

MARSHALL ISD OVERVIEW GUIDE



Plan Year: September 1, 2021 - August 31, 2022



Information Provided By:
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Overview

Marshall Independent School District and First Financial Group of America would like to take this opportunity to present to you the information for the plan year. This information has been created to bring forth a brief overview of your choices as well as offer you a reference guide when questions may arise regarding your insurance plans.

Please take the time to look over the information contained in this booklet to familiarize yourself with the benefits that are provided to you as an employee.

All new employees must review plan options and elect supplementary elections under the Cafeteria Plan. **This is the only time you can enroll in your supplemental insurance, unless there is a qualified family status change during the year.**

Your plan year is January 1 through August 31. Payroll deductions for your benefits will begin in January.



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. For a more detailed explanation of benefits you may contact First Financial Administrators at 1-800-523-8422 or visit the website listed below.

For detailed information your benefits website is:

www.ffbenefits.com/marshallisd

Online Enrollment Instructions

How do I enroll my benefits prior to open enrollment?

Conveniently, you can view your benefits, enroll or make any necessary changes for the upcoming plan year at work or at home using our secure, online website.

Where do I go to enroll in my benefits?

Go to <https://ffga.benselect.com/enroll>.

What is my login and PIN?

Your login is your social security number (123456789). Your pin is the last four digits of your social security number and the last two numbers of your birth year (678977).

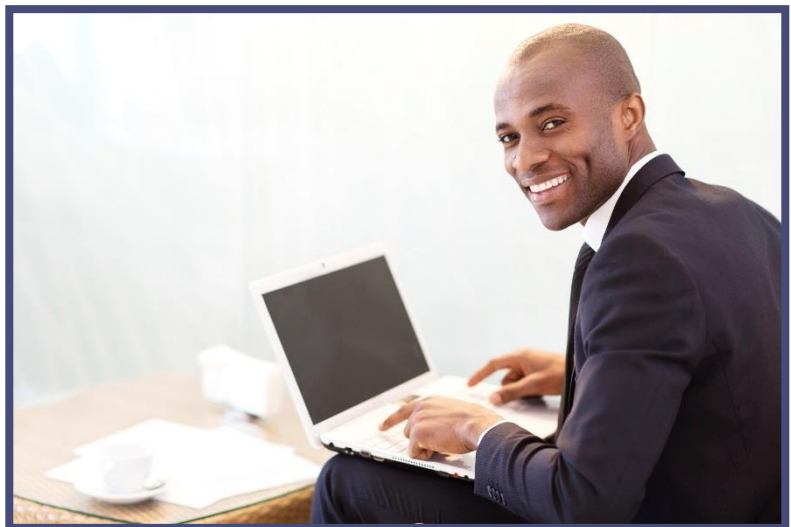
Once you login you will see a Welcome presentation. Once finished Click “Next,” then:

- Verify your personal information
- Verify all dependent information (ssn/date of birth) ****Very Important****
- View employment information

You will then see a brief presentation on each benefit available. Notify the Business Office/Payroll Department of any discrepancies.

Useful Information to know

- Contact First Financial at 855-523-8422 with any technical questions.
- No changes will be allowed until the annual open enrollment period (unless you have an IRS S125 approved event).



SECTION 125 FLEXIBLE BENEFITS PLAN



PARTICIPANT GUIDELINES FOR SPENDING ACCOUNTS

- Medical Expense Reimbursement
- Dependent Care Reimbursement

PREPARED BY:

First Financial Administrators, Inc.

For your Employer's Plan



Section 125 Flexible Spending Account

First Financial Administrators, Inc.

WE ARE COMMITTED

First Financial Administrators, Inc. is dedicated to providing excellent service to our customers and are delighted to serve as your cafeteria plan service provider. Our role is to process your requests for reimbursement according to the plan designed by your employer.

- » There are two types of Flexible Spending Accounts (FSAs): The first is unreimbursed medical (URM) and the second is dependent day care (DDC).
- » Your participation in an FSA program allows a portion of your salary to be redirected to provide reimbursement for these types of expenses on a tax-exempt basis.
- » At the beginning of each plan year, you elect a specific dollar amount for each FSA you wish to participate.
- » Participation in one or both FSAs can save you money by reducing your taxable income. This is because taxes will be calculated after the elected amount is deducted from your salary.
- » If applicable, your taxable income will be reduced for Social Security purposes; therefore, there may be a corresponding reduction in Social Security benefits.
- » Once you have elected your annual amount, you cannot change your election unless you experience a change in family status. See Election Irrevocability
- » To ensure that you are aware of your account balance at all times, we send a new explanation of benefits with each claim that is paid. The explanation of benefits will provide you with information regarding your account balance, claims paid to date, and claims pending.
- » We send notifications 45 days prior to the end of the plan year. The notification reflects your current available balance. You can view account information by logging into our secure website.



FILING A CLAIM

Before submitting your claim, make sure you have had the service(s).

TO FILE YOUR CLAIM

1. Complete a claim form, and be sure to sign and date it.
2. Attach a legible receipt(s) from the service provided or an EOB (Explanation Of Benefits) showing:
 - » A description of the service or a list of supplies furnished.
 - » The charge(s) for each service.
 - » The date(s) of service.
 - » The name of the person(s) receiving the service.
 - » The amount you are responsible for.
3. For convenient direct deposit, complete the Automatic Deposit Agreement form.

Or use your FFA Benefits Card

REQUESTING SERVICES *(Toll-free)*

For Inquires:	1-866-853-3539
For Claim Forms:	www.ffga.com
To Submit Claims by Fax:	1-800-298-7785

General IRS Rules & Information

The following rules apply to both URM and DDC FSAs

ELECTION IRREVOCABILITY

You may not make changes before the beginning of the next plan year unless there is a qualified change in status (as permitted by your plan) that affects Eligibility.

Qualified changes in status may include:

- » Change in employee's legal marital status
- » Change in number of tax dependents
- » Change in employment status that affects eligibility
- » Dependent satisfies or ceases to satisfy eligibility requirements
- » Change in residence that affects eligibility
- » Judgment, decree, or court order dictating provision of coverage
- » Entitlement of Medicare or Medicaid (URM only)
- » Change in cost of the benefit (DDC only)
 - *Addition or elimination of benefit option*
 - *Change in coverage of spouse or dependent under his/her employer's plan*
 - *Significant curtailment of coverage*

If a change in status occurs, you may make changes consistent with the qualifying event or as otherwise defined by your plan document. See your plan Sponsor for further details about making changes.

Dollar Limits

Unreimbursed Medical Account:

Your plan sponsor determines the maximum benefit that may be elected. The IRS maximum for the 2021 is \$2,750. Please see your employer for the maximum benefit amount allowed under your plan.

Dependent Daycare Account:

This reimbursement (when aggregated with all other dependent care reimbursements during the same calendar year) may not exceed the least of the following:

- » \$5,000, or
- » \$2,500, if married but filing separate tax returns
- » **2021 PLAN YEAR AMOUNTS:**
The American Rescue Plan Act has increased the DCA contribution limit for the calendar year 2021 to \$10,500.

Use-it-or-lose-it-Rule

Money remaining in your FSA account(s) will not be returned to you at the end of the plan year. Any amount remaining after the end of the runoff or grace period, if your employer offers one, will be forfeited. Because of the use-it-or-lose-it rule, it is important for you to carefully estimate your out-of-pocket URM and DDC expenses for the upcoming plan year.

TERMINATION OF EMPLOYMENT

URM Account:

Your salary redirections will end; however, you may still file claims for dates of service that were incurred within your employment period. You have 90 days after termination to submit a claim.

DDC Account:

If you have not received reimbursement for all contributions made to your DDC account upon termination, you have 90 days after the end of the plan year to submit a claim.

COBRA

COBRA does not apply to DDC. However, it may apply to your URM account and allow you to continue participation in your URM, thus allowing you to receive reimbursement for medical expenses incurred after your employment termination if:

- » The plan sponsor is subject to COBRA, and
- » When you terminate employment and you have contributed more for URM than you have received in URM benefits.

Note: Under COBRA you must elect coverage within 60 days and continue to submit contributions to your employer to continue coverage under your URM account for the current year.

General IRS Rules & Information

UNREIMBURSED MEDICAL FSA

Almost every person has a number of necessary and predictable expenses that are not paid by their insurance plans. You can save money by putting that amount directly into your Unreimbursed Medical FSA. The FSA will help you pay for these predictable expenses with your pre-tax dollars.

Please be aware of change in tax law – As of Jan. 1, 2011, money from flexible spending accounts are no longer available to pay for most over-the-counter drugs and medicines without a doctor's prescription.

ELIGIBLE EXPENSES

With the FSA, you can pay out-of-pocket health care expenses for yourself, your spouse and all of your eligible dependents for health, dental, and vision care expenses. The services must be incurred while you are actively participating in the FSA plan. The eligible expenses may be reimbursed regardless of whether you, your spouse or dependents are covered by your employer's medical, dental, or health plan.

Expenses for medical care will be limited to expenses incurred primarily for the prevention or improvement of a physical or mental defect or illness. An expense that is merely beneficial to your general health is not an eligible expense. It must be an expense to treat an existing medical condition.

INELIGIBLE EXPENSES

Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations.

» **EXPENSES NOT YET INCURRED** - Expenses that have been paid, but not yet incurred (i.e. Prepayment of service), cannot be reimbursed until the service is rendered. Expenses don't necessarily have to be PAID, but merely incurred.

» **PREMIUMS FOR INSURANCE** - Premiums and payments to insurance policies are not eligible for reimbursement.

» **EXPENSES PAID BY ANOTHER PLAN OR THIRD PARTY** - Expenses that have already been paid by an insurance company or other reimbursement through your FSA plan.

» **EXPENSES INCURRED AFTER TERMINATION/SEPARATION FROM YOUR EMPLOYER** - If you are no longer participating in the FSA plan through your employer (termination, resignation, etc) any claims incurred after your participation ends are not eligible for reimbursement.



COMMON ELIGIBLE EXPENSES

- » Co-Payments
- » Co-Insurance
- » Deductibles
- » Over-the Counter Drugs
(with physician's prescription)
- » Dental Treatment
- » Orthodontia
- » Lab Fees
- » X-Rays
- » Vision Expenses
- » Lasik Surgery
- » Physical Therapy
- » Chiropractor Services
- » Acupuncture
- » Eye Contact Solution
- » Eye Drops

COMMON INELIGIBLE EXPENSES

- » Cosmetic Surgery
- » Teeth Whitening
- » Veneers
- » Botox
- » Non Prescribed Vitamins
and Supplements
- » Toiletries
- » Medical Insurance Premiums
- » Health Club Membership Fees

General IRS Rules & Information

EXAMPLES OF ELIGIBLE MEDICAL CARE EXPENSES

The following lists are examples of the types of expenses that may or may not be reimbursed. These lists are not intended to be complete, as other expenses may also be eligible or ineligible under federal tax law or under employer's plan. To be eligible under an FSA URM account, the medical expense(s) must be incurred for medical care that is not reimbursed from any other source. Medical care means the drug or service is needed to treat a medical condition. First Financial Administrators, Inc. may request additional information from you to substantiate that an expense is for health care.



ELIGIBLE MEDICAL EXPENSES			INELIGIBLE EXPENSES
<ul style="list-style-type: none"> » Acupuncture » Alcohol and drug rehabilitation expenses » Ambulance » Anesthetist » Artificial limbs and teeth » Birth control pills » Blood donor (expense) » Chiropracist » Chiropractor » Christian Science Practitioners » Certain corrective surgery » Contact lens solution and cleaner » Co-payment for health insurance » Dental care and dentures » Drugs and medical supplies » Examinations » Eye exam, eyeglasses, and contacts » Gynecologist 	<ul style="list-style-type: none"> » Hearing aids and batteries » Home health care » Hospital and skilled nursing facility expenses » Laboratory fees » Lip-reading lessons » Midwife » Nursing care » Obstetrical expense » Oculist » Operations and related treatments » Optometrist » Orthodontist** » Osteopath » Outpatient clinic » Over-the-Counter Medications (with physician's prescription) » Pediatrician » Physician » Podiatrist » Practical nurse 	<ul style="list-style-type: none"> » Prescription drugs » Psychiatrist » Psychologist » Rental or purchase of medical equipment, including special equipment for use by handicapped persons » Sanitarium » Stop Smoking Programs and Drugs » Support or corrective devices » Surgery » Therapy » Transportation expenses » Weight Loss for Obesity* » X-ray 	<ul style="list-style-type: none"> » Dancing or swimming lessons » Medications purchased outside US » Expenses reimbursed under any health plan or other source » Health Club Dues » Face creams, moisturizers, etc. » Hair removal treatments/waxes » Vacation » Cosmetic Surgery » Teeth Whitening » Vitamins taken for overall health » OTC Medications not for Medical Care » Toothpaste/Toothbrushes » Mouth washes, oral anesthetics, etc.

