actively at work, then on last day of active employment. 	
			Guarantee Issue
Underwriting Offer	Employee:	Employee:	Up to 65% of base salary to a max benefit of \$3,000.
		Superintendents:	Up to 65% of base salary to a max benefit of \$5,000.
Target Participation	Minimum to Issue:	10 Employee applications or 1% of eligible Employees, whichever is greater.	
	Guarantee Issue:	Waived, expectation of 20% of all eligible enrolled by end of the enrollment.	
Benefit Amounts	Employee:	Minimum benefit of \$300 and maximum benefit of \$5,000* per month, not to exceed 65% of base monthly income.	

*If Enrollment technology does not support SI Underwriting all applications must be taken on paper applications.

Plan Design

Accident & Sickness – Elimination Period/Duration

0 Day Accident/7 Day Sickness (Illness)/12-month Duration
 14 Day Accident/14 Day Sickness (Illness)/12-month Duration
 30 Day Accident/30 Day Sickness (Illness)/12-month Duration

Partial Disability	50%, up to 6 months
Recurrent Disability	Recur within 180 days
Pre-existing Provision	12/12
Pregnancy	Treated as any other illness
Portability	Included
Waiver of Premium	After 90 Days

Benefit Definitions

TOTAL DISABILITY: For the first 24 months of a disability that the Employee/member is unable to perform the substantial and material duties of his or her regular occupation, not working in any other occupation, and under the care of a physician for the disability. After 24 months of total disability, totally disabled means that the Employee/member is unable to perform the duties of any occupation, and under the care of a physician for the disability.

PARTIAL DISABILITY: Because of a covered sickness or injury, the Employee/member is working more than 20% but not more than 80% of the normal pre-disability schedule, and under the regular care of a physician.

RECURRENT DISABILITY: Total and/or partial disability that is due to the same or related causes as a prior period of disability, follows a prior period for which a monthly benefit was paid, and occurs within 180 days after the end of a prior period for which a monthly benefit was paid. The elimination period is waived, and benefits are immediately available for up to the remaining benefit from the previous disability.

OCCUPATIONAL INCOME: The Eligible Persons' monthly rate of earnings from His Employer as of the day before the start of Total Disability. Occupational Income including commissions will be averaged over a period of time (see certificate of coverage). Occupational Income does not include overtime pay, bonuses, or extra compensation other than commissions.

ACCIDENT & SICKNESS: Provides coverage for disabilities caused by either an accidental injury or sickness.

ELIMINATION PERIOD: The number of continuous days, beginning with the first day of a total disability, before any monthly benefit amount is payable. Separate elimination periods apply to injury and illness.

BENEFIT PERIOD: The period of time for which Monthly Income Benefits are payable for disability due to the same cause.

WAIVER OF PREMIUM: Premium is waived if the Employee is totally disabled for more than 90 days or the elimination period, whichever is longer. Waiver of Premium will continue while the insured is receiving a Total Disability Income Benefit.

PRE-EXISTING CONDITION LIMITATION: If a member has a pre-existing condition that is diagnosed or symptoms occurred in the 12 months prior to the policy effective date, no benefits will be paid for the first 12 months of the policy effective date. Refer to the certificate of coverage for specific pre-existing limitations.

PORTABILITY: Portable after six months of continuous coverage if group master policy remains in force and the insured is less than age 70, not Totally Disabled, and no longer Actively at work for the Employer. Participants may continue coverage by paying premiums on a direct billing method. All ported certificates will be subject to any rate increases on the Employer's Master Policy. Dependents on ported certificates terminate when the spouse attained age is 70 or the child attained age is 25. If the policy terminates the ported Certificate terminates.

Disability Income Plus Rates Virginia

12 Month Benefit Period, 0/7 Elimination Period

Displaying Semi-Monthly Premiums for Non-Occ Coverage

Age	Uni-Tobacco				
Benefit	18-35	36-45	46-55	56-65	66-70
\$300	\$8.08	\$8.64	\$9.73	\$11.04	\$14.66
\$400	\$10.40	\$11.14	\$12.59	\$14.34	\$19.17
\$500	\$12.72	\$13.65	\$15.47	\$17.65	\$23.69
\$600	\$15.03	\$16.15	\$18.33	\$20.95	\$28.20
\$700	\$17.36	\$18.66	\$21.20	\$24.25	\$32.71
\$800	\$19.67	\$21.17	\$24.07	\$27.55	\$37.23
\$900	\$22.00	\$23.68	\$26.94	\$30.86	\$41.74
\$1,000	\$24.31	\$26.18	\$29.81	\$34.16	\$46.26
\$1,100	\$26.63	\$28.69	\$32.68	\$37.47	\$50.77
\$1,200	\$28.95	\$31.19	\$35.54	\$40.77	\$55.28
\$1,300	\$31.27	\$33.70	\$38.42	\$44.08	\$59.80
\$1,400	\$33.59	\$36.20	\$41.28	\$47.38	\$64.31
\$1,500	\$35.91	\$38.71	\$44.15	\$50.69	\$68.82
\$1,600	\$38.22	\$41.21	\$47.02	\$53.99	\$73.34
\$1,700	\$40.55	\$43.72	\$49.89	\$57.30	\$77.85
\$1,800	\$42.86	\$46.22	\$52.75	\$60.60	\$82.36
\$1,900	\$45.19	\$48.73	\$55.63	\$63.91	\$86.88
\$2,000	\$47.50	\$51.24	\$58.49	\$67.21	\$91.39
\$2,100	\$49.82	\$53.75	\$61.36	\$70.51	\$95.90
\$2,200	\$52.14	\$56.25	\$64.23	\$73.81	\$100.42
\$2,300	\$54.46	\$58.76	\$67.10	\$77.12	\$104.93
\$2,400	\$56.78	\$61.26	\$69.96	\$80.42	\$109.44
\$2,500	\$59.10	\$63.77	\$72.84	\$83.73	\$113.96
\$2,600	\$61.41	\$66.27	\$75.70	\$87.03	\$118.47
\$2,700	\$63.74	\$68.78	\$78.57	\$90.34	\$122.98
\$2,800	\$66.05	\$71.28	\$81.44	\$93.64	\$127.50
\$2,900	\$68.38	\$73.79	\$84.31	\$96.95	\$132.01
\$3,000	\$70.69	\$76.29	\$87.18	\$100.25	\$136.53
\$3,100	\$73.01	\$78.80	\$90.05	\$103.56	\$141.04
\$3,200	\$75.33	\$81.30	\$92.91	\$106.86	\$145.55
\$3,300	\$77.65	\$83.81	\$95.79	\$110.16	\$150.07
\$3,400	\$79.97	\$86.32	\$98.65	\$113.46	\$154.58
\$3,500	\$82.29	\$88.83	\$101.52	\$116.77	\$159.09
\$3,600	\$84.60	\$91.33	\$104.39	\$120.07	\$163.61
\$3,700	\$86.93	\$93.84	\$107.26	\$123.38	\$168.12
\$3,800	\$89.24	\$96.34	\$110.12	\$126.68	\$172.63
\$3,900	\$91.57	\$98.85	\$113.00	\$129.98	\$177.15
\$4,000	\$93.88	\$101.35	\$115.86	\$133.29	\$181.66
\$4,100	\$96.20	\$103.86	\$118.73	\$136.59	\$186.17
\$4,200	\$98.52	\$106.36	\$121.60	\$139.90	\$190.69
\$4,300	\$100.84	\$108.87	\$124.47	\$143.20	\$195.20
\$4,400	\$103.16	\$111.37	\$127.33	\$146.51	\$199.71
\$4,500	\$105.48	\$113.88	\$130.20	\$149.81	\$204.23
\$4,600	\$107.79	\$116.38	\$133.07	\$153.12	\$208.74
\$4,700	\$110.12	\$118.89	\$135.93	\$156.42	\$213.25
\$4,800	\$112.43	\$121.40	\$138.81	\$159.72	\$217.77
\$4,900	\$114.75	\$123.91	\$141.67	\$163.02	\$222.28
\$5,000	\$117.07	\$126.41	\$144.55	\$166.33	\$226.79

Disability Income Plus Rates Virginia

12 Month Benefit Period, 14/14 Elimination Period

Displaying Semi-Monthly Premiums for Non-Occ Coverage

Age	Uni-Tobacco				
Benefit	18-35	36-45	46-55	56-65	66-70
\$300	\$5.76	\$6.13	\$7.09	\$8.27	\$11.02
\$400	\$7.30	\$7.80	\$9.07	\$10.65	\$14.32
\$500	\$8.85	\$9.47	\$11.06	\$13.03	\$17.62
\$600	\$10.39	\$11.14	\$13.04	\$15.41	\$20.92
\$700	\$11.94	\$12.81	\$15.03	\$17.79	\$24.22
\$800	\$13.48	\$14.48	\$17.02	\$20.17	\$27.51
\$900	\$15.03	\$16.15	\$19.01	\$22.56	\$30.81
\$1,000	\$16.58	\$17.82	\$20.99	\$24.93	\$34.11
\$1,100	\$18.12	\$19.49	\$22.98	\$27.32	\$37.41
\$1,200	\$19.67	\$21.16	\$24.96	\$29.70	\$40.71
\$1,300	\$21.21	\$22.83	\$26.96	\$32.08	\$44.01
\$1,400	\$22.76	\$24.50	\$28.94	\$34.46	\$47.31
\$1,500	\$24.30	\$26.17	\$30.93	\$36.84	\$50.61
\$1,600	\$25.85	\$27.84	\$32.91	\$39.22	\$53.91
\$1,700	\$27.39	\$29.51	\$34.90	\$41.61	\$57.21
\$1,800	\$28.94	\$31.18	\$36.89	\$43.98	\$60.51
\$1,900	\$30.48	\$32.85	\$38.88	\$46.37	\$63.81
\$2,000	\$32.03	\$34.52	\$40.86	\$48.75	\$67.11
\$2,100	\$33.58	\$36.19	\$42.85	\$51.13	\$70.41
\$2,200	\$35.12	\$37.86	\$44.83	\$53.51	\$73.70
\$2,300	\$36.67	\$39.53	\$46.83	\$55.89	\$77.00
\$2,400	\$38.21	\$41.20	\$48.81	\$58.27	\$80.30
\$2,500	\$39.76	\$42.87	\$50.80	\$60.66	\$83.60
\$2,600	\$41.30	\$44.54	\$52.78	\$63.03	\$86.90
\$2,700	\$42.85	\$46.21	\$54.77	\$65.42	\$90.20
\$2,800	\$44.39	\$47.88	\$56.76	\$67.80	\$93.50
\$2,900	\$45.94	\$49.55	\$58.75	\$70.18	\$96.80
\$3,000	\$47.49	\$51.22	\$60.73	\$72.56	\$100.10
\$3,100	\$49.03	\$52.89	\$62.72	\$74.94	\$103.40
\$3,200	\$50.58	\$54.56	\$64.70	\$77.32	\$106.70
\$3,300	\$52.12	\$56.23	\$66.70	\$79.71	\$109.99
\$3,400	\$53.67	\$57.90	\$68.68	\$82.08	\$113.29
\$3,500	\$55.21	\$59.57	\$70.67	\$84.47	\$116.59
\$3,600	\$56.76	\$61.24	\$72.65	\$86.85	\$119.89
\$3,700	\$58.30	\$62.91	\$74.64	\$89.23	\$123.19
\$3,800	\$59.85	\$64.58	\$76.63	\$91.61	\$126.49
\$3,900	\$61.39	\$66.25	\$78.62	\$93.99	\$129.79
\$4,000	\$62.94	\$67.92	\$80.60	\$96.37	\$133.09
\$4,100	\$64.49	\$69.59	\$82.59	\$98.76	\$136.39
\$4,200	\$66.03	\$71.26	\$84.57	\$101.13	\$139.69
\$4,300	\$67.58	\$72.93	\$86.57	\$103.52	\$142.99
\$4,400	\$69.12	\$74.60	\$88.55	\$105.90	\$146.29
\$4,500	\$70.67	\$76.27	\$90.54	\$108.28	\$149.59
\$4,600	\$72.21	\$77.94	\$92.52	\$110.66	\$152.89
\$4,700	\$73.76	\$79.61	\$94.51	\$113.04	\$156.18
\$4,800	\$75.30	\$81.28	\$96.50	\$115.42	\$159.48
\$4,900	\$76.85	\$82.95	\$98.49	\$117.81	\$162.78
\$5,000	\$78.40	\$84.62	\$100.47	\$120.18	\$166.08

Disability Income Plus Rates Virginia

12 Month Benefit Period, 30/30 Elimination Period

Displaying Semi-Monthly Premiums for Non-Occ Coverage

Age	Uni-Tobacco				
Benefit	18-35	36-45	46-55	56-65	66-70
\$300	\$4.22	\$4.44	\$5.19	\$6.15	\$8.27
\$400	\$5.25	\$5.54	\$6.54	\$7.82	\$10.64
\$500	\$6.28	\$6.65	\$7.89	\$9.50	\$13.03
\$600	\$7.31	\$7.75	\$9.24	\$11.17	\$15.40
\$700	\$8.35	\$8.86	\$10.60	\$12.85	\$17.79
\$800	\$9.37	\$9.96	\$11.95	\$14.53	\$20.16
\$900	\$10.41	\$11.07	\$13.31	\$16.21	\$22.55
\$1,000	\$11.44	\$12.18	\$14.66	\$17.88	\$24.93
\$1,100	\$12.47	\$13.29	\$16.02	\$19.56	\$27.31
\$1,200	\$13.50	\$14.39	\$17.37	\$21.23	\$29.69
\$1,300	\$14.54	\$15.50	\$18.72	\$22.91	\$32.07
\$1,400	\$15.56	\$16.60	\$20.07	\$24.58	\$34.45
\$1,500	\$16.60	\$17.71	\$21.43	\$26.26	\$36.83
\$1,600	\$17.63	\$18.81	\$22.78	\$27.93	\$39.21
\$1,700	\$18.66	\$19.92	\$24.14	\$29.61	\$41.59
\$1,800	\$19.69	\$21.02	\$25.49	\$31.28	\$43.97
\$1,900	\$20.73	\$22.13	\$26.85	\$32.96	\$46.35
\$2,000	\$21.76	\$23.23	\$28.20	\$34.64	\$48.73
\$2,100	\$22.79	\$24.34	\$29.55	\$36.32	\$51.12
\$2,200	\$23.82	\$25.44	\$30.90	\$37.99	\$53.49
\$2,300	\$24.85	\$26.55	\$32.26	\$39.67	\$55.88
\$2,400	\$25.88	\$27.65	\$33.61	\$41.34	\$58.25
\$2,500	\$26.92	\$28.76	\$34.97	\$43.02	\$60.64
\$2,600	\$27.95	\$29.86	\$36.32	\$44.69	\$63.01
\$2,700	\$28.98	\$30.97	\$37.68	\$46.37	\$65.40
\$2,800	\$30.01	\$32.07	\$39.03	\$48.04	\$67.77
\$2,900	\$31.05	\$33.18	\$40.38	\$49.72	\$70.16
\$3,000	\$32.07	\$34.29	\$41.73	\$51.39	\$72.54
\$3,100	\$33.11	\$35.40	\$43.09	\$53.07	\$74.92
\$3,200	\$34.14	\$36.50	\$44.44	\$54.74	\$77.30
\$3,300	\$35.17	\$37.61	\$45.80	\$56.42	\$79.68
\$3,400	\$36.20	\$38.71	\$47.15	\$58.10	\$82.06
\$3,500	\$37.24	\$39.82	\$48.51	\$59.78	\$84.44
\$3,600	\$38.26	\$40.92	\$49.86	\$61.45	\$86.82
\$3,700	\$39.30	\$42.03	\$51.21	\$63.13	\$89.20
\$3,800	\$40.33	\$43.13	\$52.56	\$64.80	\$91.58
\$3,900	\$41.36	\$44.24	\$53.92	\$66.48	\$93.96
\$4,000	\$42.39	\$45.34	\$55.27	\$68.15	\$96.34
\$4,100	\$43.43	\$46.45	\$56.63	\$69.83	\$98.73
\$4,200	\$44.45	\$47.55	\$57.98	\$71.50	\$101.10
\$4,300	\$45.49	\$48.66	\$59.34	\$73.18	\$103.49
\$4,400	\$46.52	\$49.76	\$60.69	\$74.85	\$105.86
\$4,500	\$47.55	\$50.87	\$62.04	\$76.53	\$108.25
\$4,600	\$48.58	\$51.97	\$63.39	\$78.20	\$110.62
\$4,700	\$49.62	\$53.08	\$64.75	\$79.88	\$113.01
\$4,800	\$50.64	\$54.18	\$66.10	\$81.56	\$115.38
\$4,900	\$51.68	\$55.29	\$67.46	\$83.24	\$117.77
\$5,000	\$52.71	\$56.40	\$68.81	\$84.91	\$120.15

Cancer Insurance

Plan Options



American Fidelity | www.AmericanFidelity.com | 800.654.8489

Thousands of Americans are diagnosed with cancer each day. No doubt, the news is devastating, both personally and financially. It's impossible to anticipate a cancer diagnosis, but it is possible to prepare for it with a cancer insurance plan.

It is likely that your major medical coverage will not cover all the costs associated with a cancer diagnosis. Supplementing your major medical with cancer insurance may help you pay for related expenses, such as copays and deductibles, specialists, experimental treatment, specialty hospitals, travel expenses, in-home care and more.

Premiums are paid through convenient payroll deduction to ensure your policy remains in force if you should need it. Benefits are paid directly to you, so you can choose how to spend the money. Visit the Employee Benefits Center and view policy for more details.

C12M CANCER *Insurance Plan*

Underwritten by American Fidelity Assurance Company



Limited Benefit Specified Disease Cancer Indemnity Insurance Policy



Marketed by:
First Financial Capital Corporation
P.O. Box 670329 • Houston, TX 77267-0329
Local (281) 847-8422 | Toll Free (800) 523-8422
www.ffga.com

Cancer C12M Insurance

Focus on the fight

A Cancer diagnosis may be both a physical and emotional drain. But thanks to advances in medicine and procedures to treat Cancer, more and more people are beating the disease. However, with the arrival of these advances also comes the continuing rise in the cost of Cancer treatment.

AF™ Limited Benefit Individual Cancer Insurance offers a solution to help you and your family focus on fighting the disease.

Cancer Insurance Benefits

With over 25 benefits specifically designed to help with the financial impact of being diagnosed, **Individual Cancer Insurance** may help pay for expenses not covered by your major medical insurance.

Example Cancer insurance benefits include:



Experimental Treatment

This benefit may help pay for experimental treatment to give you alternatives in your healing. These treatment types may not be covered by major medical plans.



Transportation and Lodging

This benefit may help pay for qualified transportation and lodging for the patient and family.

Plan Highlights

This plan is designed to help cover expenses, should you be diagnosed with cancer. With more than 25 built-in plan benefits, this plan provides benefits for the treatment of cancer, transportation, hospitalization, and more.

In addition, this is a portable plan, so you own the policy. You can take the coverage with you if you choose to leave your current job, and your premiums will not increase because you left your employment.

American Fidelity's Limited Benefit Cancer Insurance features:

- **Helps cover expenses**
for the treatment of Cancer, transportation, hospitalization, and more.
- **Benefits paid directly to you**
to be used however you see fit.
- **Portable to take with you**
even if you leave employment.
- **Coverage options available**
for you, your spouse, and your children under age 26.

SCREENING BENEFIT⁺

Receive a benefit for your annual internal cancer screening test, including but not limited to Mammogram, PAP, Prostate-Specific Antigen Blood Test (PSA), Chest X-ray, Flexible Sigmoidoscopy, ThinPrep Pap test, and Colonoscopy.

DIAGNOSTIC AND PREVENTION BENEFIT (per calendar year)

Basic
\$60

Enhanced
\$75

Plan Options

You can take advantage of the following options to extend coverage to your family:

- **Individual Plan**
The Insured, age 18 through 70, at the date of policy issue, is the only Covered Person.
- **Single Parent Family Plan**
The Insured, age 18 through 70, at the date of policy issue, and each Eligible Child, to age 26, or as defined in the policy.
- **Family Plan**
The Insured and spouse age 18 through 70, at the date of policy issue, and Eligible Child, to age 26, or as defined in the policy.

⁺The premium and amount of benefits vary based upon the plan selected.

Schedule of Benefits by Plan⁺

Marketed by: First Financial Group of America

	Basic	Enhanced
SCREENING BENEFITS		
Diagnostic and Prevention Benefit <i>(one per calendar year)</i>	\$60	\$75
Cancer Screening Follow-Up Benefit <i>(one per calendar year)</i>	\$60	\$75
TREATMENT BENEFITS		
Radiation Therapy/Chemotherapy/Immunotherapy Benefit <i>(per calendar month) (no lifetime max)</i>	\$1,500	\$2,000
Medical Imaging Benefit <i>(per image - max 2 per calendar year)</i>	\$200	\$300
Hormone Therapy Benefit <i>(per image - max 12 treatments/calendar year)</i>	\$50	\$50
Administrative/Lab Work Benefit <i>(per calendar month)</i>	\$75	\$100
Blood, Plasma, and Platelets Benefit <i>(per day)</i> <i>(per calendar year max)</i>	\$150 \$7,500	\$200 \$10,000
Experimental Treatment Benefit	Paid as any non-experimental benefit	
Bone Marrow/Stem Cell Transplant Benefit Autologous <i>(Patient provided) (per calendar year)</i> Non-autologous <i>(Donor provided) (per calendar year)</i>	\$1,000 \$3,000	\$1,500 \$4,500
Donor Benefit	\$1,000 per donation	
Inpatient Special Nursing Services Benefit <i>(benefit per day while Hospital Confined)</i>	\$150	\$150
Dread Disease Benefit <i>(benefit per day for the first 30 days per Hospital Confinement)</i> <i>(benefit per day thereafter)</i>	\$200 \$400	\$300 \$600
HOSPITALIZATION BENEFITS		
Hospital Confinement Benefit* <i>(per day for the first 30 days)</i> <i>(per day after the first 30 days)</i>	\$200 \$400	\$300 \$600
Drugs & Medicine Benefit Hospital Confinement <i>(per Confinement)</i> Outpatient <i>(per prescription - \$100 monthly max for Basic; \$150 for Enhanced) per calendar month</i>	\$200 \$50	\$300 \$50
Attending Physician Benefit <i>(per day while Hospital Confined)</i>	\$40	\$50
U.S. Government/Charity Hospital or HMO Benefit <i>(per day in lieu of most benefits)</i> Hospital Confinement Outpatient Services	\$200 \$200	\$300 \$300
AMBULANCE, TRANSPORTATION, & LODGING BENEFITS		
Ambulance Benefit <i>(per trip - max 2 trips any combination per confinement)</i> Ground Air	\$200 \$2,000	\$200 \$2,000
Transportation & Lodging Benefit (Patient and/or Family) Transportation <i>(\$1,500 max per round trip; max 12 trips/calendar year)</i> Outpatient Lodging <i>(per day up to 90 days per calendar year)</i>	Coach fare or \$.50/mile by car \$60	Coach fare or \$.50/mile by car \$80