* This service requires a letter of medical necessity with a diagnosis from the referring physician.

** Requires an active orthodontia contract be on file.



General IRS Rules & Information

The following rules apply to both URM and DDC FSAs

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars while you (and your spouse) are working, seeking employment, or attending school as a full-time student for at least 5 months during the year.

ELIGIBILITY REQUIREMENTS

Eligible dependents must be claimed as an exemption on your tax return. These dependents can include step-children, grandchildren, adopted children, or foster children. In a divorce situation, you must have custody of the child in order for the child to be considered an eligible dependent. Under IRS regulations, eligible dependents are further defined as: under the age of 13, and/or physically or mentally unable to care for themselves, such as a disabled spouse, disabled child, or elderly parents that live with you.

ELIGIBLE EXPENSES

Eligible dependent care expenses are those expenses you must pay for the care of a dependent so that you and your spouse can work. The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, the service cannot be provided by another child of yours under the age of 19, by your spouse, or by your dependents.

INELIGIBLE EXPENSES

Only those dependents care expenses that enable you and your spouse to work are eligible. Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations

- » Educational Costs
- » Weekends/Evening-out babysitting
- » Transportation, books, clothing, food, activities, entertainment, and registration fees are ineligible if these expenses are shown separately on your bill



COMMON ELIGIBLE EXPENSES

- » Day Camps
- » Before/After School Care
- » Babysitters/Day Care Centers
- » Au Pair
- » Nanny
- » Nursery School

COMMON INELIGIBLE EXPENSES

- » Registration Fees
- » Care for child while not working
- » Kindergarten
- » Food/Activity expenses if separate from cost of care
- » Care provided by anyone under age 19
- » Books and Supplies
- » Field Trips

Claims Information

THE REIMBURSEMENT PROCESS

REIMBURSEMENTS- The healthcare/medical FSAs are pre-funded; therefore, you are eligible to receive reimbursement up to your elected annual contribution from the beginning of your FSA plan year. The healthcare/medical FSA funds that are reimbursed to you will be recovered as your deductions are taken from your paycheck throughout the plan year. Dependent Care FSAs are NOT pre-funded; therefore, you will only receive reimbursement up to your year-to-date contributions from payroll deductions. The remainder of the reimbursement request is paid when additional funds are received from payroll deductions.

PAYMENT METHOD CHOICE- For Unreimbursed Medical expenses you may pay with your FFA Benefits Flex Card at the time you incur the expense, or pay the provider out-of-pocket and file a manual (paper) claim to receive a reimbursement. The FFA Benefits Flex Card is only available for Healthcare/Medical FSAs.

MANUAL CLAIMS-To obtain reimbursement from your FSA, you must complete a manual claim form and attach all itemized receipts from the service provider. Cancelled checks, bankcard/credit card receipts, and credit card statements are NOT acceptable forms of documentation. The receipt must come from the service provider or the Explanation of Benefits from your medical health carrier and must include the following information:

- » Patient name
- » Date of service incurred
- » Provider / Merchant name
- » Amount of your out-of-pocket charge incurred
- » Type of service incurred
- » Must include prescription number

REMEMBER-You must sign and date all claim forms.

FFGA recommends submitting an Explanation of Benefits (EOB) from your insurance company, if available.



CLAIMS PROCESSING AND PAYMENTS

All claim reimbursements are handled with strict adherence to IRS adjudication and reporting regulations. Claims are processed daily, and our turn around time upon receipt is 3-5 business days and during peak periods (August-September and December-January) 5-10 business days. Your reimbursement check will be mailed to your home address on file. You may also elect to receive payment via direct deposit. You have a 2 ½ month grace period (employer permitting) to incur claims with an additional 2 weeks to file claims.

Online Service to View Account Information, visit www.ffga.com

FFA Benefits Flex Card

Medical reimbursement accounts only

BENEFITS FLEX CARD

The First Financial Administrators, Inc. Benefits Flex Card is available for Medical Reimbursement Flexible Spending Accounts. Cards can be issued to spouses and dependent children (ages 18 to 26) for no additional fee. The initial cards are free, but if a replacement card is issued, the cost is \$10.00 per card and will be deducted from your account balance. Cards are good for three years from the issue date as long as you participate each consecutive plan year. Claims can also be submitted directly for reimbursement. If funds remain in your account after the end of the plan year, you may use the debit card during the 2½ month grace period (if your employer has elected to participate in the grace period option). The system will deduct all remaining funds from your old plan year and then deduct any balance from the new plan year, if you continue to participate. New cards (not replacement cards) are only activated with the upcoming plan year -- they are not activated to use money from the prior plan year.

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

Claim forms can be found on our website, www.ffga.com.

Copies can either be mailed to:

First Financial Administrators, Inc.
PO Box 161968
Altamonte Springs, FL 32716

or faxed to:
(800) 298-7785



WHERE TO USE YOUR DEBIT CARD FOR ELIGIBLE UNREIMBURSED MEDICAL EXPENSES:

- » Pharmacies – always use your debit card at the pharmacy counter only.
- » In-Store Pharmacies – If “merchant code” is programmed “pharmacy,” the expense will be authorized. However, if the MasterCard transaction code is programmed “grocery/retail,” **the transaction may be denied. The debit card may not work, and the expense may be declined in some grocery/discount stores.**
- » Physician Offices
- » Specialist Physician Offices
- » Dental Offices
- » Over-the-counter drugs
- » Vision Care Providers
- » Medical Facilities
- » Medical Clinics
- » Hospitals, including Emergency Rooms

(Your FFA Benefits Flex Card cannot be used past your termination date. If you have available funds in your account, a manual claim will be required.)

First Financial Administrators, Inc. can provide you with a list of eligible expenses associated with your Medical Reimbursement Flexible Spending Account. This card is a signature debit card and does not require a PIN for use. Transactions must always be submitted as “credit.” Participants may review Flexible Spending Account balances online at www.ffga.com.

CALL (866) 853-FLEX FOR MORE INFORMATION.

Flexible Benefits Reimbursement Voucher

PO Box 161968, Altamonte Springs, FL 32716 • Telephone: (866) 853-3539 • Fax: (800) 298-7785

PARTICIPANT INFORMATION

ADDRESS CHANGE? Yes No

NAME _____

EMPLOYER _____

MAILING ADDRESS _____

SOCIAL SECURITY # _____

E-MAIL ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (_____) _____

COMPLETE ONLY FOR DEPENDENT CARE PROVIDER

NAME _____

NAME _____

ADDRESS _____

AMOUNT DUE \$ _____ DATE _____

CITY _____ STATE _____ ZIP _____

SERVICE PERFORMED _____

SS # _____

I certify that the dental procedure for the above patient

TAX ID # _____

HAS BEEN COMPLETED IS IN PROGRESS

SIGNATURE OF PROVIDER _____

SIGNATURE OF DENTIST / ORTHODONTIST _____

BENEFIT TYPE (please check as appropriate)

MEDICAL REIMBURSEMENT

DEPENDENT CARE REIMBURSEMENT

PREMIUM REIMBURSEMENT

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT
GRAND TOTAL ALL PAGES			\$0.00

IMPORTANT NOTICE

Effective January 1, 2011, all over-the-counter drugs eligible for reimbursement must be accompanied by a doctor's prescription and a reimbursement voucher.

I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105(h) or 129 of the IRS Code and in accordance with my contract with First Financial Administrators, Inc. I further certify that these expenses have not been, nor will not be, reimbursed under any other health plan coverage. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-866-853-3539.

Please send me additional envelopes (additional voucher given with every reimbursement)

SIGNATURE _____

NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for Insufficient funds. Please call your financial Institution to verify deposit before writing any checks on the amount

DATE _____

Mail or Fax Completed Form To: First Financial Administrators, Inc. • P.O. Box 161968, Altamonte Springs, FL 32716 • Fax Number: 1-800-298-7785

Debit Card Agreement

Medical reimbursement accounts only

I ACCEPT RESPONSIBILITY FOR THE FOLLOWING:

- All card transactions will be solely for qualified expenditures **incurred** (not billed or paid) during the plan year;
- To the extent that if I misrepresent any card transaction as a qualified expenditure when it is a non-qualified expenditure, I hold you harmless for whatever penalties and consequences that may occur as a result of my actions;
- If I misrepresent any card transaction on a non-qualified expenditure, I must immediately repay all expenses to the account upon notification; if not repaid, I understand the amount will be considered taxable income.
- I agree to submit expense receipts to the third party administrator for all purchases when requested; If failure to substantiate, card will be suspended.
- Each time I present the card for payment, I will sign a receipt evidencing that the expense has been incurred and reaffirming my representation that it is a qualified expenditure that has not been and will not be reimbursed from any other source.

DEBIT CARD VALID FOR 3 YEARS OF CONTINUAL PARTICIPATION

PLEASE PRINT

EMPLOYER _____

NAME _____

SOCIAL SECURITY NUMBER _____

MAILING ADDRESS _____

CITY / STATE / ZIP _____

DAYTIME TELEPHONE NUMBER _____

E-MAIL ADDRESS _____

SIGNATURE _____ DATE _____

ADDITIONAL CARDS

DEPENDENT CARDS – ISSUED TO SPOUSES AND/OR DEPENDENT CHILDREN (AGES 18-26)

NAME	RELATIONSHIP	DATE OF BIRTH

PLEASE MAIL COMPLETED FORM TO: FIRST FINANCIAL ADMINISTRATORS, INC. • P.O. Box 161968, Altamonte Springs, FL 32716

PHONE: 1-800-523-8422 OR 281-847-8422 FAX: 1-800-298-7785

UMB

Health Savings Account



HEALTH SAVINGS ACCOUNTS

Administered by First Financial Administrators, Inc.

What is a Health Savings Account (HSA)?

HSAs were created to help control healthcare costs. They provide a savings vehicle that allows you to set aside money to pay for higher deductibles associated with lower monthly premium High Deductible Health Plans (HDHP). The money you save in monthly insurance premiums may be aside for eligible medical expenses you incur in the future. Your HSA balance rolls over from year-to-year earning interest along the way. The account is portable. Upon retirement or separation of service, you take the HSA with you because it's your money and your account.

HSAs Offer a Triple Tax Advantage

- » The money you put in to the account is deducted from your paycheck before tax
- » The interest and earnings you make on the account grow tax free
- » Distributions for eligible medical expenses are tax free

Key Advantages of an HSA

- » No end-of-year forfeiture of funds
- » Portable account
- » Provides an excellent savings vehicle for healthcare expenses
- » No monthly account fees
- » Free eStatements when you opt in for electronic delivery

Year-to-year Comparison

Minimum Health Insurance Plan Deductible Amounts for the Qualifying HDHP

	2021	2022
Individual coverage	\$1,400	\$1,400
Family coverage	\$2,800	\$2,800

Annual Maximum Contribution Levels

	2021	2022
Individual coverage	\$3,600	\$3,650
Family coverage	\$7,200	\$7,300

Catch up allowed for those 55 and over - \$1,000

Maximums for HDHP Out-of-Pocket Expenses

	2021	2022
Individual coverage	\$7,000	\$7,050
Family coverage	\$14,000	\$14,100

Who can participate in an HSA and are there any restrictions?

- » You must be enrolled in a qualified High Deductible Health Plan (HDHP)
- » You cannot be enrolled in Tricare or Medicare or covered under your spouse's traditional (non-HDHP) health care plan
- » You cannot participate in a general purpose Flexible Spending Account (FSA) or Health Reimbursement Arrangement
 - » *Limited Purpose Flexible Spending Accounts are permitted (dental and vision expenses only)*
- » You cannot participate if your spouse has a general purpose FSA or HRA at their place of employment
- » You cannot participate if you are being claimed as a dependent on another person's tax return



FFGA-2048-0621

Examples of Eligible HSA Expenses

For a complete list, visit <https://www.ffga.com/individuals>

- » Copays & Deductibles
- » Prescriptions
- » Dental Care
- » Contacts & Eyeglasses
- » Hearing aids
- » Laser Eye Surgery
- » Orthodontia
- » Chiropractic Care

Your HSA as an Investment Account

HSA's are often overlooked as powerful retirement tools. The more you save, the more you earn. The account offers significant tax advantages and provides opportunities to invest in mutual funds. Account holders can choose to invest any funds over the minimum threshold the bank requires for various investment options. This is a great way to potentially grow your savings for future healthcare costs or retirement.

Distributions and accessing the funds in your HSA

Online Reimbursement

You can request funds online and receive a check or a direct deposit into your selected account.

Online Bill Pay

You can request funds online to pay your provider directly from your HSA account.

Distribution Request Form

You can fax or mail a Distribution Request Form to receive your funds by check or direct deposit.

Is it possible to get a distribution without an eligible medical expense?

- » If you are 65 and older, the funds may be used for any expense with no penalty. The distribution is subject to taxation.
- » If you are under 65, you may incur a 20% penalty and the funds are subject to taxation.

Keep good records of your expenses

Receipts are NOT required at the time of distribution. Be sure to keep receipts for all of your medical expenses, for which you received a reimbursement, for at least three years for tax-reporting purposes. Keep track of your receipts and payments by using the portal to see balances, view transactions, create reports, and upload receipts.

HSA RESOURCES

Benefits Card

The Benefits Card is available to all employees that participate in a Health Savings Account (HSA) and Limited Purpose Flexible Spending Account. The Benefits Card gives you immediate access to your money at the point of purchase. Cards are available for participating employees, their spouse, and eligible dependents that are at least 18 years old.

Online & Mobile Access

Get account information from our easy-to-use online portal and mobile application. See your account and investment balances in real time, request distributions, and save receipts by snapping a photo!

Visit www.ffga.com to set up your online account.

Search for **FF Mobile Account App** from your Apple or Android device to download the mobile app today!

HSA Store

<https://www.ffga.com/individuals>

First Financial has partnered with the HSA Store to bring you an easy to use online store to better understand and manage your HSA. Shop at the HSA Store for eligible items from bandages to wheel chairs and thousands of products in between, browse or search for eligible products and services using the HSA Eligibility List, and visit the HSA Learning Center to help find answers to questions you may have about your HSA.





Welcome to your UMB Health Savings Account (HSA)

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Congratulations!

Thank you for opening a Health Savings Account (HSA) with UMB Healthcare Services. We are here to help you and your family understand how to take full advantage of your HSA. Our goal is to provide you with an affordable, convenient and “Worry Free” approach to begin saving for your medical expenses. Our WealthCare portal provides easy to follow tutorials that will simplify your HSA. Additionally, we provide access to our staff of financial wellness professionals.

Your account has been opened, “Now let’s get started!”

The fundamentals

A Health Savings Account (HSA) enables you to save, invest and spend funds for qualified medical expenses on a tax-advantaged basis. Your funds grow tax-free¹ and unused HSA funds roll over from year to year. HSAs are a convenient and easy way to save for future medical expenses.

Note: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor. HSA funds used to pay for non-qualified medical expenses are subject to income taxes on the amount and a possible additional 20% penalty, if you’re under age 65.

What’s next

This Welcome Kit provides an overview of how your HSA works, including accessing your account online, ways to contribute and use your funds, benefits associated with maximizing your contributions and utilizing beneficial online tools and resources within the WealthCare portal. In addition, you will receive your HSA Debit Card within 10 business days.

Use this guide to get started

Now that your account is open, you can begin making deposits as well as using funds from your account to begin paying for qualified medical expenses.

Read through this guide for helpful hints and guidance on how to take control of your healthcare costs and begin saving for your future medical expenses.

For more detailed information, visit [www.ffga.com] or contact First Financial Administrators, Inc. at 866-853-3539 or contact UMB Healthcare Services at 844-383-9826.

¹All mention of taxes is made in reference to federal tax law. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. Please check with each state’s tax laws to determine the tax treatment of HSA contributions, or consult your tax adviser. Neither UMB Bank n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice and this document is not intended as tax or legal advice.

Managing your account

Online or on the go with your mobile device, the WealthCare portal puts you in control. At the beginning of your plan year you can register for the portal by going to www.ffga.com and going to login. You will need to follow the prompts to register your account. Online access can be fulfilled either during or following HSA enrollment. If following enrollment, visit www.ffga.com and select Register. During this process, you will be prompted to enter both the Employee ID and Employer ID provided.

To register for the mobile app search FF Flex Mobile at the apple or google store. you will need to complete the registration for the phone app. As part of the registration process, you will choose your own username and password. Once registered, you can sign-in to take control of your HSA. Log in, navigate to "My HSA" and get started! If you have any questions, feel free to contact First Financial Administrators, Inc. at 866-853-3539 or contact UMB Healthcare Services at 844-383-9826.

Online account access

You are getting much more than just an HSA; we are providing a suite of services through the WealthCare portal that will simplify your account. Through the portal, you gain access to the following features:

- View account and investment balances
- Access to current and historical activity and balances
- Mobile and tablet access if you are on the go
- Graphs and reports to monitor contribution limits
- "Shoe Box" to record and upload related medical invoices
- Easy to use Bill Pay feature
- Access e-Statements
- Establish account alerts
- View and maintain account owner information
- Utilize contribution feature to set up electronic transfers
- Integrated investment option
- Access to online videos, calculators and other useful tools

Your HSA is easy to manage!

- *An array of mutual funds, including an interest-bearing account, gives you competitive investment choices.²*
- *Enjoy earning a tax free¹, competitive interest rate on all contributions*
- *Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.*

^{1,2}See pages 3 and 9 for disclosures

Mobile application

When you're on the go, save time and hassles with the WealthCare Mobile App. Check your balances, transactions, and claim details for all your reimbursement accounts.

Easy and Convenient

- Designed to work just as other iOS and Android apps, making it easy to learn and use

Connects You with Details

- Check available balances 24/7
- View account activity for your accounts
- View investment portfolio

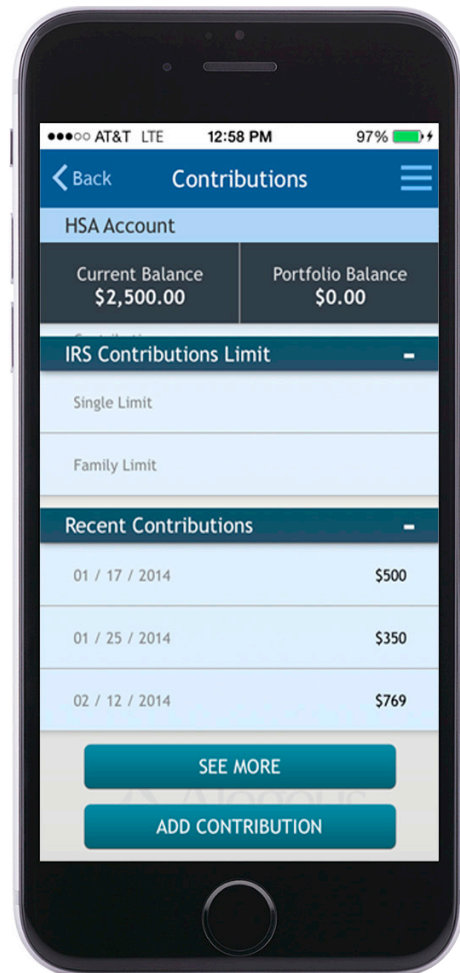
It's Secure

- No sensitive account information is ever stored on your mobile device and secure encryption is used to protect all transmissions.

Mobile SMS Alerts

The WealthCare Mobile App supports a wide variety of customizable SMS alerts to empower consumers to more pro-actively manage their accounts. Participants may opt-in or out of receiving SMS alerts at any time.

- Low balance
- Annual deductible met
- Address change
- Email change
- Password change
- Payroll deposit received
- HSA statement available
- Monthly balance update



Contributing is easy

Contributing funds help lower your taxable income and allow you to build a “Nest Egg” for future health care expenses. Contributions to your HSA may be made by you, your employer or anyone; however, the preferred tax treatment will only be realized by you.

Contribution methods

You can contribute money to your account in several convenient ways including;

Direct Deposit

Your HSA account acts just like a personal checking account. If your employer offers direct deposit, you can give them your HSA account information to begin contributing via direct deposit.

Funds Transfer

Within the WealthCare portal you can schedule electronic transfers from other financial institutions. They are fast and easy!

Account Transfer

If you have an existing HSA, you may be eligible to either rollover or transfer the funds to your new HSA. Required forms are available within the WealthCare portal or you may contact First Financial Administrators, Inc. at 866-853-3539 or UMB Healthcare Services 844-383-9826 for further assistance.

Checks

Contributions may be made using a check and corresponding HSA Contribution Form (which can be obtained on the WealthCare portal). Mail check and contribution form to the following address:

UMB Bank Contributions
P.O. Box 874264
Kansas City, MO 64187-4264



Maximizing your contributions

As you decide how much to contribute, it's important to note that contributing the maximum allowable amount helps you to get the most from your HSA. At the very least, you'll want to contribute enough to cover anticipated healthcare expenses. Because your balance rolls over year-to-year, there is no penalty for contributing more than you're able to use in one year. The tax advantages of an HSA make it a powerful long-term savings vehicle.

The maximum annual contribution can be made even if you become HSA- eligible after your tax year begins, as long as you are covered under a HDHP on the first day of the last month of your tax year (December 1 for most taxpayers) and remain in a HDHP for the following 12 months. See IRS publication 969 for details. Contributions are allowed until April 15 for the previous calendar year. Additionally, if you are 55 or older, you are allowed to make a \$1,000 catch up contribution.

Keep in mind that HSA contribution limits, established by the IRS, may change each year and you must not over contribute to avoid adverse tax consequences.

	2019 Contribution Limit	Catch-up Contribution*
Single	\$3,500	\$1,000
Family	\$7,000	\$1,000

**Participants age 55 or older may make additional contributions above the set HSA maximum. Catch-up contributions can be made any time during the year in which the HSA participant turns 55.*

Catch-up contributions for account holders 55 and older

If you are age 55 or older, you may be able to make a catch-up contribution above the annual limit. Even if you join a qualified HDHP after the start of the year, you can contribute the maximum amount, as long as you have HDHP coverage for the last month of the taxable year and for the following 12 months. Catch-up contributions for the partial year of HDHP coverage must be pro-rated.

Does this sound complicated? Don't worry. There are tools within the WealthCare portal that will help you monitor your contributions and help prevent over contributing. Contact First Financial Administrators, Inc. at 866-853-3539 if you have questions or UMB Healthcare Services at 844-383-9826.

Using your HSA funds

HSA funds can be used to pay for qualified medical expenses, such as:

- Medical
- Dental
- Vision
- Prescription
- Medical Equipment
- Chiropractic

Go to [www.fga.com] and use the Eligible HSA Expense tool to see which types of expenses are qualified. You can also go to www.irs.gov and download Publication 502. Generally, qualified medical expenses are those expenses directly related to the alleviation or prevention of physical or mental illness. If you use HSA funds for medical expenses that are not qualified, they will be included in your taxable income. (HSA withdrawals made for non-qualified expenses are subject to ordinary income tax and IRS penalties may be applicable to non-qualified expenses paid for with funds from your HSA. Additionally, state taxes may vary so please consult your tax advisor.)

Pay for qualified expenses

- Use your benefits debit card where accepted, such as the pharmacy or doctor's office.
- Write your benefits debit card number on medical bills to have your HSA funds directed to the expense.
- Use online bill payment to pay for a healthcare expense or to reimburse yourself for an out-of-pocket medical expense.