Schedule of Benefits by Plan⁺ (continued)

	Basic	Enhanced
SURGICAL TREATMENT BENEFITS		
Surgical Benefit <i>Unit Dollar Amount (per surgical unit)</i> <i>Maximum Per Operation</i>	\$30 \$3,000	\$40 \$4,000
Anesthesia Benefit	25% of the amount paid for covered surgery	
Outpatient Hospital or Ambulatory Surgical Center Benefit <i>No lifetime maximum.</i>	\$400	\$600
Second & Third Surgical Opinion Benefit (<i>per diagnosis</i>) <i>(Additional \$300 for 3rd if required)</i>	\$300	\$300
CONTINUING CARE BENEFITS		
Prosthesis Benefit <i>Non-Surgical (per device - 1 per site, lifetime max of 3)</i> <i>Surgical Implantation (per device, includes surgical fee - 1 per site, lifetime max of 2)</i> <i>Hair Prosthesis (once per life)</i>	\$150 \$1,500 \$150	\$200 \$2,000 \$200
Extended Care Facility Benefit <i>(per day for the first 30 days)</i> <i>(per day thereafter)</i> <i>up to 100 days per lifetime of the covered person.</i>	\$75 \$100	\$100 \$150
Physical or Speech Therapy Benefit <i>(per visit up to 4 per calendar month - lifetime max of \$1,000)</i>	\$25	\$25
Hospice Care Benefit <i>(per day - \$13,500 lifetime max for Basic; \$18,000 lifetime max for Enhanced)</i>	\$75	\$100
Home Health Care Benefit <i>(per day for the first 30 days)</i> <i>(per day thereafter)</i> <i>up to 100 days per lifetime of the covered person.</i>	\$75 \$100	\$100 \$150
Waiver of Premium <i>(as long as the primary insured remains disabled)</i>	after 90 continuous days of disability	

Refer to Plan Benefit Highlights for more complete Benefit Descriptions and limits on the Cancer Insurance Plan.

Enhance your plan⁺⁺

First Occurrence of Internal Cancer Benefit Rider

Thanks to medical technology more people are surviving illnesses, like Cancer, that were once considered fatal. This rider is designed to help with the cost associated in surviving Internal Cancer.

Schedule of Benefits	
Cancer Benefit <i>(per unit - maximum \$10,000)</i>	\$2,500

Summary of First Occurrence of Internal Cancer Benefit Rider Benefits:

- Pays when diagnosed with Internal Cancer after 30-day Waiting Period depending upon the coverage elected at time of application.
- Pays the specified Maximum Benefit Amount, as defined under this rider.
- Each benefit is a one-time paid benefit.

⁺The premium and amount of benefits provided vary based upon the plan selected.

⁺⁺Availability of riders may vary by state and employer. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed.

Plan Benefits Highlights

Plan Benefit Highlights

Only loss for Cancer The policy pays only for loss resulting from definitive Cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. The policy also covers other conditions or diseases directly caused or aggravated by Cancer or the treatment of Cancer. The policy does not cover any other disease, sickness, or incapacity, even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically provided in the dread disease benefit.

Cancer means a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratosis; myelodysplastic and non-malignant myeloproliferative disorders; aplastic anemia; atypia; non-malignant monoclonal gammopathy; carcinoid; or pre-malignant lesions, benign tumors or polyps.

All diagnosis of Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. Benefits under this policy pays the benefit amount shown per covered person due to a covered Cancer unless otherwise specified.

Diagnostic, Prevention and Cancer Screening Benefit Pays for a generally medically recognized internal Cancer screening test when a charge is incurred for the test. Tests include but are not limited to mammogram, thinprep pap test, prostate-specific antigen blood test (PSA), colonoscopy, and chest x-ray. Refer to the policy for more examples. Screening tests payable under this benefit will ONLY be paid under this benefit and does not include any test payable under the medical imaging benefit. This benefit is available without a diagnosis of Cancer.

Cancer Screening Follow-Up Benefit Payable for one invasive follow-up screening test needed due to an abnormal result from a covered screening test. Diagnostic surgeries which result in a positive diagnosis of Cancer will be paid under the surgical benefit.

Radiation/Chemotherapy/Immunotherapy Benefit Pays an indemnity amount when radiation therapy, chemotherapy, or immunotherapy is received as defined in the policy. We will pay only one Radiation/Chemotherapy/Immunotherapy benefit per calendar month regardless of the number of radioactive, chemotherapy or immunotherapy treatments received during the month.

This benefit does not cover other procedures related to Radiation/Chemotherapy/Immunotherapy as defined in the policy. This benefit does not include any drugs/ medicines covered under the drugs and medicine benefit or the hormone therapy benefit.

Medical Imaging Benefit Pays the indemnity amount for either an MRI; CT scan; CAT scan; or PET scan when performed at the request of a physician.

Hormone Therapy Benefit Drugs and medicines covered under the drugs and medicine benefit or the radiation/ chemotherapy/immunotherapy benefit are not included. This benefit does not cover associated administrative processes.

Administrative/Lab Work Benefit Pays when procedures related to radiation therapy/chemotherapy/immunotherapy treatment occur and benefits are payable during the same calendar month as the radiation therapy/chemotherapy/ immunotherapy benefit.

Blood, Plasma and Platelets Benefit Benefits for blood, plasma and platelets are only provided under this benefit. Laboratory processes and colony stimulating factors are not covered.

Bone Marrow/Stem Cell Transplant Benefit Harvesting of bone marrow or stem cells from a donor are not covered under this benefit.

Hospital Confinement Benefit Payable while confined to a Hospital for at least 18 continuous hours. *A Hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction. This benefit is not payable for outpatient treatment.

Drugs and Medicine Benefit Pays for anti-nausea and pain medication prescribed by a physician and administered while also receiving radiation therapy/chemotherapy/ immunotherapy, a covered surgery, or a bone marrow/stem cell transplant. It does not include associated administrative processes or drugs or medicines covered under the radiation therapy/chemotherapy/immunotherapy benefit or the hormone therapy benefit.

Attending Physician Benefit Pays for one physician's visit per day when the services of a physician, other than a surgeon, are required while confined in a Hospital.

U.S. Government/Charity Hospital /HMO Benefit Payable when an itemized list of services is not available due to confinement in a charity Hospital or a Hospital owned or operated by the U.S. government or covered under an HMO or diagnostic related group where no charges are made for treatment of Cancer or a covered dread disease. This benefit will be paid in lieu of most benefits covered under this policy.

Ambulance Benefit If air and ground ambulance services are both required on the same day, we will only pay the higher benefit amount. The covered person must be admitted as an inpatient and Hospital confined for at least 18 consecutive hours.

Transportation and Lodging Benefits Pays a benefit for transportation by scheduled bus, plane or train, or by car and outpatient lodging to receive radiation therapy, chemotherapy, or immunotherapy treatment, bone marrow or stem cell transplant, or surgery in a Hospital not available locally and at least 50 miles from the covered person's residence. Payable for the covered person and one adult family member. If traveling in the same car or lodging in the same room, the benefit is payable only for the covered person. Travel must be within the United States or its Territories.

Plan Benefit Highlights (continued)

Surgical Benefit Payable when a surgical operation is performed for covered diagnosed Cancer, skin Cancer, or reconstructive surgery due to Cancer. Benefits are calculated up to a maximum benefit by multiplying the surgical unit value assigned to the procedure, as shown in the most current physician's relative value table, by the unit dollar amount shown in the policy. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Bone marrow surgeries, surgeries to implant a permanent prosthetic device, are not covered under this benefit.

Anesthesia Benefit Services of an anesthesiologist for bone marrow transplants, skin Cancer or surgical prosthesis implantation are not covered.

Outpatient Hospital or Ambulatory Surgical Center Benefit Surgical procedures for skin Cancer are not covered.

Second and Third Surgical Opinion Benefit Payable once per diagnosis of Cancer for a second surgical opinion, and a third if the second disagrees with the first. Surgical opinions for reconstructive, skin Cancer, or prosthesis surgeries are not covered.

Prosthesis Benefit Payable for a prosthetic device and, if surgery required, its surgical implantation. Prosthetic related supplies such as special bras or ostomy pouches and supplies are not covered. **Hair Prosthesis Benefit** is payable once per covered person per lifetime when a hair prosthesis is needed.

Extended Care Facility Benefit Pays for physician authorized confinement that begins within 14 days after a Hospital confinement.

Physical or Speech Therapy Benefit Therapy must be provided by a caregiver licensed in physical or speech therapy.

Hospice Care Benefit Payable when a physician determines terminal illness with life expectancy of 6 months or less and approves hospice care at home or in a hospice facility. This benefit does not include well baby care, volunteer services, meals, housekeeping services, or family support after the death.

Home Health Care Benefit Pays for physician authorized private nursing care that begins within 14 days of a hospital confinement. This benefit does not include nutrition counseling, medical social services, medical supplies, prosthesis or orthopedic appliances, rental or purchase of durable medical equipment, drugs or medicines, child care, meals or housekeeping services, or physical or speech therapy. The service must be provided by a nurse or home health nurse's aid and can not be a family member.

Experimental Treatment Benefit Benefits for experimental treatment prescribed by a physician for treatment of Cancer will be provided the same as non-experimental treatment. Coverage for treatments received outside of the United States or its territories is not provided.

Donor Benefit Pays if a donor incurs expenses on behalf of a covered person for a covered surgery due to organ transplant or a bone marrow/ stem cell transplant. Blood donor expenses are not covered under this benefit. Benefits shall be provided to reimburse any medical expenses of a live donor to the extent that benefits remain and are available under this policy, after benefits for the Covered Person's expenses have been paid.

Dread Disease Benefit Covered dread diseases are: addison's disease; amyotrophic lateral sclerosis; cystic fibrosis; diphtheria; encephalitis; grand mal epilepsy; legionnaire's disease; meningitis; multiple sclerosis; muscular dystrophy; myasthenia gravis; niemann-pick disease; osteomyelitis; poliomyelitis; reye's syndrome; rheumatic fever; rocky mountain spotted fever; sickle cell anemia; systemic lupus erythematosus; tay-sach's disease; tetanus; toxic epidermal; toxic shock syndrome; tuberculosis; tularemia; typhoid fever; whipple's disease.