Keep good records of your expenses

Keep track of your expenses and payments by using the WealthCare portal to see balances, view transactions, create reports and upload receipts. Be sure to keep receipts for all of your medical expenses for at least three years for tax-reporting purposes.

If you use your HSA funds for non-qualified medical expenses, and are under the age of 65, you may incur a 20% penalty and owe income taxes on the amount used. After the age of 65, HSA funds can be used for any expense with no penalty, but you may still owe income taxes on those funds. Qualified medical expenses are always tax-free.

HSA investment options

Are you a spender or saver?

Unlike other healthcare accounts, funds in your HSA do not expire and are not contingent upon your employment. Not only does your balance accrue interest, you have a unique opportunity to grow your money even more by investing in a select list of mutual funds.

‘Spender’ or short-term investor: Competitive interest rates

The basic UMB Healthcare Services HSA deposit account is similar to an interest-bearing checking or savings account. Savers will enjoy earning a competitive interest rate on all contributions, and the interest accumulates tax-free¹.

‘Saver’ or long-term investor: Powerful options

The UMB HSA investment² account was designed for account holders who are interested in using their HSA as a long-term savings vehicle. You must maintain a balance in your HSA of \$1,000 and anything in excess of that may be invested in increments of \$1.00. After you access your account online go to the Investment tab and Documents and Forms tab to find out more information about investing.

HSA investment account choices

You can view transactions, holdings, and statements online, update your account information or place a trade all from within the WealthCare portal using your existing username and password. After establishing an investment account, you will have the ability to view your HSA balances and manage your portfolio holdings and transactions with ease.

This material is provided for informational purposes only and contains no investment advice or recommendations to buy or sell any specific securities.

Investors should carefully consider the fund’s investment objectives, associated risks, charges and expenses before investing. To obtain a summary prospectus or prospectus obtaining this and other information (you must have already enrolled in the HSA Investment account through mywealthcareonline.com), log into the website and go to the ‘My HSA’ tab, then select ‘HSA Investments’ and then ‘View/Trade Investments’. This will lead you to the list of available funds and all their information. Please carefully read the summary prospectus or prospectus before investing.

Investments in securities through HSA investment account are:
Not FDIC Insured • May Lose Value • No Bank Guarantee

²UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB Investment program. UMB Investment Management is a department of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation

UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB investment program. UMB Custody Services is a division of UMB Bank, n.a.

Useful tips and suggestions

Make the most of your HSA

- Contribute the maximum to your HSA.
- Manage your health care expenses wisely.
- Learn about and practice healthcare consumerism.
- Take good care of yourself and your family – a healthy lifestyle makes a big difference.
- Invest unused HSA funds and make your money work harder for you.

Your UMB HSA is triple tax-advantaged. You can save tax-free with your HSA. You can fund your HSA with pre-tax or tax-deductible contributions. Balances grow tax-free and withdrawals are also tax-free as long as the money is used for IRS-qualified medical expenses.

Note: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor. HSA funds used to pay for non-qualified medical expenses are subject to income taxes on the amount and a possible additional 20% penalty, if you're under age 65.

Recordkeeping for tax purposes

You will be responsible for retaining your monthly statements with your HSA records and all receipts for qualified medical expenses. Online Statements are available for 18 months. Statements are generated on the monthly anniversary of your enrollment so please access your account regularly. Consult your tax advisor to determine how HSAs are treated for state tax purposes for the state in which you file your taxes.

At year end, UMB Healthcare Services will send you the following:

- 1099 SA – Received by January 31 and shows your annual distributions
- 5498 SA – Received by May 31 and shows your annual contributions

When you receive these forms, if you feel there is an error, contact UMB Healthcare Services at 844-383-9826 and we will work with you to make corrections and provide a corrected form.

Thank you for choosing UMB Healthcare Services.

For more information about HSAs, visit [www.ffga.com] or call First Financial Administrators, Inc. at 866-853-3539 or call UMB Healthcare Services at 844-383-9826.

MASA

Transport



EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away from home.

Many American employers and employees believe that their health insurance policies cover most, if not all ambulance expenses. The truth is, they DONOT!

Even after insurance payments for emergency transportation, you could receive a bill up to \$5,000 for ground ambulance and as high as \$70,000 for air ambulance. The financial burdens for medical transportation costs are very real.



HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.



Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit *	Platinum \$39/Month	Emergent Plus \$14/Month
Emergent Ground Transportation	U.S./Canada	U.S./Canada
Emergent Air Transportation	U.S./Canada	U.S./Canada
Non-Emergent Air Transportation	Worldwide	U.S./Canada
Repatriation	Worldwide	U.S./Canada
Escort Transportation	Worldwide	
Mortal Remains Transportation	Worldwide	
Visitor Transportation	BCA**	
Minor Children/Grandchildren Return	BCA**	
Vehicle Return	BCA**	
Pet Return	BCA**	
Organ Retrieval	U.S./Canada	
Organ Recipient Transportation	U.S./Canada	

* Please refer to the MSA for a detailed explanation of benefits and eligibility.

** Basic Coverage Area (BCA) includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).



A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

For more information, please contact

Keith Loeffler, B2B Manager

713.817.3178 | KLoeffler@masamts.com

EVERY FAMILY DESERVES A MASA MEMBERSHIP

Metlife Dental



Plan Design for: Marshall Independent School District

Date Prepared: 01/1/2019

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

Coverage Type:	In-Network ¹ % of PDP Fee ²	Out-of-Network ¹ % of R&C Fee ⁴
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$1000	\$1000
Orthodontia Lifetime Maximum - Ortho applies to Adult and Child		
	Up to dependent age limit	
	\$1500 per Person	\$1500 per Person

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
 - the dentist's actual charge (the 'Actual Charge'),
 - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
 - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 80th percentile. Services must be necessary in terms of generally accepted dental standards.

IMPORTANT RATE INFORMATION

Monthly Premium Payment	
Employee	\$29.09
Employee + Spouse	\$67.30
Employee + Child(ren)	\$66.61
Employee + Family	\$101.16

Cancellation/Termination of Benefits:

Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. The dependent's coverage terminates when a dependent ceases to be a dependent. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

IMPORTANT ENROLLMENT INFORMATION

You may only enroll for Dental Expense Benefits within 31 days of your Personal Benefits Eligibility Date, or if you have a Qualifying Event or during the Plan's Annual Open Enrollment Period.

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

If there is a Qualifying Event you may request to be covered, or to change your coverage, only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under this Plan because of a loss of the prior dental coverage. If you make a request to be covered under this Plan or request a change(s) in coverage under this Plan within thirty-one days of a Qualifying Event, your coverage or the change(s) in coverage will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

Selected Covered Services and Frequency Limitations*

Type A - Preventive

How Many/How Often:

Oral Examinations	2 in a year
Full Mouth X-rays	1 in 60 months
Bitewing X-rays (Adult/Child)	2 in a year
Prophylaxis - Cleanings	2 in a year
Topical Fluoride Applications	2 in a year - Children to age 14
Sealants	1 in 60 months - Children to age 14
Space Maintainers	1 per lifetime per tooth area - Children up to age 14
Emergency Palliative Treatment	

Type B - Basic Restorative

How Many/How Often:

Amalgam and Composite Fillings	1 in 24 months. Anterior teeth only
Prefabricated Crowns	1 per tooth in 10 years
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	

Type C - Major Restorative

How Many/How Often:

Crowns/Inlays/Onlays	1 per tooth in 10 years
Repairs	1 in 12 months
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 60 months per quadrant
Periodontal Scaling & Root Planing	1 in 60 month per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Bridges	1 in 10 years
Dentures	1 in 10 years
General Anesthesia	
Consultations	2 in 12 months
Implant Services	1 service per tooth in 10 years - 1 repair per 12 months
Harmful Habits Appliances	

Type D – Orthodontia

- Adult and Child Coverage. Dependent children up to age 26. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

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

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments.**For NY Sitused Groups, this exclusion does not apply.**
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law;
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.**For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
 - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
 - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.**This exclusion only applies for North Carolina Sitused Groups.**
15. Services:
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
This exclusion only applies for Virginia Sitused Groups.
17. Services:
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for Virginia Sitused Groups.**
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

33. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.¹
35. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.¹
36. Repair or replacement of an orthodontic device.¹
37. Duplicate prosthetic devices or appliances.
38. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
39. Intra and extraoral photographic images.
40. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
This exclusion only applies for Maryland Sitused Groups

¹Some of these exclusions may not apply. Please see your plan design and certificate for details.

Common Questions ... Important Answers

Who is a participating dentist?

A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

In addition to the standard MetLife network, your employer may provide you with access to a select network of dental providers that may be unique to your employer's dental program. When visiting these providers, you may receive a better benefit, have lower out-of-pocket costs and/or have access to care at facilities at your worksite. Please sign into MyBenefits for more details.

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit participating dentists and the cost of services rendered. Negotiated fees are subject to change.

How do I find a participating dentist?

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

What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits summary to learn more.*

*The information in this document represents an overview of your plan benefits, but is not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs.

May I choose a non-participating dentist?

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

Can my dentist apply for participation in the network?

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

* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

How are claims processed?

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

Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

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

Can MetLife help me find a dentist outside of the U.S. if I am traveling?

Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. (AXA Assistance). AXA Assistance provides dental referral services only. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife. Referral services are not available in all locations.

** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans?

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

Do I need an ID card?

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

Do my dependents have to visit the same dentist that I select?

No. You and your dependents each have the freedom to choose any dentist.

Superior Vision

Vision Plan Benefits for Marshall ISD

Co-Pays		Monthly Premiums		Services/Frequency	
Exam	\$10	Emp. only	\$8.11	Exam	12 months
Materials	\$10	Emp. + spouse	\$13.83	Frame	24 months
		Emp. + child(ren)	\$14.51	Lenses	12 months
		Emp. + family	\$21.94	Contact Lenses	12 months

(Based on date of service)

Benefits

	<u>In-Network</u>	<u>Out-of-Network</u>
Exam	Covered in full	Up to \$35 retail
Frames	\$125 retail allowance	Up to \$70 retail
Lenses (standard) per pair		
Single Vision	Covered in full	Up to \$25 retail
Bifocal	Covered in full	Up to \$40 retail
Trifocal	Covered in full	Up to \$45 retail
Progressive	See description ¹	Up to \$45 retail
Lenticular	Covered in full	Up to \$80 retail
Contact Lenses ²	\$150 retail allowance	Up to \$80 retail
Medically Necessary Contact Lenses	Covered in full	Up to \$150 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

¹ Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

² Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

Discount Features

Non-Covered Eyewear Discount: Members may also receive a discount of 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens "extras" such as tints and coatings. Eyewear purchased from a Walmart Vision Center does not qualify for this additional discount because of Walmart's "Always Low Prices" policy.

SuperiorVision.com
Customer Service
800.507.3800

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

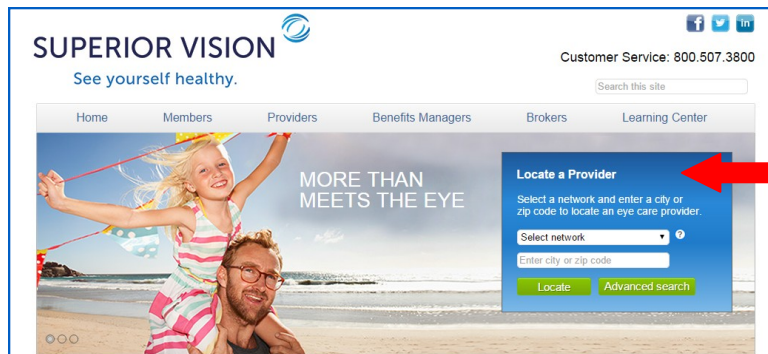
Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions

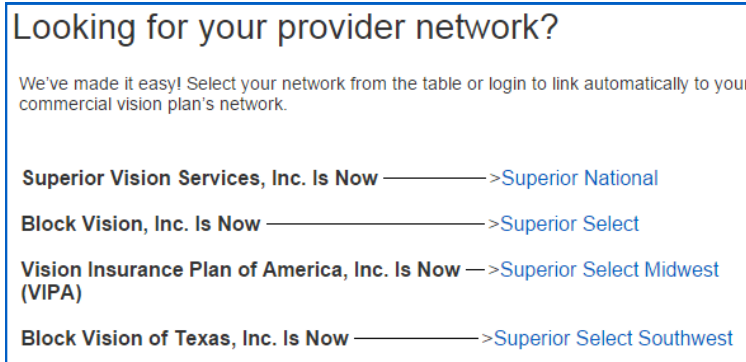
FINDING IN-NETWORK PROVIDERS

3 Easy Steps to Finding an In-Network Provider

STEP 1: Go to **SuperiorVision.com**. In the **“Locate a Provider”** box, select your provider network, enter your city or ZIP code and click the **“Locate”** button. You can also click the **“Advanced Search”** button to search by mile radius, eye care provider’s name or practice name.



If you’re unsure of your provider network name, select **“I don’t know”** from the drop-down menu or click the **“?”** icon to view our helpful chart. You may also **login** to the member area of the website, select **“Locate a Provider”** from the navigation and your network will be auto-populated on the page.



STEP 2: Review the list of results from your search and choose an eye care provider.

- Call your selected eye care provider prior to your appointment to verify provider network participation and to confirm services and acceptance of your vision plan.
- It’s important to note that not all providers at each office or optical store location are in-network providers, nor do they participate in all networks.

STEP 3: You may also call Customer Service at 800.507.3800 for assistance in locating an in-network provider.

UNUM Disability



MARSHALL INDEPENDENT SCHOOL DISTRICT

Costs Effective as of January 1, 2019
 Costs below are based on a **Monthly** payroll deduction
 (Employer billing mode is based on **12 Payments** per year)

Product: Educator Select Income Protection Plan			Plan A			
			ADEA I Duration of Benefits			
			Elimination Period (Days)			
Injury (Days)			7*	14*	30	90
Sickness (Days)			7*	14*	30	90
Annual Earnings	Monthly Earnings	Maximum Monthly Benefit	4.38 per \$100	4.24 per \$100	2.35 per \$100	0.89 Per \$100
3960	330	200	8.76	8.48	4.70	1.78
6000	500	300	13.14	12.72	7.05	2.67
8040	670	400	17.52	16.96	9.40	3.56
9960	830	500	21.90	21.20	11.75	4.45
12000	1000	600	26.28	25.44	14.10	5.34
14040	1170	700	30.66	29.68	16.45	6.23
15960	1330	800	35.04	33.92	18.80	7.12
18000	1500	900	39.42	38.16	21.15	8.01
20040	1670	1000	43.80	42.40	23.50	8.90
21960	1830	1100	48.18	46.64	25.85	9.79
24000	2000	1200	52.56	50.88	28.20	10.68
26040	2170	1300	56.94	55.12	30.55	11.57
27960	2330	1400	61.32	59.36	32.90	12.46
30000	2500	1500	65.70	63.60	35.25	13.35
32040	2670	1600	70.08	67.84	37.60	14.24
33960	2830	1700	74.46	72.08	39.95	15.13
36000	3000	1800	78.84	76.32	42.30	16.02
38040	3170	1900	83.22	80.56	44.65	16.91
39960	3330	2000	87.60	84.80	47.00	17.80
42000	3500	2100	91.98	89.04	49.35	18.69
44040	3670	2200	96.36	93.28	51.70	19.58
45960	3830	2300	100.74	97.52	54.05	20.47
48000	4000	2400	105.12	101.76	56.40	21.36
50040	4170	2500	109.50	106.00	58.75	22.25
51960	4330	2600	113.88	110.24	61.10	23.14
54000	4500	2700	118.26	114.48	63.45	24.03
56040	4670	2800	122.64	118.72	65.80	24.92
57960	4830	2900	127.02	122.96	68.15	25.81
60000	5000	3000	131.40	127.20	70.50	26.70
62040	5170	3100	135.78	131.44	72.85	27.59
63960	5330	3200	140.16	135.68	75.20	28.48
66000	5500	3300	144.54	139.92	77.55	29.37
68040	5670	3400	148.92	144.16	79.90	30.26
69960	5830	3500	153.30	148.40	82.25	31.15
72000	6000	3600	157.68	152.64	84.60	32.04
74040	6170	3700	162.06	156.88	86.95	32.93
75960	6330	3800	166.44	161.12	89.30	33.82
78000	6500	3900	170.82	165.36	91.65	34.71
80040	6670	4000	175.20	169.60	94.00	35.60
81960	6830	4100	179.58	173.84	96.35	36.49
84000	7000	4200	183.96	178.08	98.70	37.38
86040	7170	4300	188.34	182.32	101.05	38.27
87960	7330	4400	192.72	186.56	103.40	39.16
90000	7500	4500	197.10	190.80	105.75	40.05
92040	7670	4600	201.48	195.04	108.10	40.94
93960	7830	4700	205.86	199.28	110.45	41.83
96000	8000	4800	210.24	203.52	112.80	42.72
98040	8170	4900	214.62	207.76	115.15	43.61
99960	8330	5000	219.00	212.00	117.50	44.50
102000	8500	5100	223.38	216.24	119.85	45.39
104040	8670	5200	227.76	220.48	122.20	46.28

REF #: 4305872

*** If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.**

Find your Annual/Monthly Earnings above to determine your Maximum Monthly Benefit. If your Annual/Monthly Earnings are not shown, use the next lower Annual/Monthly Earnings and corresponding Maximum Monthly Benefit. Or, you may refer to the Plan Highlights to calculate your Maximum Monthly Benefit based on your earnings.



MARSHALL INDEPENDENT SCHOOL DISTRICT

Costs Effective as of January 1, 2019
 Costs below are based on a **Monthly** payroll deduction
 (Employer billing mode is based on **12 Payments** per year)

Product: Educator Select Income Protection Plan			Plan A			
			ADEA I Duration of Benefits			
			Elimination Period (Days)			
Injury (Days)			7*	14*	30	90
Sickness (Days)			7*	14*	30	90
Annual Earnings	Monthly Earnings	Maximum Monthly Benefit	4.38 per \$100	4.24 per \$100	2.35 per \$100	0.89 Per \$100
105960	8830	5300	232.14	224.72	124.55	47.17
108000	9000	5400	236.52	228.96	126.90	48.06
110040	9170	5500	240.90	233.20	129.25	48.95
111960	9330	5600	245.28	237.44	131.60	49.84
114000	9500	5700	249.66	241.68	133.95	50.73
116040	9670	5800	254.04	245.92	136.30	51.62
117960	9830	5900	258.42	250.16	138.65	52.51
120000	10000	6000	262.80	254.40	141.00	53.40
122040	10170	6100	267.18	258.64	143.35	54.29
123960	10330	6200	271.56	262.88	145.70	55.18
126000	10500	6300	275.94	267.12	148.05	56.07
128040	10670	6400	280.32	271.36	150.40	56.96
129960	10830	6500	284.70	275.60	152.75	57.85
132000	11000	6600	289.08	279.84	155.10	58.74
134040	11170	6700	293.46	284.08	157.45	59.63
135960	11330	6800	297.84	288.32	159.80	60.52
138000	11500	6900	302.22	292.56	162.15	61.41
140040	11670	7000	306.60	296.80	164.50	62.30
141960	11830	7100	310.98	301.04	166.85	63.19
144000	12000	7200	315.36	305.28	169.20	64.08
146040	12170	7300	319.74	309.52	171.55	64.97
147960	12330	7400	324.12	313.76	173.90	65.86
150000	12500	7500	328.50	318.00	176.25	66.75
152040	12670	7600	332.88	322.24	178.60	67.64
153960	12830	7700	337.26	326.48	180.95	68.53
156000	13000	7800	341.64	330.72	183.30	69.42
158040	13170	7900	346.02	334.96	185.65	70.31
159960	13330	8000	350.40	339.20	188.00	71.20

REF #: 4305872

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Find your Annual/Monthly Earnings above to determine your Maximum Monthly Benefit. If your Annual/Monthly Earnings are not shown, use the next lower Annual/Monthly Earnings and corresponding Maximum Monthly Benefit. Or, you may refer to the Plan Highlights to calculate your Maximum Monthly Benefit based on your earnings.

AFA Accident

LIMITED BENEFIT ACCIDENT ONLY *Insurance Plan*

Underwritten by American Fidelity Assurance Company



Wellness Benefit • Benefits Paid Directly to You • Excellent Customer Service • Learn More » »



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

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

Accident Only Insurance

Life Provides the Accidents, First Financial Offers a Solution!

Whether you're a weekend warrior with an active lifestyle or just a busy family, accidents can happen to you anytime, anywhere without warning. First Financial is pleased to offer American Fidelity Assurance Company's (AFA) Limited Benefit Accident Only Insurance. Accident Only policy and rider Insurance can offer a solution to help you and your family prepare for those rising medical costs if you have to receive medical treatment for an Accidental injury.

Think It Couldn't Happen to You? Consider this...

Know The Facts:

Total costs of accidental injuries averaged \$20,657 per injury in 2012.

National Safety Council, Injury Facts, 2014 Edition, p. 2-6.

\$20,657

How Would You Cover Your Out-of-Pocket Costs?

Just going for a walk around the block or heading to your driveway could lead to a twisted knee and torn meniscus, one of the more common claims submitted under this plan.



EMERGENCY ACCIDENT - Hypothetical Example¹

Twisted knee in the parking lot resulting in a torn meniscus and treatment is received within 72 hours.

ENHANCED PLAN BENEFITS

Accident Emergency Treatment	\$200
Accident Follow-Up Treatment (4 visits)	\$200
Physical Therapy (8 treatments)	\$200
Medical Imaging	\$200
X-Ray	\$100
Appliances	\$100
Surgical Facility	\$250
Torn Knee Cartilage Repair	\$500
Anesthesia	\$200

**Paid Directly
To You!**

Total

\$1,950

¹Hypothetical example of a covered accident based on policy AO-03 and rider AMDI-258.

Solutions For Life's Accidents...

The Accident Only Plan is the insurance policy that provides payments direct to you protecting you and your family from some of the expenses brought about by injuries suffered in an Accident, regardless of any additional coverage you may have. It's guaranteed renewable for as long as you pay your premiums.

Accident Only Insurance Features:

- » No medical questions.
- » Available conveniently through your employer with payroll deduction.
- » Benefits paid directly to you, to be used however you see fit.
- » Policy is guaranteed renewable at the option of the primary insured for life as long as premiums are paid as required. Any additional insureds must meet eligibility as outlined in the policy. The company has the right to change premium rates by class.
- » Benefits regardless of other coverage.
- » Coverage for you and each covered family member 24 hours a day, 7 days a week.



Currently participating in, or possibly moving to a High Deductible Health Plan? Health Savings Account (HSA) and qualified High Deductible Health Plan enrollments have quadrupled in the past six years and are on the rise².

The Choice is Yours:

Be prepared with either of American Fidelity's two plan options (Basic and Enhanced) that provide the benefit amounts you require. Plus, American Fidelity supplies the coverage you need with four choices of coverage including individual, individual and spouse, individual and child(ren), and family.

Ready To Learn More?

Contact your First Financial Account Representative for more details or to schedule a one-on-one appointment.



First Financial Group of America
11811 N. Freeway, Suite 900 Houston, TX 77060
Local: (281) 847-8422 / Toll Free: (800)523-8422
www.ffga.com

²AHIP: January 2012 Census Shows 13.5 Million People covered by HSA/High-Deductible Health Plans, May 2012, p.3.

Schedule of Benefits For Policy ³ and Benefit Enhancement Rider

Emergency Accident Benefits

	Basic	Enhanced
Emergency Accident Treatment		
Emergency Accident Treatment	\$150	\$200
Emergency Accident Follow-up Treatment <i>(up to four visits)</i>	\$50	\$50

Accident Injury Benefits

Benefit amounts for the following Benefits are the same for Basic and Enhanced Plans for all Persons: Primary, Spouse, and Child(ren).