Inpatient Special Nursing Services Benefit Pays when Hospital confined and receiving physician authorized special nursing care (other than that regularly furnished by a Hospital) of at least 8 consecutive hours during a 24 hour period. See your policy for more information regarding the benefits listed above.

Eligibility The policy/rider(s) will be issued only to those persons who meet American Fidelity's insurability requirements, which includes satisfactory responses to medical questions. You, your lawful spouse and each natural, adopted or step child who is under 26 years of age are eligible to apply for coverage.

Limitations and Exclusions The policy does not cover any other disease, sickness or incapacity except for conditions specifically provided in the dread disease benefit.

Pre-Existing Condition No benefits are payable for any covered person for any loss incurred during the first year of the policy as a result of a Pre-Existing Condition. Pre-Existing Condition is a Specified Disease:

- (1) for which within 12 months prior to the Effective Date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession; or
- (2) that manifested itself within six months prior to the Covered Person's effective date of coverage.

Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered. All benefits payable only up to the maximum amount listed in the Schedule of Benefits in the policy.

Waiver of Premium If the Primary Insured becomes disabled due to Cancer and remains so for more than 90 continuous days, we will pay all premiums due after the 90th day so long as the Primary Insured remains disabled. "Disabled" means the Primary Insured is:

- (1) unable to engage in any employment or occupation for which you are, or become, qualified by education, training, or experience; and
- (2) not engaged in any employment or occupation for wage or profit; and
- (3) under the care of a Physician for the treatment of Cancer.

This policy must be in force at the time disability begins and the Primary Insured must be under age 65.

Termination of Insurance Policy/rider(s) will terminate and coverage will end on the earliest of: the end of the grace period if the premium remains unpaid; or the date the Internal Cancer Maximum Benefit Amount has been paid for all covered persons under this rider; the date we receive a written request from you to terminate the policy/rider(s), or such later date as may be specified in the request; or the date of your death, if this is an Individual Plan. If the plan is other than individual the remaining covered persons may have the right to continue or convert their coverage. Coverage will terminate when they no longer meet the eligibility requirements. In the event of cancellation by you, we will return the unearned portion of any premium paid, pro rated.

Limitations and Exclusions

For the spouse, policy/rider(s) will terminate and coverage will end on the earliest of: The date we receive a written request from you to delete the spouse from the policy/rider(s); the end of the premium term in which a divorce, annulment, legal separation is obtained; or upon their death. The date the rider terminates.

For the child(ren), policy/rider(s) will terminate and coverage will end the earliest of: The date we receive a written request from you to delete the child(ren) from the policy/rider(s); or upon their death. The date the rider terminates.

Guaranteed Renewable You are guaranteed the right to renew your policy/rider(s) during your lifetime as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

Limitations and Exclusions Benefits will only be paid for a First Occurrence of Internal Cancer as shown on the Policy Schedule page in the policy. We will not pay benefits for any loss caused by or resulting from: a pre-existing condition during the 12 month period following the covered person's effective date; an internal Cancer when the date of Diagnosis occurs during the waiting period, if applicable.

Pre-Existing Condition As defined as any sickness or condition for which, within 12 months prior to the Effective Date of coverage under this rider, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or that manifested itself within six months prior to the Covered Person's effective date of coverage; or an internal Cancer when the Date of Diagnosis occurs during the Waiting Period, if applicable. If any Covered Person is diagnosed as having an Internal Cancer during the 30-day period immediately following the Effective Date, you may elect to void this rider from the beginning and receive a full refund of premium. Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: acquired immune deficiency syndrome (AIDS); or actinic keratosis; or myelodysplastic and non-malignant myeloproliferative disorders; or aplastic anemia; or atypia; or nonmalignant monoclonal gamopathy; or pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or cancer in situ or any skin cancer, as defined in the policy, other than invasive malignant melanoma into the dermis or deeper.

Waiting Period Pays when diagnosed by a Physician after a 30 day waiting period with Internal Cancer or Heart Attack/Stroke, depending upon the coverage elected at time of application. If any Covered Person is diagnosed as having an Internal Cancer during the 30-day period immediately following the Effective Date, you may elect to void the rider from the beginning and receive a full refund of premium.

Termination Each Covered Person's coverage will terminate when the maximum benefit amount for the Covered Critical Illness(es) has been paid for him/her.

First Occurrence of Internal Cancer Benefit Rider

Pre-Existing Condition As defined as any sickness or condition for which, within 12 months prior to the Effective Date of coverage under this rider, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or that manifested itself within six months prior to the Covered Person's effective date of coverage; or an internal Cancer when the Date of Diagnosis occurs during the Waiting Period, if applicable. If any Covered Person is diagnosed as having an Internal Cancer during the 30-day period immediately following the Effective Date, you may elect to void this rider from the beginning and receive a full refund of premium. Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: acquired immune deficiency syndrome (AIDS); or actinic keratosis; or myelodysplastic and non-malignant myeloproliferative disorders; or aplastic anemia; or atypia; or nonmalignant monoclonal gamopathy; or pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or cancer in situ or any skin cancer, as defined in the policy, other than invasive malignant melanoma into the dermis or deeper.

Cancer Insurance Premiums

Base Plan Monthly Premiums*

BASIC	18-40	41-50	51-60	61+
Individual	16.70	24.40	35.00	49.30
1 Parent Family	24.90	36.30	52.10	73.60
2 Parent Family	32.50	47.20	67.80	95.80

ENHANCED	18-40	41-50	51-60	61+
Individual	21.40	31.80	46.10	65.70
1 Parent Family	31.90	47.40	68.80	98.00
2 Parent Family	41.50	61.60	89.50	127.50

Optional Benefit Rider Monthly Premiums*

First Occurrence of Internal Cancer Benefit Rider

Rates based on One Unit (One Unit = \$2,500; Two Units = \$5,000; Three Units = \$7,500; Four Units = \$10,000)

INTERNAL CANCER												
\$2,500			\$5,000			\$7,500			\$10,000			
Individual	One Parent Family	Two Parent Family	Individual	One Parent Family	Two Parent Family	Individual	One Parent Family	Two Parent Family	Individual	One Parent Family	Two Parent Family	
18-40	1.50	2.20	2.90	3.00	4.40	5.80	4.50	6.60	8.70	6.00	8.80	11.60
41-50	3.00	4.50	5.80	6.00	9.00	11.60	9.00	13.50	17.40	12.00	18.00	23.20
51-60	4.90	7.30	9.40	9.80	14.60	18.80	14.70	21.90	28.20	19.60	29.20	37.60
61+	7.10	10.60	13.80	14.20	21.20	27.60	21.30	31.80	41.40	28.40	42.40	55.20

*The premium and amount of benefits provided vary based upon the plan selected.

This product may contain limitations and exclusions. This product is inappropriate for people who are eligible for Medicaid coverage.



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Critical Illness Insurance

Aflac | www.aflacgroupinsurance.com | 800.433.3036

Prepare For the Unexpected

If you've heard of heart attacks, strokes, organ transplants or paralysis, then you're familiar with critical illness. It's likely you or someone you know has experienced one of these life-altering events. Often times, a critical illness has a powerful impact on people's lives, affecting their livelihood and finances.

A critical illness plan can help with the treatment costs of covered illnesses. Benefits are paid directly to you, unless otherwise assigned, giving you the choice of how to spend the money. Plus, there are plans available to provide coverage for you, your spouse and dependent children.

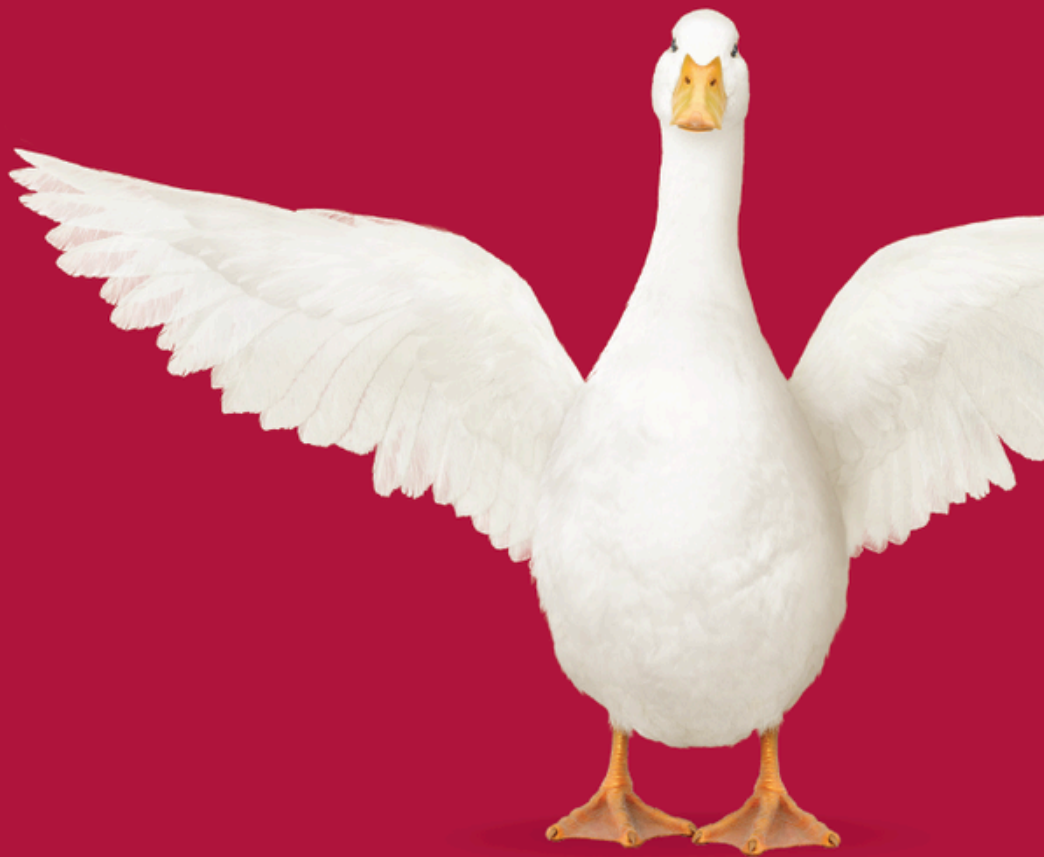
Prepare now for the unexpected with a critical illness insurance plan. The plan helps you focus on getting well rather than worrying about finances. Visit the Employee Benefits Center and view policy for more details.



Aflac Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS
FOR CANCER AND HEALTH SCREENING

We help take care of your
expenses while you take
care of yourself.



Continental American Insurance Company, a wholly-owned subsidiary of
Aflac Incorporated, is the insuring company.



Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who's been diagnosed with a critical illness. You can't help notice the difference in the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

What you need, when you need it.

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



Here's why the Aflac Group Critical Illness plan may be right for you.

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

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
 - Cancer
 - Heart Attack (Myocardial Infarction)
 - Stroke
 - Kidney Failure (End-Stage Renal Failure)
 - Major Organ Transplant
 - Bone Marrow Transplant (Stem Cell Transplant)
 - Sudden Cardiac Arrest
 - Coronary Artery Bypass Surgery
 - Non-Invasive Cancer
 - Severe Burn
 - Coma
 - Paralysis
 - Loss of Sight / Hearing / Speech
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How it works



Amount payable based on \$10,000 Initial Diagnosis Benefit.