Basic / Enhanced

Injury Treatment	
Fractures Benefit <i>(Depending on open or closed reduction, bone involved, or chip fracture).</i>	\$25 to \$3,000
Lacerations Benefit	
Not requiring sutures	\$25
Sutured lacerations up to two inches	\$100
Sutured lacerations totaling two to six inches	\$200
Sutured lacerations totaling over six inches	\$400
Appliances Benefit <i>(crutches, leg braces, etc.)</i>	\$100
Torn Knee Cartilage or Ruptured Disc Benefit	\$500
Eye Injury Benefit	
Injury with surgical repair, for one or both eyes.	\$250
Removal of foreign body by a Physician, for one or both eyes.	\$50
Dislocations Benefit <i>Depending on open or closed reduction, with or without anesthesia and joint involved. No other amount will be paid under this benefit.</i>	\$25 to \$3,000
Concussion Benefit	\$200
2nd & 3rd Degree Burns <i>(Skin grafts are 25% of benefit)</i>	\$100 to \$10,000
Internal Injuries Benefit <i>Resulting in open abdominal or thoracic surgery</i>	\$1,000
Paralysis Benefit: Paraplegia / Quadriplegia	\$5,000 / \$10,000
Tendons, Ligaments and Rotator Cuff Benefit	
One Tendon, Ligament or Rotator Cuff	\$500
More than One Tendon, Ligament or Rotator Cuff	\$750
Blood, Plasma and Platelets	\$250
Exploratory Surgery without Surgical Repair	\$250
Physical Therapy <i>(per treatment up to eight treatments)</i>	\$25
Prosthesis	\$500
Emergency Dental Work	
Broken teeth repaired with crown	\$150
Extraction of broken teeth <i>(regardless of number)</i>	\$50

Refer to Plan Benefit Highlights for complete Benefit Descriptions and limits on the Accident Only Insurance Plan.

A Highlight of Benefits Available Under The Plan

Wellness Benefit

Basic

Enhanced

Wellness		
Annual Routine Physical Exam <i>(Requires a 12-month waiting period before use and one exam per policy per calendar year.)</i>	\$50	\$75

Accidental Death & Dismemberment Benefit

Accidental Death & Dismemberment			
Basic	Primary	Spouse	Child
Common Carrier	\$50,000	\$50,000	\$25,000
Other Accident	\$15,000	\$15,000	\$7,500
Dismemberment	\$1,000 to \$15,000	\$1,000 to \$15,000	\$500 to \$7,500
Enhanced	Primary	Spouse	Child
Common Carrier	\$100,000	\$100,000	\$50,000
Other Accident	\$30,000	\$30,000	\$15,000
Dismemberment	\$1,500 to \$30,000	\$1,500 to \$30,000	\$750 to \$15,000

Additional Accident Benefits For Policy/ Benefit Enhancement Rider

Basic

Enhanced

Non-Emergency Accident Treatment		
Non-Emergency Accident Treatment	\$75	\$100
Non-Emergency Follow-up Treatment <i>(up to two visits)</i>	\$50	\$50
Hospital Confinement		
Hospital Admission	\$500	\$1,000
Intensive Care Unit <i>(up to 15 days)</i>	\$300	\$600
Hospital Confinement <i>(up to 365 days)</i>	\$100	\$200
Medical Imaging		
MRI, CT, CAT, PET, US	\$200	\$200
X-Rays	\$50	\$100
Ambulance		
Ground	\$300	\$300
Air	\$1,500	\$1,500
Treatment		
Outpatient Hospital or Ambulatory Surgical Center	\$150	\$250
Anesthesia	\$150	\$200
Transportation Benefits		
Transportation (Patient Only) <i>(per round trip for up to three round trips per calendar year)</i>	\$300	\$300
Family Member Lodging and Meals <i>(per day per Accident; up to 30 days per confinement)</i>	\$100	\$100

Plan Benefit Highlights for Policy and Benefit Enhancement Rider

A Covered Person (hereafter referred to as "Person") under American Fidelity's Limited Benefit Accident Only Policy can expect the following benefits when a Covered Accident (hereafter referred to as "Accident") happens. All benefits are paid once per Person per Accident unless otherwise specified. All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. These references are not intended to change or modify any definitions in the AO-03 policy series.

Accident Emergency Treatment Benefit

Payable for receiving emergency treatment in a Physician's office or emergency room within 72 hours, including physician fees and emergency services.

Accident Follow-up Treatment Benefit

Payable for necessary follow-up treatment of Injuries in addition to the emergency treatment administered within 72 hours for up to four treatments. Not payable for a visit in which a Physical Therapy Benefit or Non-Emergency Follow-Up Benefit is paid.

Accidental Death and Dismemberment Benefit

The applicable benefits apply when an Accidental Death or Dismemberment occurs within 90 days of an Accident. In the event that Accidental Death and Dismemberment result from the same Accident, only the Accidental Death Benefit will be paid.

Ambulance Benefit

If air and ground transportation is required for the same Accident, only the highest benefit will be paid.

Anesthesia Benefit

Pays the amount shown in the Schedule of Benefits for the services of an anesthesiologist for a surgery performed due to an Accident. Hospital Confinement is not required to receive this benefit. We will only pay one Anesthesia Benefit per Person in a 24-hour period even if more than one surgical procedure is performed. This benefit is not payable for local anesthesia.

Appliances Benefit

Payable for one of the following: crutches, leg braces, back braces, walkers, or wheel chairs. Not payable for Prosthetic Devices.

Blood, Plasma and Platelets Benefit

Payable for blood, plasma and platelets. This benefit does not provide benefits for immunoglobulins.

Burns Benefit

Payable for burns when treated by a Physician within 72 hours.

Concussion Benefit

Payable for a Person who sustains a concussion and is diagnosed by a Physician within 72 hours using any type of medical imaging.

Dislocations Benefit

Amount payable varies by the joint involved, type of treatment, and type of anesthesia. If a Person receives more than one Dislocation in an Accident, we will pay for all Dislocations up to two times the amount shown in the Schedule of Benefits for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit. Benefits are payable only for the first dislocation of a joint which occurs while this policy is in force.

Emergency Dental Work Benefit

Payable for repair to natural teeth when treated by a Physician or dentist. Initial dental treatment must be received within 72 hours.

Exploratory Surgery Benefit

Payable when an exploratory surgical operation without surgical repair is performed.

Eye Injury Benefit

Payable for one or both eyes requiring treatment.

Family Member Lodging and Meals Benefit

Payable for lodging and meals for a family member to be near a Person who is Confined in a non-local Hospital. The Hospital must be at least 50 miles one way from the Person's residence or site of the Accident.

Fractures Benefit

Varies based on the bone involved, type of fracture and type of treatment. If the Person fractures more than one bone, payment is made for all fractures up to two times the amount for the bone involved that has the highest benefit amount.

Hospital Admission Benefit

Pays per admission for confinement to a Hospital. This benefit does not pay for outpatient treatment, emergency room treatment, or a stay of less than 18 hours in an observation unit.

Hospital Confinement Benefit

Payable for a one-time Hospital Admission Benefit due to accidental Injuries (does not include emergency room and outpatient treatment). You will also receive a daily benefit for a Hospital Confinement that is longer than 18 hours for up to 365 days and an additional daily benefit for Confinement in an Intensive Care Unit up to 15 days.

Intensive Care Unit Benefit

Payable for each day of confinement in an Intensive Care Unit, as defined in the policy, up to 15 days. This benefit is paid in addition to the Hospital Confinement Benefit amount.

Internal Injuries Benefit

Payable for an open abdominal or thoracic surgery performed within 72 hours.

Lacerations Benefit

This benefit varies based on the severity of the laceration.

Medical Imaging Benefit

Payable for a Magnetic Resonance Imaging (MRI), a Computed Tomography (CT) scan, a Computed Axial Tomography (CAT) scan, a Positron Emission Tomography (PET) scan or an ultrasound.

Non-Emergency Accident Initial Treatment Benefit

Payable for initial medical treatment when treatment is received more than 72 hours after the Accident. Initial medical treatment must: (1) be received in a Physician's office or emergency room; and (2) be the first treatment; and (3) occur within 30 days.

Non-Emergency Accident Follow-up Treatment Benefit

Payable only if the Non-Emergency Accident Initial Treatment Benefit is payable and later requires additional treatment: we will pay over and above the initial medical treatment administered. We will pay for up to two treatments. Not payable for the same visit that the Physical Therapy Benefit or the Accident Follow-Up Benefit is paid.

Outpatient Hospital or Ambulatory Surgical Center Benefit

When a surgical procedure is performed on an outpatient basis in a Hospital or at an Ambulatory Surgical Center, we will pay the indemnity amount shown in the Schedule of Benefits for the facility fee charged by such Hospital or Ambulatory Surgical Center. We will only pay one Outpatient Hospital or Ambulatory Surgical Center Benefit in a 24-hour period even if more than one surgical procedure is performed. This benefit will not be paid for surgery performed in a Hospital emergency room or in a Physician's office.

Paralysis Benefit

The duration of the Paralysis must be a minimum of 3 consecutive months. Paid once per lifetime per Person.

Physical Therapy Benefit

Payable for one treatment per day for up to eight treatments by a caregiver licensed in physical therapy. This benefit is not payable for the same visit that the Accident Follow-up Treatment Benefit or Non-Emergency Follow-Up Benefit.

Prosthesis Benefit

Payable for the use of a Prosthesis. This benefit is not payable for hearing aids; dental aids; eyeglasses; false teeth; or for cosmetic aids such as wigs.

Tendons, Ligaments and Rotator Cuff Benefit

Payable for the repair of one or more tendons, ligaments, or rotator cuffs. The tendons, ligaments, or rotator cuff must be repaired through surgery.

Torn Knee Cartilage or Ruptured Disc Benefit

Payable for surgical repair.

Transportation Benefit

Payable for the transportation when specialized treatment and Hospital Confinement in a non-local Hospital is required. A non-local Hospital must be at least 50 miles away, one way, using the most direct route, from the closer of the Person's residence or site of the Accident. Travel must be by scheduled bus, plane, train, or by car. Ambulance service does not qualify for this benefit. The treatment must be prescribed by a Physician and not be available locally.

Wellness Benefit

After coverage is in force for the waiting period shown, you can receive a benefit for an annual routine physical exam, including immunizations and preventive testing. Services must be supervised by a Physician and a charge must be incurred for the service. The benefit does not apply to dental or eye exams and is payable once per policy per calendar year.

Limitations and Exclusions

Base Policy and Benefit Enhancement Rider

No benefits will be provided for an Accident that is caused by or occurs as a result of:

- (1) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
- (2) participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft;
- (3) any act that was caused by war, declared or undeclared, or service in any of the armed forces;
- (4) participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions;
- (5) participation in, or attempting to participate in, a felony, riot or insurrection. (A felony is as defined by the law of the jurisdiction in which the activity takes place.)
- (6) participation in any sport for pay or profit;
- (7) participation in any contest of speed in a power driven vehicle for pay or profit;
- (8) participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause. The policy will not pay benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or a 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.

You cannot be singled out for a rate increase for any reason. The Insurer has the right to change premium rates by class at the time of renewal of the policy. This is a brief description of the coverage. For additional benefits, limitations, exclusions and other provisions, please refer to the policy, AO-03, and Accident Only Benefit Enhancement Rider, AMDI-258TX.R613 Series, and AMDI388 Amendment Rider. This coverage does NOT replace Workers' Compensation Insurance. **This product is inappropriate for people who are eligible for Medicaid coverage.**

Accident Only Insurance Premiums

Monthly Premiums for Base Plan and Benefit Enhancement Rider

	Basic	Enhanced
Individual	\$19.90	\$26.10
Individual & Spouse	\$28.30	\$34.90
Individual & Child(ren)	\$31.50	\$41.00
Family	\$39.90	\$49.80

³The premium and amount of benefits provided vary based upon the plan selected.

Plan Options

» **Individual Plan**

The Insured, age 18 through 64, at the date of policy issue, is the only Person.

» **Individual and Lawful Spouse Plan**

Covers you and your Lawful Spouse (ages 18 to 64 at Policy Issue).

» **Individual and Child(ren) Plan**

Covers you (ages 18 to 64 at Policy Issue) and each Eligible Child, as defined in the policy.

» **Family Plan**

Covers you, your Lawful Spouse (ages 18 to 64 at Policy Issue) and each Eligible Child, as defined in the policy.

Underwritten and administered by:



Our Family, Dedicated To Yours.®

2000 N. Classen Boulevard • Oklahoma City, Oklahoma 73106 • 800-654-8489 • www.americanfidelity.com

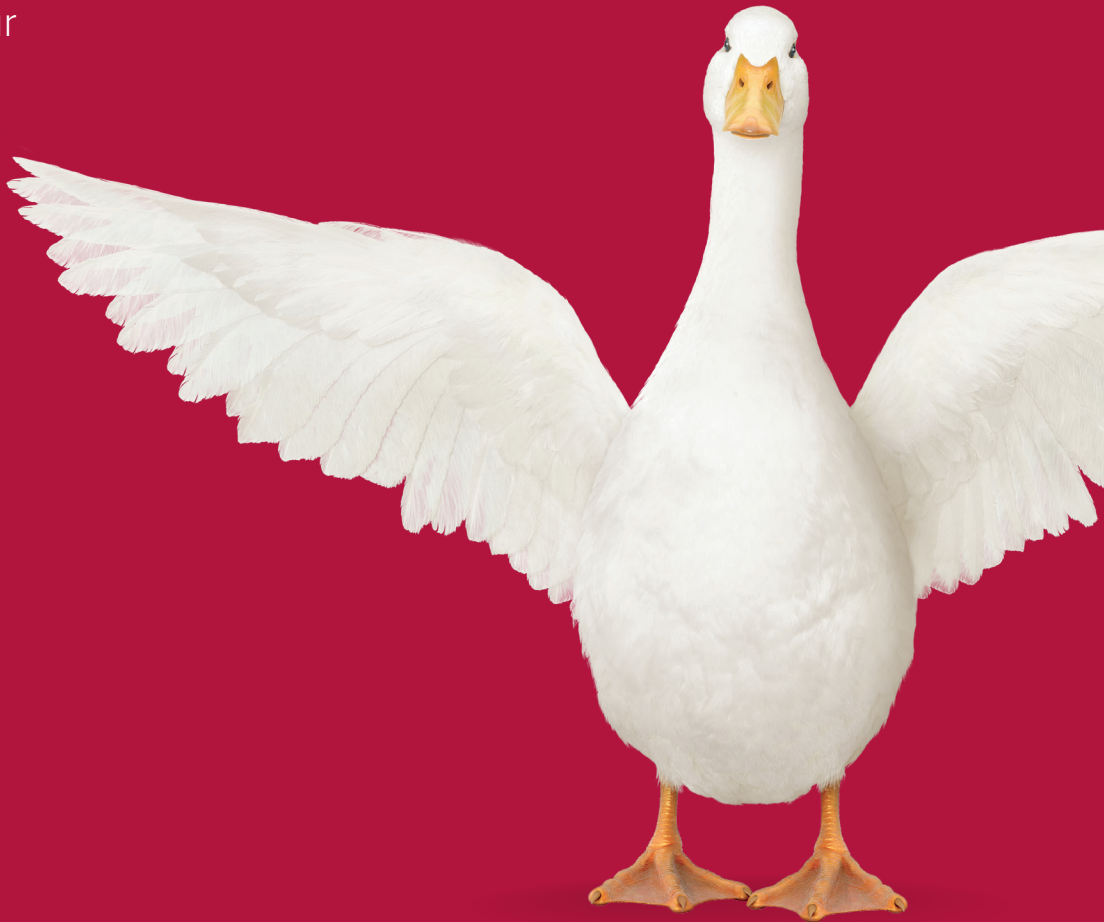
AFLAC

Critical Illness

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.



The plan does not contain comprehensive adult wellness benefits as defined by law.



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.

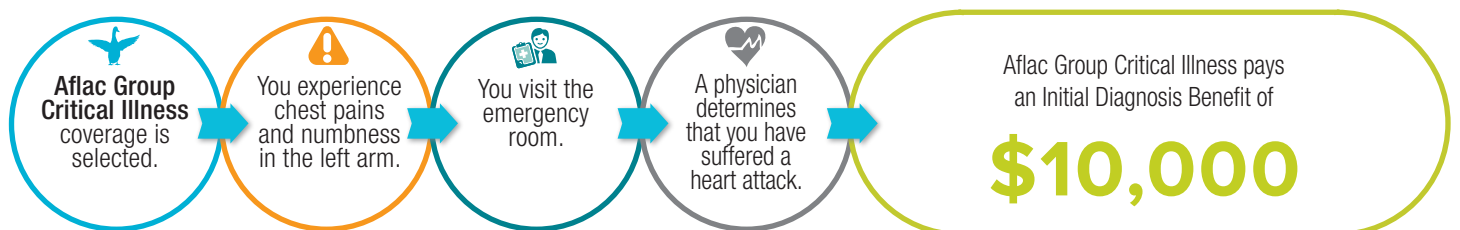
The Aflac Group Critical Illness plan benefits include:

- 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
 - Skin Cancer
 - Severe Burn
 - Coma
 - Paralysis
 - Loss of Sight
 - Loss of Hearing
 - Loss of 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%
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
<p>SKIN CANCER BENEFIT We will pay \$250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.</p>	

*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.

PROGRESSIVE DISEASE RIDER

AMYOTROPHIC LATERAL SCLEROSIS (ALS OR LOU GEHRIG'S DISEASE)	100%
SUSTAINED MULTIPLE SCLEROSIS	100%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

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%

We will pay the benefit shown if an insured is diagnosed with one of the diseases listed and the date of diagnosis is while the rider is in force.

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.

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 critical illness 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;
 - In Alaska: injuring or attempting to injure oneself intentionally
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
 - In Missouri: committing or attempting to commit suicide, while sane
 - In Illinois and Minnesota: this exclusion does not apply
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job:
 - In Arizona: participating in or attempting to commit a felony, or being engaged in an illegal occupation;
 - In Florida: participating or attempting to participate in an illegal activity, or

working at an illegal occupation;

- In Illinois and Pennsylvania: Illegal Occupation - committing or attempting to commit a felony or being engaged in an illegal occupation;
 - In Michigan: Illegal Occupation – the commission of or attempt to commit a felony, or being engaged in an illegal occupation;
 - In Nebraska: being engaged in an illegal occupation, or commission of or attempting to commit a felony;
 - In Ohio: committing or attempting to commit a felony, or working at an illegal job
 - **Participation in Aggressive Conflict:**
 - War (declared or undeclared) or military conflicts;
 - In Florida: War does not include acts of terrorism
 - In Oklahoma: War, or act of war, declared or undeclared when serving in the military service or an auxiliary unit thereto
 - 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
 - In Arizona: Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician
 - In Michigan, Nevada, and South Dakota: this exclusion does not apply
- 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 0.77mm,
- 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 0.77mm, 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
 - Clark's Level I or II,
- Squamous cell carcinoma of the skin
 - Breslow depth less than 0.77mm, or
- Melanoma in Situ
 - Stage 1A melanomas under TNM Staging
- Melanoma that is diagnosed as

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.

Civil Union: In Washington DC, Civil Union is defined as a relationship similar to marriage that is recognized by law. In Illinois, a Civil Union is defined as a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

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. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

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 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
- Hypoxia
- Optic nerve disease

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

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs. samples are taken for microscopic examination.
- 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).
- 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.
- 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).
- Skin Cancer: The date the skin biopsy
- Severe Burn: The date the burn takes place.
- 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).
- 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.
- 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.

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, (In Delaware, Illinois, Nevada, Oregon, or Washington DC - or a person who is in a legally recognized domestic partnership, civil union, or similar relationship with you), 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 (in Indiana, this includes children subject to legal guardianship).

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 (in Arkansas, chiefly 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 (in Indiana, 120 days) following the dependent child's 26th birthday.

- In South Dakota, this limit will not apply to any child who is incapable of self-sustaining employment and is chiefly dependent upon the insured for support and maintenance.
- In Texas, 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 and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.
- In New Mexico, coverage may be provided for the children of custodial and non-custodial parents.
- In Illinois, coverage of an unmarried dependent child who is under age 30 and who served in the military will not terminate if he/she is an Illinois resident, served as a member of the active or reserve components of any United States Armed Forces branch, and has received a release or discharge (other than a dishonorable discharge). To be eligible for coverage, the eligible dependent must submit to us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.
- In Louisiana, dependent children must be unmarried and may also include grandchildren who are in the legal custody of and residing with a grandparent. Regarding the Age 26 limit exception - we will not require proof of incapacity and dependency more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

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

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.
- In Montana, for purposes of treatment, you have full freedom of choice in the selection of any licensed physician,
- Physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, licensed social worker, psychologist, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse.
- In New Mexico, a doctor is also a practitioner of the healing arts.

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

- In South Dakota, a doctor who is your family member may treat you if that doctor is the only doctor in the area and acts within the scope of his or her practice.

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.

Domestic Partner:

- In Washington DC, 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.
- In Nevada, Domestic Partner is defined as a person who is party to a valid domestic

partnership, has not terminated that domestic partnership, and meets the requisites for a valid domestic partnership. In order to enter into a valid domestic partnership, it is necessary that the two persons register with the state of Nevada when it is established, by having previously furnished proof to the state of Nevada, that both persons have a common residence, neither person is married or a member of another domestic partnership, the two persons are not related by blood in a way that would prevent them from being married to each other in the state of Nevada, both persons are at least 18 years of age, and both persons are competent to consent to the domestic partnership.

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.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

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)
- Magnetic Resonance Imaging (MRI) images, or

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.
 - In Ohio, Unable to Work is defined as the inability to perform duties of any gainful occupation for which you are reasonably fitted by training, experience, and accomplishment.

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.

In Montana, Consultation is not considered treatment or medical treatment.

PROGRESSIVE DISEASE 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,
- Speech disturbances, or
- Loss of coordination,
- Visual disturbances.

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
- Contenance – 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.

CHILDHOOD CONDITIONS RIDER

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

No benefits will be paid for loss which occurred prior to the effective date of the plan.

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 DISEASE 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 Series C21000. In Arkansas, C21100AR. In Oklahoma, C21100OK. In Oregon, C21100OR. In Pennsylvania, C21100PA. In Texas, C21100TX.

AFLAC

Hospital Indemnity

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.



AFLAC GROUP HOSPITAL INDEMNITY

Policy Series C80000



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.

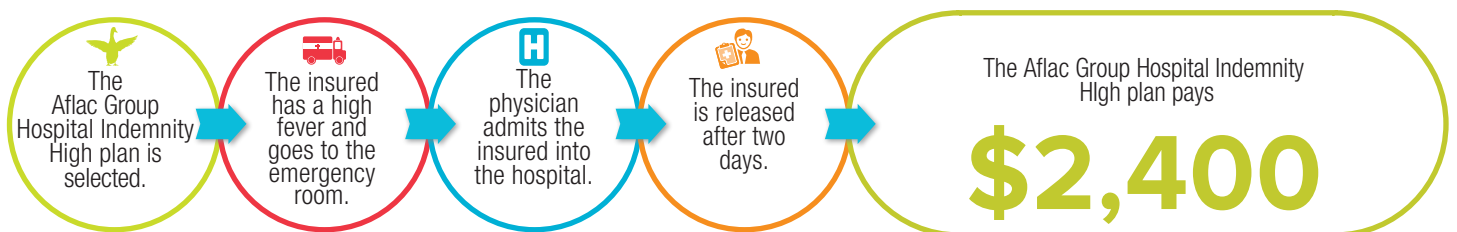
It provides financial assistance to enhance your current coverage. It may help avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from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

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Successor Insured Benefit



How it works



Amount payable was generated based on benefit amounts for: Hospital Admission (\$2,000), and Hospital Confinement (\$200 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

	HIGH	LOW
<p>HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured)</p> <p>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.</p> <p>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).</p>	\$2,000	\$1,000
<p>HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)</p> <p>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.</p> <p>This benefit is payable in addition to the Hospital Confinement Benefit.</p>	\$400	\$300
<p>HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured)</p> <p>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.</p>	\$200	\$150
<p>SUCCESSOR INSURED BENEFIT</p> <p>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.</p>		

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 (in Washington, twelve months).