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

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a 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%

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. 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. 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.

*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.

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

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 \$100 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.

OPTIONAL BENEFITS RIDER

BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

PROGRESSIVE DISEASES RIDER

AMYOTROPHIC LATERAL SCLEROSIS (ALS or Lou Gehrig's Disease)	100%
SUSTAINED MULTIPLE SCLEROSIS	100%

This benefit is paid based on your selected Progressive Disease Benefit amount. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

SPECIFIED DISEASES RIDER

Percentage of Face Amount

Addison's Disease, Cerebrospinal Meningitis, Diphtheria, Huntington's Chorea, Legionnaire's Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis	25%
Benefits are payable if an insured is diagnosed with one of the diseases listed. These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.	

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%

One Time Benefit Amount

AUTISM SPECTRUM DISORDER (ASD)	\$3,000
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Benefits are payable if a dependent child is diagnosed with one of the conditions listed and the date of diagnosis is while the rider is in force. (In Indiana, diagnosis must not be specifically excluded by the plan.)

LIMITATIONS AND EXCLUSIONS

IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.

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

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or

taking action that causes oneself to become injured

- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict:**
 - War (declared or undeclared) or military conflict
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

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

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by:

- The uncontrolled growth and spread of malignant cells, and
- The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77 mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77 mm, or
 - Stage 1A melanomas under TNM Staging

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of the plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77 mm, or
 - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, Non-Invasive Cancer, or Skin Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist and conform to the American Board of Pathology standards.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
 - A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the diagnosis, and
 - A doctor is treating you for cancer or carcinoma in situ

Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).

- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- Paralysis: The date a doctor diagnoses an insured with paralysis

due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.

- Severe Burn: The date the burn takes place.
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, who is listed on your application. Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days following the dependent child's 26th birthday.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and investigations, as supported by your medical records.
- Is based on clinical or laboratory

Doctor is a person who is:

- Legally qualified to practice medicine, where treatment is received, and
- Licensed as a doctor by the state
- Licensed to treat the type of condition for which a claim is made.

A doctor does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-family members and family-members-in-law.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart

- attack (myocardial infarction), and
 - Elevation of cardiac enzymes above generally accepted laboratory levels
- of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment.

Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. **Maintenance Drug Therapy** is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis
- Cardiomyopathy
- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Pathologist is a doctor who is licensed:

- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or

- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
 - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
 - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

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.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

OPTIONAL BENEFITS RIDER

Date of Diagnosis is defined as follows:

- **Advanced Alzheimer's Disease:** The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease:** The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.
- **Benign Brain Tumor:** The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Optional Benefit is one of the illnesses defined below and shown in the rider schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease.

To be incapacitated due to Alzheimer's Disease, the insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the insured to be incapacitated. Parkinson's Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the insured must:

- Exhibit at least two of the following clinical manifestations:
 - Muscle rigidity
 - Tremor
 - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses), and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the

brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

- Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
- Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.
- Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:

- Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;
- Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and
- Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

PROGRESSIVE DISEASES RIDER

Date of Diagnosis is defined for each specified critical illness as follows:

- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease): The date a Doctor Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records.
- Sustained Multiple Sclerosis: The date a Doctor Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- Muscular weakness,
- Loss of coordination,
- Speech disturbances, or
- Visual disturbances.

CHILDHOOD CONDITIONS RIDER

Date of Diagnosis is defined as follows:

- Cystic Fibrosis: The date a doctor diagnoses a dependent child as having Cystic Fibrosis and where such diagnosis is supported by medical records.

- Cerebral Palsy: The date a doctor diagnoses a dependent child as having Cerebral Palsy and where such diagnosis is supported by medical records.
- Cleft Lip or Cleft Palate: The date a doctor diagnoses a dependent child as having Cleft Lip or Cleft Palate and where such diagnosis is supported by medical records.
- Down Syndrome: The date a doctor diagnoses a dependent child as having Down Syndrome and where such diagnosis is supported by medical records.
- Phenylalanine Hydroxylase Deficiency Disease (PKU): The date a doctor diagnoses a dependent child as having PKU and where such diagnosis is supported by medical records.
- Spina Bifida: The date a doctor diagnoses a dependent child as having Spina Bifida and where such diagnosis is supported by medical records.
- Type I Diabetes: The date a doctor diagnoses a dependent child as having Type I Diabetes and where such diagnosis is supported by medical records.
- Autism Spectrum Disorder: The date a doctor diagnoses a dependent child as having Autism Spectrum Disorder and where such diagnosis is supported by medical records.

If a dependent child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

A doctor must diagnose Phenylalanine Hydroxylase Deficiency Disease (PKU) based on a PKU test.

A doctor must diagnose Type I Diabetes based on one of the following diagnostic tests:

- Glycated hemoglobin (A1C) test
- Random blood sugar test
- Fasting blood sugar test

A doctor must diagnose Autism Spectrum Disorder based on DSM-V diagnostic criteria.

SPECIFIED DISEASES RIDER

Date of Diagnosis is defined for each Specified Disease as follows:

Adrenal Hypofunction (Addison's Disease): The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.

Cerebrospinal Meningitis: The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.

Diphtheria: The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.

Huntington's Chorea: The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.

Legionnaire's Disease: The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding Legionella bacteria in a clinical specimen taken from the Insured.

Malaria: The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.

Muscular Dystrophy: The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.

Myasthenia Gravis: The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.

Necrotizing Fasciitis: The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.

Osteomyelitis: The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.

Poliomyelitis: The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.

Rabies: The date a Doctor Diagnoses an Insured as having Rabies and where such Diagnosis is supported by medical records.

Sickle Cell Anemia: The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.

Systemic Lupus: The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.

Systemic Sclerosis (Scleroderma): The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.

Tetanus: The date a Doctor Diagnoses an Insured as having Tetanus by finding *Clostridium tetani* bacteria in a clinical specimen taken from the Insured.

Tuberculosis: The date a Doctor Diagnoses an Insured as having Tuberculosis by finding *Mycobacterium tuberculosis* bacteria in a clinical specimen taken from the Insured.

Adrenal Hypofunction (Addison's Disease) means a disease occurring when the body's adrenal glands do not produce sufficient steroid hormones.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

Cerebrospinal Meningitis means a disease resulting in the inflammation of the meninges of both the brain and spinal cord caused by infection from viruses, bacteria, or other microorganisms or from Cancer.

Diphtheria means an infectious disease caused by the bacterium *Corynebacterium diphtheriae* and characterized by the production of a systemic toxin and the formation of a false membrane lining of the mucous membrane of the throat and other respiratory passages, causing difficulty in breathing, high fever, and/or weakness.

Diphtheria can be Diagnosed either through laboratory tests that confirm Diphtheria through a culture obtained from the infected area or through clinical observation of visible symptoms.

Huntington's Chorea means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Legionnaire's Disease means an infectious lung disease caused by species of the aerobic bacteria belonging to the genus *Legionella*.

Malaria means an infectious disease characterized by cycles of chills, fever, and sweating, caused by the bite of an anopheles mosquito infected with a protozoan of the genus *Plasmodium*.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive

skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Necrotizing Fasciitis means a severe soft tissue infection by bacteria that is marked by edema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over the affected areas.

Osteomyelitis means an infectious inflammatory disease of the bone that typically results from a bacterial infection and may result in the death of bone tissue.

Poliomyelitis (Polio) means an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. It often results in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

Rabies means an acute viral disease of the nervous system caused by a rhabdovirus, which is usually transmitted through the bite of a rabid animal. It is typically characterized by increased salivation, abnormal behavior, and eventual paralysis.

Sickle Cell Anemia means a hereditary disease caused by a genetic blood disorder. It is characterized by red blood cells that assume an abnormal, rigid, sickle shape due to a mutation on the hemoglobin gene.

Systemic Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Tetanus means a disease marked by rigidity and spasms of the voluntary muscles, caused by the bacterium *Clostridium tetani*.

Tuberculosis means an infectious disease caused by *Mycobacterium tuberculosis* bacteria. It is characterized by the growth of nodules in the bodily tissues, as well as by fever, cough, difficulty breathing, caseation, pleural effusions, and fibrosis.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force. See certificate for details.

NOTICES

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

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

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

Continental American Insurance Company • Columbia, South Carolina

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

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

This brochure is subject to the terms, conditions, and limitations of Policy Form C21100VA.

RATES TABLE FOR: NORTHAMPTON COUNTY PUBLIC SCHOOL - VA - GP-13585 / GROUP CRITICAL ILLNESS - PLAN-75491

DEDUCTION FREQUENCY : Semimonthly (24pp / yr)

Employee - Non-Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.59	\$3.72	\$4.86	\$5.99	\$7.12	\$8.25	\$9.39	\$10.52	\$11.65	\$12.78
30-39	\$3.22	\$4.98	\$6.74	\$8.49	\$10.25	\$12.01	\$13.77	\$15.53	\$17.29	\$19.04
40-49	\$4.76	\$8.06	\$11.35	\$14.65	\$17.95	\$21.25	\$24.55	\$27.84	\$31.14	\$34.44
50-59	\$7.41	\$13.37	\$19.32	\$25.28	\$31.23	\$37.19	\$43.14	\$49.10	\$55.05	\$61.00
60-69	\$11.21	\$20.97	\$30.72	\$40.47	\$50.23	\$59.98	\$69.74	\$79.49	\$89.24	\$99.00

Employee - Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$3.00	\$4.53	\$6.07	\$7.60	\$9.14	\$10.68	\$12.21	\$13.75	\$15.29	\$16.82
30-39	\$4.13	\$6.79	\$9.46	\$12.12	\$14.79	\$17.46	\$20.12	\$22.79	\$25.46	\$28.12
40-49	\$6.57	\$11.68	\$16.78	\$21.89	\$27.00	\$32.11	\$37.21	\$42.32	\$47.43	\$52.54
50-59	\$10.99	\$20.53	\$30.06	\$39.59	\$49.12	\$58.66	\$68.19	\$77.72	\$87.25	\$96.79
60-69	\$16.62	\$31.77	\$46.93	\$62.09	\$77.25	\$92.40	\$107.56	\$122.72	\$137.88	\$153.03

Spouse - Non-Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.46	\$3.45	\$4.45	\$5.44	\$6.44	\$7.44	\$8.43	\$9.43	\$10.43	\$11.42
30-39	\$3.08	\$4.70	\$6.33	\$7.95	\$9.57	\$11.19	\$12.82	\$14.44	\$16.06	\$17.68
40-49	\$4.62	\$7.78	\$10.95	\$14.11	\$17.27	\$20.43	\$23.59	\$26.76	\$29.92	\$33.08
50-59	\$7.29	\$13.11	\$18.94	\$24.76	\$30.59	\$36.41	\$42.24	\$48.07	\$53.89	\$59.72
60-69	\$11.10	\$20.75	\$30.39	\$40.03	\$49.67	\$59.32	\$68.96	\$78.60	\$88.24	\$97.89

Spouse - Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.86	\$4.26	\$5.66	\$7.06	\$8.46	\$9.86	\$11.26	\$12.66	\$14.06	\$15.46
30-39	\$3.99	\$6.52	\$9.05	\$11.58	\$14.11	\$16.64	\$19.17	\$21.70	\$24.23	\$26.76
40-49	\$6.43	\$11.40	\$16.37	\$21.35	\$26.32	\$31.29	\$36.26	\$41.23	\$46.20	\$51.18
50-59	\$10.86	\$20.27	\$29.67	\$39.08	\$48.48	\$57.88	\$67.29	\$76.69	\$86.10	\$95.50
60-69	\$16.51	\$31.55	\$46.60	\$61.64	\$76.69	\$91.74	\$106.78	\$121.83	\$136.87	\$151.92

Accident Insurance

Manhattan Life | www.ManhattanLife.com | 800.669.9030

The costs associated with an injury can add up. Between hospital visits, exams and treatment, out-of-pocket costs could put you in a financial hardship. An accident plan pays benefits directly to you so you can determine where to spend the money. It's comforting to know that an accident insurance policy can be there through all stages of your care, from initial treatment to follow-up care. Accident coverage is available to you through payroll deduction and may provide a benefit for costs associated with:

- Concussions
- Lacerations
- Broken teeth
- Emergency room visits
- Ambulance, ground or air
- Intensive care unit



Accident

Protection that surrounds you and your family



Accident coverage can protect your whole family

An Accident plan offers coverage for accidents, injuries, ambulance services, and accidental death in addition to your primary medical insurance. It is also available to your spouse and children – a plan that can protect your whole family.

Why do I need Accident coverage?

Here are a few facts to consider from the National Center for Health Statistics:

- Nearly 40 percent of self-reported episodes of injury leading to hospitalization occurred during sports or leisure activities, and 44 percent occurred in or around the home.
- Where the external cause of nonfatal injuries is specified, falls are the leading cause of inpatient and outpatient care in emergency rooms, outpatient clinics and doctors' offices.
- Injuries due to motor vehicle traffic accidents and striking against or being struck accidentally by objects also make up a large portion of injuries.

Here's how it works

When you or a covered family member has an Accident, you may seek treatment from a physician, urgent care or hospital. Based on the Accident plan you choose, you will receive a benefit paid directly to you to assist with medical plan deductibles and bills from your provider.

Accident Indemnity Plus Coverage

Coverage type

There are no annual maximums. Benefits start all over with each accident and are paid in addition to any other coverage in place. Payroll deduction for your premiums makes it easy, too.

Product	Policy Type:	Group	
	Policy Name:	Accident Indemnity Plus Insurance	
	Policy Form:	M-8026	
Eligibility	Issue Ages:	Employee:	18 – 70
		Spouse:	18 – 70
		Child:	Under age 26
	Criteria:	<ul style="list-style-type: none"> Employee is benefit eligible, actively at work full-time, working at least 20 hours per week. Spouse and children not eligible if Employee is not issued coverage. Spouse includes domestic partner where allowed by state and Employer. 	
	Termination Age:	<ul style="list-style-type: none"> Employee: Age 71 unless actively at work, then on last day of active employment. Spouse: Age 71, or when Employee terminates, whichever is earlier. Child: Age 26, or when Employee terminates, whichever is earlier. 	
		Guarantee Issue	
Underwriting Offer	Employee:	Guarantee Issue	
	Spouse:	Guarantee Issue	
	Child(ren):	Guarantee Issue	
Target Participation	Minimum to Issue:	2 Employees enrolled	
	Participation Expectation:	2 Employees enrolled	

Benefits and Features

	Enhanced	Premier
Urgent Care	\$150	\$200
Doctor's Office Visit	\$100	\$150
Emergency Room Treatment	\$100	\$150
Ground Ambulance	\$200	\$300
Air Ambulance	\$800	\$1,000
First Hospitalization Benefit	\$1,000	\$1,500
Intensive Care Unit Admission	\$2,000	\$3,000
Hospital Confinement	\$250 per day	\$375 per day
Intensive Care Unit Confinement	\$500 per day	\$750 per day
Rehabilitation – Admission:	\$1,000	\$1,500
Daily Benefit/Confinement:	\$150	\$200
Physical Therapy	\$30	\$45
Chiropractic Treatment	\$30 per day	\$45 per day
Accident Follow-Up Treatment	\$25 per visit/max of 4 per accident	\$50 per visit/max of 4 per accident
Blood and Plasma	\$100	\$150
Major Diagnostic – X-Ray:	\$75	\$100
Medical Imaging:	\$150	\$200
EEG:	\$150	\$200
Exploratory Surgery without repair	\$200	\$300
Concussion	\$200	\$300
Coma	\$10,000	\$12,500
Ruptured Disc	\$400	\$500
Medical Appliances	\$100	\$150
Prosthesis – Single:	\$500	\$750
Multiple:	\$1,000	\$1,500
Transportation - Train or Plane:	\$300	\$400
Bus:	\$150	\$200
Family Lodging	\$100 per night	\$150 per night



Accidental Death, Dismemberment, and Loss of Sight (AD&D)	Enhanced	Premier
Loss of Life	\$50,000	\$75,000
Double Dismemberment - Any Combination of Two or More Hands, Feet, or Sight in Both Eyes	\$50,000	\$75,000
Single Dismemberment Loss of Single Hand, Foot or Sight	\$12,500	\$18,750
Loss of Four Fingers of the Same Hand	\$2,500	\$3,750
Loss of Thumb and Index Finger of Same Hand	\$500	\$750
Severance and Reattachment of Hand or Foot	\$500	\$750
Common Carrier Accidental Death	\$100,000	\$150,000

Spouse benefit 50% and dependent child(ren) 25% of the Employee amounts.



Fractures (Closed Reduction)	Enhanced	Premier
Hip/Thigh	\$4,000	\$5,000
Vertebrae (Except Process)	\$3,600	\$4,500
Pelvis	\$3,200	\$4,000
Skull (Depressed)	\$3,000	\$3,750
Skull (Simple)	\$1,400	\$1,750
Leg	\$2,400	\$3,000
Foot/Ankle/Kneecap	\$2,000	\$2,500
Fore/Hand	\$2,000	\$2,500
Lower Jaw	\$1,600	\$2,000
Shoulder Blade/Collar Bone	\$1,600	\$2,000
Upper Arm/Upper Jaw	\$1,400	\$1,750
Facial Bones (Except Teeth)	\$1,200	\$1,500
Vertebral Processes	\$800	\$1,000
Coccyx, Rib, Finger, Toe	\$320	\$400
Chips	25%	25%
Open Reduction	200% of Closed Reduction	200% of Closed Reduction



Dislocations (Closed Reduction)	Enhanced	Premier
Hip	\$2,700	\$3,600
Knee (Excluding Patella)	\$1,950	\$2,600
Shoulder	\$1,500	\$2,000
Foot/Ankle	\$1,200	\$1,600
Ankle Joint	\$600	\$800
Hand	\$1,050	\$1,400
Lower Jaw	\$900	\$1,200
Wrist	\$750	\$1,000
Elbow	\$600	\$800
Finger/Toe	\$240	\$320
Partial	25%	25%
Open Reduction	200% of Closed Reduction	200% of Closed Reduction
Repaired Ligament – Single:	\$400	\$500
Multiple:	\$600	\$750
Repaired Knee Cartilage – Single:	\$400	\$500
Multiple:	\$600	\$750
Repaired Tendon – Single:	\$400	\$500
Multiple:	\$600	\$750
Repaired Rotator Cuff – Single:	\$250	\$375
Multiple:	\$500	\$750



	Enhanced	Premier
Burns - Second Degree (<10%):	\$200	\$300
Second Degree (10%-25%):	\$400	\$600
Second Degree (25%-35%):	\$1,000	\$1,500
Second Degree (>35%):	\$2,000	\$3,000
Third Degree (<10%):	\$1,000	\$1,500
Third Degree (10%-25%):	\$6,000	\$9,000
Third Degree (25%-35%):	\$10,000	\$15,000
Third Degree (>35%):	\$20,000	\$30,000
Paralysis Benefit – Quadriplegia:	\$10,000	\$12,500
Paraplegia:	\$5,000	\$6,250
Eye Injury Benefit - Surgical Repair:	\$250	\$375
Removal of Foreign Body:	\$50	\$75
Laceration Benefit - Over 6":	\$400	\$600
2"-6":	\$200	\$300
Under 2":	\$50	\$75
Lacerations not Requiring Stitches:	\$50	\$75
Emergency Dental Work – Repaired with Crown:	\$200	\$300
Resulting in Extraction:	\$60	\$90
Total Disability Premium Waiver	Included	
Portability	Included	

Employer Elected Optional Benefits

On the Job (24 Hour Insurance) Benefit	Included
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Benefit Definitions

ACCIDENT FOLLOW-UP TREATMENT: For an injury received as a result of a Covered Accident, a benefit will be paid if the covered person receives initial treatment within 72 hours after covered accident, receives doctor prescribed follow up treatment, and the follow up treatment begins within 90 days after the covered accident or discharge from the hospital. Treatment received within 30 days in TX.

GROUND AMBULANCE: Pays a benefit when a covered person requires transportation in an ambulance from a covered accident. The total amount payable for all ground ambulance services in connection with any one covered accident will not exceed the benefit chosen. The benefit is limited to one trip per accident.

AIR AMBULANCE: Pays a benefit when a covered person requires transportation in an ambulance from a covered accident. The total amount payable for all ground ambulance services in connection with any one covered accident will not exceed the benefit chosen. The benefit is limited to one trip per accident.

HOSPITAL CONFINEMENT: Pays a benefit if a covered person is confined as an inpatient in a hospital for an injury received because of a covered accident, for each day of Hospital Confinement starting with the first full day of confinement. A day is a 24-hour period. The benefit is limited to 365 days per accident.

FIRST HOSPITALIZATION BENEFIT: Pays benefit amount for covered person's first hospital confinement for an injury received as a result of a covered accident; must be admitted for at least 24 hours and be at the direction of and under the supervision of a doctor. Benefit limited to one (1) per calendar year for each covered person.

INTENSIVE CARE UNIT ADMISSION: Pays a benefit amount if a covered person is confined to a hospital and is placed in a hospital intensive care unit (ICU) within the first 48 hours of admission for an injury received as a result of a covered accident. This benefit is payable in addition to the First Hospital Admission Benefit. Limited to one (1) per calendar year for each covered person.

INTENSIVE CARE UNIT CONFINEMENT: Pays a benefit if a covered person is confined as an inpatient in a hospital intensive care unit (ICU) for an injury received because of a covered accident. The benefit is limited to 30 days per accident.

EMERGENCY ROOM TREATMENT: Pays a benefit amount chosen for an injury because of a covered accident when a covered person requires examination and treatment by a doctor in a hospital emergency room within 72 hours after the covered accident. This benefit is paid once per covered accident and limited to 5 covered accidents per covered person per calendar year. Treatment will be covered within 30 days of accident in TX.

URGENT CARE: Pays a benefit if a covered person receives initial treatment and/or advice by a doctor in an urgent care facility for an injury received because of a covered accident. Treatment must be within 60 days of covered accident and must be the result of the covered accident, and not for routine examinations or preventative testing. Benefit paid once per covered accident and is not payable if Emergency Room Treatment benefit is paid for the same covered accident.

DOCTOR'S OFFICE VISIT: Pays a benefit if a covered person receives initial treatment and/or advice by a doctor in a doctor's office for an injury received because of a covered accident. Treatment must be within 60 days of covered accident and must be the result of the covered accident, and not for routine examinations or preventative testing. Benefit paid once per covered accident and is not payable if Emergency Room Treatment benefit is paid for the same covered accident.

CHIROPRACTIC TREATMENT: Pays a benefit if a covered person suffers a structural imbalance for an injury received because of a covered accident and receives Chiropractic Care Services by a Chiropractor in a chiropractor's office. Treatment must begin within 60 days after the covered accident and must be completed within 180 days after the covered accident. Maximum of 3 visits per accident.

PHYSICAL THERAPY: Pays a benefit amount for each day a covered person receives physical therapy for an Injury received because of a covered accident. Therapy must begin within 90 days after the covered accident and be completed within 1 year after the covered accident. Benefit is not payable for the same visit that the Accident Follow-Up benefit is paid. Maximum of 10 visits per accident.

TRANSPORTATION: Pays a benefit for train, plane, or bus transportation. This benefit is payable if, because of an Injury received because of a Covered Accident, a Covered Person: is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the covered person's resident city. Use of such transportation must begin within 90 days after the covered accident date. The distance to the hospital treatment or diagnostic study must be greater than 50 miles from the Covered Person's residence. Maximum of 1 trip.

FAMILY LODGING: Pays a benefit each night's lodging in a motel/hotel room for an adult family member of a covered person. Benefit is payable for an injury received as a result of a covered accident: the covered person must be confined to a hospital for treatment of an injury, the hospital and motel/hotel must be more than 100 miles from the covered person's residence; and the treatment must be prescribed by the covered person's local doctor. Max 30 nights per covered accident.

BLOOD AND PLASMA: Pays a benefit for an injury received because of a covered accident, the covered person is injured and receives blood or plasma within 90 days after the covered accident.

PROSTHESIS: Pays a benefit for each covered prosthetic device the covered person uses when needed due to a covered accident. Benefit paid will be based on the number (single or multiple) of prosthetics received and is limited to one (1) payment per covered accident.

MEDICAL APPLIANCES: Pays a benefit if a doctor advises a covered person to use a medical appliance. The medical appliance must be used for an injury received because of a covered accident. It must be used as an aid in personal locomotion. Benefit is limited to one (1) payment per covered accident.

MAJOR DIAGNOSTIC: Pays a benefit if a covered person receives one of the following exams for an Injury received as a result of a covered accident CT (computerized tomography) scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), or X-rays. Exams must be performed in a hospital or a doctor's office. Benefit amount paid once per covered accident.

EXPLORATORY SURGERY: Pays a benefit if an injury received because of a covered accident requires a covered person to have exploratory surgery (without repair).

CONCUSSION: Pays a benefit if a covered person has a concussion from an injury received as a result of a covered accident. The concussion must be diagnosed by a doctor within 72 hours after the Covered Accident using any type of medical imaging such as x-ray (computerized tomography) scan; CT (computerized tomography); or MRI (magnetic resonance imaging). Treatment must be within 30 days of the accident in TX.

RUPTURED DISC: Pays a benefit if a covered person receives an injury as a result of a covered accident and ruptures a disc in the spine, receives treatment from a doctor within 60 days after the covered accident, and has surgical repair by a doctor within one year after the Covered Accident.

COMA: If a Covered Person is in a coma lasting 30 days or more from an injury received because of a covered accident, a benefit is payable based on the amount selected. The diagnosis of a coma must indicate that permanent neurological deficit is present. This benefit is paid once per covered person per covered accident.

REHABILITATION DAILY/CONFINEMENT AND ADMISSION: Pays a benefit for an Injury received as a result of a Covered Accident if the Covered Person is admitted for a Hospital Confinement, is transferred to a bed in a Rehabilitation Unit of a Hospital for Treatment and incurs a charge. Benefit is limited to 30 days for each covered person per period of hospital confinement. Benefit is also limited to a Calendar Year Max of 60 days.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF LIFE: Pays a benefit chosen based on loss of life of covered person or dismemberment of covered person based on a covered accident.

FRACTURE BENEFITS: Fracture is a break in a bone that can be seen by X-ray. If a bone is fractured in an injury received because of a covered accident and is diagnosed and treated by a doctor within 90 days of the accident, pays benefit selected based upon the fracture benefit listed.

DISLOCATION BENEFITS: Dislocation refers to a completely separated joint. If a joint is dislocated in an injury received because of a covered accident and is diagnosed and treated by a doctor within 90 days of the accident, pays benefit selected based upon the dislocation benefit listed.

BURNS BENEFIT: Pays a benefit if a Covered Person receives burns because of a covered accident, according to the percentage of body surface burned. Must be treated for burns by a Doctor within 72 hours after the Covered Accident. First-degree burns are not covered. Treatment must be within 30 days of the accident in TX.

PARALYSIS BENEFIT: Pays a benefit for an Injury received as a result of a covered accident where the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the Covered Accident. The amount paid will be based on the number of limbs paralyzed.

EYE INJURY BENEFIT: Pays a benefit for eye injuries requiring surgical repair, for an Injury received as a result of a Covered Accident and the insured injures an eye, doctor repairs the eye through surgery, and the eye surgery occurs within 90 days after the Covered Accident. For eye injuries requiring removal of a foreign body, benefit pays the amount selected if a Doctor removes a foreign body from the eye.

LACERATION BENEFIT: Pays a benefit if a covered person receives a laceration from an injury received because of a covered accident. Laceration must be repaired with stitches by a doctor within 72 hours after the covered accident. The amount paid will be based on the length of the laceration. The covered person may receive a laceration that does not require stitches. If treated by a doctor within 72 hours after the covered accident, the benefit will pay the appropriate amount shown in the certificate. Treatment must be within 30 days of the accident in TX.

EMERGENCY DENTAL WORK: Pays a benefit if the covered person has an injury to sound natural teeth as the result of a covered accident.

TOTAL DISABILITY PREMIUM WAIVER: If the insured becomes disabled before age 65, and as results of injuries suffered in an accident, premiums will be waived after 90 days of total and continuous disability. Limit 12 months per disability.

LIMITED PORTABILITY: Employees are able to continue their coverage if they leave their Employer, as long as master contract remains in force. Coverage is portable assuming the following parameters are met Employee is less than 70, Insured is not totally disabled, Master Policy issued to the Employer is active. Employees on ported coverage terminate at age 70. Dependents on ported certificates terminate when the spouse attained age is 70 or the child attained age is 25, or when the primary insured's insurance terminates.

ON-THE-JOB COVERAGE: Pays a benefit for injuries, (including Total Disability Premium Waiver), due to an Accident, that are covered by Worker's Compensation or occupational disease law.

Accident Rates

Rate Assumption Information

Rate Structure:	Composite
Tobacco Status:	Uni-Tobacco
Rate Guarantee Period:	One (1) Year
Contributions:	100% Employee paid
Coverage Type:	24 Hour Coverage
Benefits Included:	As shown above in the Benefits and Optional Benefits sections.
Participation Expectation:	2 Employees enrolled

Semi-Monthly (24) premium				
Benefit:	Employee	Employee/Spouse	Employee/Child(ren)	Family
Enhanced	\$5.40	\$9.18	\$11.80	\$15.69

Semi-Monthly (24) premium				
Benefit:	Employee	Employee/Spouse	Employee/Child(ren)	Family
Premier	\$7.51	\$12.75	\$16.51	\$21.88

Note: Final implementation rate may vary slightly due to rounding

PRODUCT QUALIFICATIONS AND CONTINGENCIES

- If benefit is elected, they are included on all covered lives.
- Group may elect a maximum of two coverage plans.
- Riders apply to all accident plans chosen.
- If spouse is also an Employee, they may apply as an Employee or as a dependent, but not as both.
- If both parents are Employees of the company, then the child(ren) may be covered under only one parent, not both.
- Offer is based on no other accident plans are in force.
- Please refer to certificate/policy for full benefit and limitation information.

403(b) Retirement Plans

First Financial Administrators, Inc. | www.ffga.com |
800-523-8422, option 2 | retirement@ffga.com

The 403(b) can be an excellent way to save money for retirement. It can serve as a supplement to a traditional pension plan or other retirement plan(s), or as a stand-alone plan. The 403(b) is a tax deferred retirement plan available to employees of educational institutions and certain non-profit organizations as determined by section 501(c)(3) of the Internal Revenue Code. Contributions and investment earnings in a 403(b) grow tax deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income. The 403(b) is named after the section of the IRS code governing it.

How a 403(b) Works

Employees enroll and participate through their employer. Contributions to a 403(b) are made on a pre-tax basis through a Salary Reduction Agreement. This is an arrangement where the participating employee agrees to take a reduction in salary. The amount by which the salary is reduced is directed to investments offered through the employer and selected by the employee. These contributions are called elective deferrals and are excluded from the employee’s taxable income. Contributions grow tax-deferred until the time of retirement when withdrawals are taxed as ordinary income.

Benefits

- Tax deferred growth: no annual taxation on earnings
- Investment options: fixed annuities, variable annuities, or mutual funds
- Competitive interest rates
- Flexibility: start, stop, and adjust your contributions as allowed by your employer’s plan.
- Receive periodic account statements

Contribution Limits	
2024	2025
\$23,000	\$23,500
Participants aged 50 and older at any time during the calendar year are permitted to contribute an additional \$7,500.	

All investing involves risk. Past performance is not a guarantee of future returns.

457(b) Retirement Plans



First Financial Administrators, Inc. | www.ffga.com |
800-523-8422, option 2 | retirement@ffga.com

A 457(b) plan is a Tax Deferred Retirement Plan available to employees of state and local governmental agencies, including public school employees. They are similar to 401(k) plans because they allow you to place a percentage of your salary into an employer-sponsored plan that helps you save for retirement. You will not have to pay taxes on what you contribute or your earnings made until you withdraw the money.

Benefits

- Investment options: fixed annuities, variable annuities, or mutual funds
- Flexibility: start, stop, and adjust your contributions as allowed by your employer's plan
- Receive periodic account statements
- No 10% federal penalty on interest or earnings for early withdrawal
- No current federal income taxes on the money you put into the plan until it is time to take withdrawals

Contribution Limits	
2024	2025
\$23,000	\$23,500
Participants aged 50 and older at any time during the calendar year are permitted to contribute an additional \$7,500.	

All investing involves risk. Past performance is not a guarantee of future returns.

Hospital Indemnity Insurance

Aflac | www.aflacgroupinsurance.com | 800.433.3036

Hospital stays are costly. If you or a family member find yourself in the hospital due to a sudden accident or illness, you may struggle financially, even if you have a good medical plan. With a hospital indemnity plan, you can rest assured those extra expenses won't be a financial burden.

Unlike medical plans, there are no deductibles to meet with a hospital indemnity plan. As soon as you incur a qualified event, you can file a claim and start receiving benefits.

The plan pays a lump sum benefit in a previously specified amount. The money can be used for medical costs, insurance deductibles, groceries, transportation, childcare – the choice is up to you!



Aflac Group Hospital Indemnity

INSURANCE

Even a small trip to the hospital can have a major impact on your finances.

Here's a way to help make your visit a little more affordable.



Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, is the insuring company.



AFLAC GROUP HOSPITAL INDEMNITY

Policy Form C80100VA



The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all of your bills?

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

That's how the Aflac Group Hospital Indemnity plan can help.

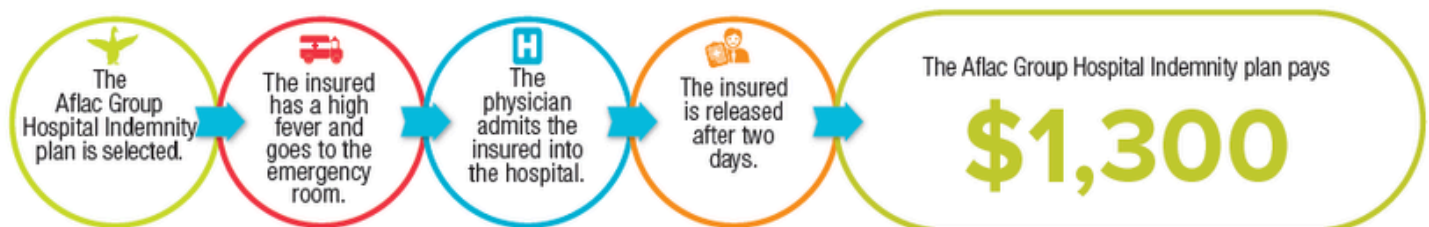
It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Intermediate Intensive Care Step-Down Unit



How it works



Amount payable was generated based on benefit amounts for: Hospital Admission (\$1,000), and Hospital Confinement (\$150 per day).

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

Benefits Overview

BENEFIT AMOUNT

HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured)

Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).

\$1,000

HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured)

Payable for each day that an insured is confined to a hospital as an inpatient as the result of a covered accidental injury or 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 BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)

Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if 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.

\$150

This benefit is payable in addition to the Hospital Confinement Benefit.

INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)

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.

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.

\$75

This benefit is payable in addition to the Hospital Confinement Benefit.

SUCCESSOR INSURED BENEFIT

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

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.

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.

- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.

- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a family member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

TERMS YOU NEED TO KNOW

A Covered Accident is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

Dependent means your spouse or domestic partner or dependent children, as defined in the applicable rider, who have been accepted for coverage. Spouse is your legal wife or husband. Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state or local domestic partner registry with you. Refer to your certificate for details.

Dependent Children are your or your spouse or domestic partner's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption. Newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered for 60 days also. See certificate for details. Dependent children must be younger than age 26, however this limit will not apply to any insured dependent child who is incapable of self-sustaining employment due to intellectual disability or physical handicap and is chiefly dependent on a parent for support and maintenance.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and: is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A Doctor does not include you or any of your Family Members. For the purposes of this definition, Family Member includes your spouse or domestic partner as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

A Hospital is not a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a rehabilitation facility; a facility for the treatment of alcoholism or drug addiction; an assisted living facility; or any facility not meeting the definition of a Hospital as defined in the certificate.

A Hospital Intensive Care Unit is not any of the following step-down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a Hospital Intensive Care Unit as defined in the certificate.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A Covered Sickness is one that is not excluded by name, specific description, or any other provision in this plan. For a benefit to be payable, loss arising from the covered sickness must occur while the applicable insured's coverage is in force.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

You May Continue Your Coverage

Your coverage may be continued with certain stipulations. See certificate for details.

Termination of Coverage

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

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

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

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

Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies. This brochure is a brief description of coverage and is not a contract. Benefits, terms, and conditions may vary by state.

This brochure is subject to the terms, conditions, and limitations of Policy Form C80100VA.

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

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Policy Series C80000



TREATMENT BENEFITS

BENEFIT AMOUNT

OUTPATIENT DOCTOR'S OFFICE VISIT (maximum of 6 visits per calendar year for each insured)

We will pay the amount shown for each day that an insured visits a doctor's office. This benefit is not payable for visits to a chiropractor's office.

\$25

TELEMEDICINE SERVICES (maximum of 6 per calendar year for each insured)

We will pay the benefit amount shown for each day that, because of a covered accidental injury or covered sickness, an insured seeks medical advice from a doctor via telemedicine services. The telemedicine services must be provided in lieu of an outpatient doctor's office visit.

\$15

CHIROPRACTOR VISIT (maximum of 4 visits per calendar year for each insured)

We will pay the amount shown for each day that an insured receives services from a chiropractor for treatment of a covered accidental injury or because of a covered sickness. Visits to a chiropractor's office are not payable under the outpatient doctor's office visit benefit.

\$20

MAJOR DIAGNOSTIC EXAMS (once per covered sickness or accident per calendar year)

We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams:

- Computerized Tomography (CT/CAT scan)
- Magnetic Resonance Imaging (MRI)
- Electroencephalography (EEG)

\$150

OUT OF HOSPITAL PRESCRIPTION DRUG (maximum of \$100 per calendar year for each insured)

We will pay the amount shown for each day an insured has a prescription filled. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the insured.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) 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; (d) immunization agents, biological sera, blood or blood plasma; or (e) contraceptive materials, devices or medications or infertility medication, except where required by law.

\$20

HOSPITAL EMERGENCY ROOM VISIT (maximum of 5 visits per calendar year for each insured)

We will pay the amount shown for each day that an insured visits a hospital emergency room due to a covered accidental injury or for treatment due to a covered sickness.

\$100

EMERGENCY ROOM OBSERVATION (1 visit for each covered sickness or accident per calendar year, maximum of 5 total visits per calendar year for each insured)

We will pay the amount shown for each period of observation that, because of a covered accidental injury or covered sickness, an insured:

- Receives treatment in a hospital emergency room, and
- Is held in a hospital for observation without being admitted as an inpatient.

\$100
Each 24 hour
period
\$50
Less than 24
hours, but at
least 4 hours

REHABILITATION FACILITY per day (maximum of 15 days per confinement, no more than 30 days total per calendar year for each insured)

We will pay the amount shown for each day that, due to a covered accidental injury or a covered sickness, 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. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid.

\$75



Residents of Massachusetts are not eligible for these benefits.

TERMS YOU NEED TO KNOW

Chiropractor means a person, other than the insured or the insured's family member, who

- Is licensed as a chiropractor in the state in which treatment is received, and
- While working under the scope of his license, uses manual or mechanical means to detect or correct disorders of structural imbalance, distortion, or subluxation of the musculoskeletal system and the nervous system for the purpose of removing nerve interference and related effects. The interference must result from or relate to distortion, misalignment, or subluxation of or in the vertebral column.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the treatment of alcoholism or drug addiction (except in Vermont).

Telemedicine Service means a medical inquiry with a doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Observation Unit means a unit in which observation services are given through hospital outpatient services to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital.

For a complete list of limitations and exclusions please refer to the brochure.

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

This piece is intended to be used in conjunction with the product brochure for Policy Series C80000 and is subject to the terms, conditions, and limitations of the plan.

Continental American Insurance Company • Columbia, South Carolina

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website [([naic.org](https://www.naic.org))] under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

RATES TABLE FOR: NORTHAMPTON COUNTY PUBLIC SCHOOL - VA - GP-13585 / GROUP HOSPITAL INDEMNITY - PLAN-75490

DEDUCTION FREQUENCY : Semimonthly (24pp / yr)

Deduction Frequency
Semimonthly (24pp / yr)

Employee Periodic Cost
\$19.63

Employee And Spouse Periodic Cost
\$38.88

Employee And Child Periodic Cost
\$33.33

Family Periodic Cost
\$52.58

COBRA

First Financial Administrators, Inc. | www.ffga.com | 800-523-8422, option 4

Life is full of unexpected events that may impact your health insurance coverage. Under the Consolidated Omnibus Budget Reconciliation Act, better known as COBRA, you have the right to continue your group health coverage such as medical, dental, vision insurance and flexible spending accounts for a limited period of time.

COBRA Highlights

- Temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work, divorce, death or a child no longer qualifying as a dependent. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
- Either you or your family member are responsible for notifying your employer of a divorce, legal separation or child losing dependent status within 60 days of the event. In the case of termination, death or reduction in hours, your employer will be responsible for letting the provider know that you have the right to continue coverage under COBRA.
- Benefits will remain identical to what you had while employed. However, you will be responsible for paying the full premium, plus any applicable fees.

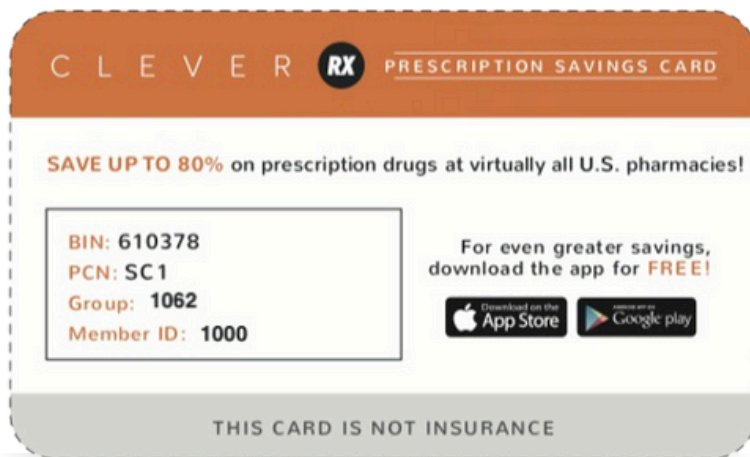


Clever RX

Clever RX | <https://partner.cleverrx.com/ffga> | 800-873-1195

Clever RX helps you save money by using a prescription drug savings card. They partner with the healthcare community to bring state-of-the-art, money-savings tools to participants. It helps you save up to 80% off prescriptions drugs and often beats the average copay. Plus, it's completely free. Thanks to Clever RX, you will never overpay for prescriptions again!

Use Clever RX every time you pay for a medication for instant savings!



Download the app or visit the site to price a drug: <https://partner.cleverrx.com/ffga>.

Clever RX Highlights

- 100% FREE to use.
- Unlock discounts on thousands of medications.
- Save up to 80% on prescription medication – Often beats your copay!
- Download the Clever RX app by using the information on your card below to unlock exclusive savings at over 60,000 pharmacies nationwide.
- Available to use now!

Contact Information

NCPS Finance Office
7207 Young Street | Machipongo, VA 23405
757.678.5151 x2201

Michael Shelly, Sr. Account Administrator
800.924.3539 / Michael.Shelly@FFGA.com

Don Kennedy, Sr. Account Administrator
FFGA Retirement Services
800.924.3539 / Don.Kennedy@FFGA.com

Product	Carrier	Website	Phone
Vision	Ameritas	www.ameritas.com	800.487.5553
Flexible Spending	FFFirst Financial Administrators, Inc.	www.FFGA.com	866.853.3539
Permanent Life	Texas Life	www.TexasLife.com	800.283.9233
Short-Term Disability	Manhattan Life	www.ManhattanLife.com	800.669.9030
Cancer	AFA	www.AmericanFidelity.com	800.654.8489
Critical Illness	Aflac	www.AflacGroupInsurance.com	800.433.3036
Accident	Manhattan Life	www.ManhattanLife.com	800.669.9030
Hospital Indemnity	Aflac	www.AflacGroupInsurance.com	800.433.3036
Retirement Services	First Financial Administrators, Inc.	www.Retirement@FFGA.com	800.523.8422, option 2