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

(in Montana: 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 (except in Illinois).
 - In Connecticut: a riot is not excluded.
 - In Oklahoma: War, or any act of war, declared or undeclared, when serving in the military, armed forces, or an auxiliary unit thereto. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
 - In Missouri, Montana, and Vermont: committing or attempting to commit suicide, while sane.
 - In Minnesota: this exclusion does not apply.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
 - In Missouri: injuring or attempting to injure oneself intentionally which is obviously not an attempted suicide.
 - In Vermont: injuring or attempting to injure oneself intentionally, while sane.
- 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.
 - In Connecticut: voluntarily participating in, committing, or attempting to commit a felony.
 - In Illinois: committing or attempting to commit a felony or being engaged in an illegal occupation.
 - In Nebraska and Tennessee: voluntarily participating in, committing, or attempting to commit a felony or voluntarily working at, or being engaged in, an illegal occupation or job.
 - In Pennsylvania: committing or attempting to commit a felony, or being engaged in an illegal occupation.
 - In South Dakota: voluntarily committing a felony.
- 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.
 - In Arizona: this exclusion does not apply.

- In South Dakota: this exclusion does not apply.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
 - In Washington D.C. and Washington: Services related to 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.
 - In Tennessee, or if the pregnancy was the result of rape or incest, or if the fetus is non-viable.
- 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 dependent children, as defined in the applicable rider, who have been accepted for coverage. Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Dependent Children are your or your spouse'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. (In Florida, coverage may be provided for the children of custodial and non-custodial parents.) 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 (and in Louisiana, unmarried), however this limit will not apply to any insured dependent child who is incapable of self-sustaining employment due to mental 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.

In Montana: For purposes of treatment, the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, licensed social worker, psychologist, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse.

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, or brother. In Arizona, however, a doctor who is your family member may treat you. In South Dakota, however, a doctor who is your family member may treat you if that doctor is the only doctor in the area and acts within the scope of his or her practice.

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 (except in Vermont); 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 (In Maine, illness or disease of an insured). 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 (except in Montana).

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 (except in Kansas).

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

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

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Continental American Insurance Company • Columbia, South Carolina

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Benefits, terms, and conditions may vary by state.

This brochure is subject to the terms, conditions, and limitations of Policy Series C80000. In Arkansas, C80100AR. In Oklahoma, C80100OK. In Oregon, C80100OR. In Pennsylvania, C80100PA. In Texas, C80100TX. In Virginia, C80100VA.

AFA

Term Life



Term Life Monthly Rate Sheets

AMERICAN FIDELITY
a different opinion



ISSUE AGE	Premium										
	<i>Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (W/P). All riders are optional.</i>										
	Death Benefit										
	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
18	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
19	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
20	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
21	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
22	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
23	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
24	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
25	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
26	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
27	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
28	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
29	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
30	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
31	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
32	9.10	10.49	13.38	18.99	24.61	27.55	32.64	37.72	42.80	52.97	63.13
33	9.36	10.81	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
34	9.36	10.81	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
35	9.36	10.81	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
36	9.63	11.13	14.45	20.60	26.75	30.23	35.85	41.46	47.08	58.32	69.55
37	9.90	11.45	14.98	21.40	27.82	31.57	37.45	43.34	49.22	60.99	72.76
38	10.17	11.77	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
39	10.43	12.09	16.05	23.01	29.96	34.24	40.66	47.08	53.50	66.34	79.18
40	10.70	12.41	16.59	23.81	31.03	35.58	42.27	48.95	55.64	69.02	82.39
41	10.97	12.73	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
42	11.50	13.38	18.19	26.22	34.24	39.59	47.08	54.57	62.06	77.04	92.02
43	11.77	13.70	18.73	27.02	35.31	40.93	48.69	56.44	64.20	79.72	95.23
44	12.04	14.02	19.26	27.82	36.38	42.27	50.29	58.32	66.34	82.39	98.44
45	12.57	14.66	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
46	13.38	15.62	21.40	31.03	40.66	47.62	56.71	65.81	74.90	93.09	111.28
47	14.45	16.91	23.01	33.44	43.87	50.29	59.92	69.55	79.18	98.44	117.70
48	15.52	18.19	24.08	35.04	46.01	54.30	64.74	75.17	85.60	106.47	127.33
49	16.59	19.47	25.68	37.45	49.22	58.32	69.55	80.79	92.02	114.49	136.96
50	17.92	21.08	27.29	39.86	52.43	--	--	--	--	--	--
51	18.73	22.04	28.89	42.27	55.64	--	--	--	--	--	--
52	19.80	23.33	29.96	43.87	57.78	--	--	--	--	--	--
53	20.87	24.61	31.57	46.28	60.99	--	--	--	--	--	--
54	21.94	25.89	33.71	49.49	65.27	--	--	--	--	--	--
55	23.01	27.18	35.31	51.90	68.48	--	--	--	--	--	--
56	24.88	29.43	38.52	56.71	74.90	--	--	--	--	--	--
57	26.75	31.67	41.73	61.53	81.32	--	--	--	--	--	--
58	28.89	34.24	45.48	67.14	88.81	--	--	--	--	--	--
59	31.30	37.13	49.76	73.56	97.37	--	--	--	--	--	--
60	33.97	40.34	54.04	79.98	105.93	--	--	--	--	--	--
61	33.00	39.20	54.50	80.75	107.00	--	--	--	--	--	--
62	34.00	40.40	58.50	86.75	115.00	--	--	--	--	--	--
63	35.25	41.90	63.00	93.50	124.00	--	--	--	--	--	--
64	36.75	43.70	68.00	101.00	134.00	--	--	--	--	--	--
65	38.00	45.20	73.50	109.25	145.00	--	--	--	--	--	--

Spouse Coverage Available!

*This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. *Maximum face amount available is \$50,000.*

10 Year Term Tobacco Monthly Rates

ISSUE AGE	Premium										
	Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (WP). All riders are optional.										
	Death Benefit										
	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	10.97	12.73	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
18	10.97	12.73	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
19	10.97	12.73	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
20	10.97	12.73	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
21	10.97	12.73	17.66	25.41	33.17	36.92	43.87	50.83	57.78	71.69	85.60
22	10.97	12.73	18.19	26.22	34.24	36.92	43.87	50.83	57.78	71.69	85.60
23	10.97	12.73	18.19	26.22	34.24	36.92	43.87	50.83	57.78	71.69	85.60
24	10.97	12.73	18.73	27.02	35.31	36.92	43.87	50.83	57.78	71.69	85.60
25	10.97	12.73	19.26	27.82	36.38	36.92	43.87	50.83	57.78	71.69	85.60
26	10.97	12.73	19.80	28.62	37.45	36.92	43.87	50.83	57.78	71.69	85.60
27	11.24	13.05	19.80	28.62	37.45	36.92	43.87	50.83	57.78	71.69	85.60
28	11.24	13.05	20.33	29.43	38.52	38.25	45.48	52.70	59.92	74.37	88.81
29	11.50	13.38	20.33	29.43	38.52	38.25	45.48	52.70	59.92	74.37	88.81
30	11.50	13.38	20.87	30.23	39.59	38.25	45.48	52.70	59.92	74.37	88.81
31	11.77	13.70	21.40	31.03	40.66	39.59	47.08	54.57	62.06	77.04	92.02
32	12.31	14.34	22.47	32.64	42.80	40.93	48.69	56.44	64.20	79.72	95.23
33	12.57	14.66	23.01	33.44	43.87	42.27	50.29	58.32	66.34	82.39	98.44
34	12.84	14.98	23.54	34.24	44.94	44.94	53.50	62.06	70.62	87.74	104.86
35	13.38	15.62	24.61	35.85	47.08	46.28	55.11	63.93	72.76	90.42	108.07
36	14.18	16.59	25.68	37.45	49.22	50.29	59.92	69.55	79.18	98.44	117.70
37	14.98	17.55	27.29	39.86	52.43	54.30	64.74	75.17	85.60	106.47	127.33
38	15.78	18.51	28.89	42.27	55.64	58.32	69.55	80.79	92.02	114.49	136.96
39	16.59	19.47	30.50	44.67	58.85	63.67	75.97	88.28	100.58	125.19	149.80
40	17.66	20.76	32.10	47.08	62.06	69.02	82.39	95.77	109.14	135.89	162.64
41	18.99	22.36	34.78	51.09	67.41	71.69	85.60	99.51	113.42	141.24	169.06
42	20.33	23.97	37.45	55.11	72.76	75.70	90.42	105.13	119.84	149.27	178.69
43	21.67	25.57	40.66	59.92	79.18	78.38	93.63	108.87	124.12	154.62	185.11
44	23.27	27.50	44.41	65.54	86.67	82.39	98.44	114.49	130.54	162.64	194.74
45	25.15	29.75	48.15	71.16	94.16	86.40	103.26	120.11	136.96	170.67	204.37
46	27.82	32.96	49.76	73.56	97.37	89.08	106.47	123.85	141.24	176.02	210.79
47	31.03	36.81	51.36	75.97	100.58	93.09	111.28	129.47	147.66	184.04	220.42
48	34.78	41.30	52.97	78.38	103.79	97.10	116.10	135.09	154.08	192.07	230.05
49	38.79	46.12	54.57	80.79	107.00	101.12	120.91	140.71	160.50	200.09	239.68
50	43.34	51.57	56.18	83.19	110.21	--	--	--	--	--	--
51	45.48	54.14	60.99	90.42	119.84	--	--	--	--	--	--
52	47.88	57.03	66.34	98.44	130.54	--	--	--	--	--	--
53	50.56	60.24	71.69	106.47	141.24	--	--	--	--	--	--
54	52.97	63.13	78.11	116.10	154.08	--	--	--	--	--	--
55	55.91	66.66	85.07	126.53	167.99	--	--	--	--	--	--
56	62.60	74.69	94.16	140.17	186.18	--	--	--	--	--	--
57	70.09	83.67	103.79	154.62	205.44	--	--	--	--	--	--
58	78.38	93.63	115.03	171.47	227.91	--	--	--	--	--	--
59	88.01	105.18	127.87	190.73	253.59	--	--	--	--	--	--
60	98.98	118.34	141.78	211.59	281.41	--	--	--	--	--	--
61	92.75	110.90	141.50	211.25	281.00	--	--	--	--	--	--
62	93.25	111.50	151.50	226.25	301.00	--	--	--	--	--	--
63	93.50	111.80	162.50	242.75	323.00	--	--	--	--	--	--
64	94.00	112.40	174.00	260.00	346.00	--	--	--	--	--	--
65	94.25	112.70	186.50	278.75	371.00	--	--	--	--	--	--

Spouse Coverage Available¹

This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. ¹Maximum face amount available is \$50,000.

ISSUE AGE	Premium										
	Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (WP). All riders are optional.										
	Death Benefit										
	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
18	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
19	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
20	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
21	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
22	9.10	10.49	13.91	19.80	25.68	27.55	32.64	37.72	42.80	52.97	63.13
23	9.10	10.49	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
24	9.10	10.49	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
25	9.10	10.49	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
26	9.10	10.49	13.91	19.80	25.68	28.89	34.24	39.59	44.94	55.64	66.34
27	9.10	10.49	13.91	19.80	25.68	30.23	35.85	41.46	47.08	58.32	69.55
28	9.10	10.49	14.45	20.60	26.75	30.23	35.85	41.46	47.08	58.32	69.55
29	9.10	10.49	14.45	20.60	26.75	31.57	37.45	43.34	49.22	60.99	72.76
30	9.10	10.49	14.45	20.60	26.75	31.57	37.45	43.34	49.22	60.99	72.76
31	9.36	10.81	14.98	21.40	27.82	32.90	39.06	45.21	51.36	63.67	75.97
32	9.63	11.13	14.98	21.40	27.82	32.90	39.06	45.21	51.36	63.67	75.97
33	9.63	11.13	15.52	22.20	28.89	34.24	40.66	47.08	53.50	66.34	79.18
34	9.90	11.45	16.05	23.01	29.96	34.24	40.66	47.08	53.50	66.34	79.18
35	10.17	11.77	16.59	23.81	31.03	35.58	42.27	48.95	55.64	69.02	82.39
36	10.43	12.09	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
37	10.70	12.41	18.19	26.22	34.24	39.59	47.08	54.57	62.06	77.04	92.02
38	10.97	12.73	18.73	27.02	35.31	40.93	48.69	56.44	64.20	79.72	95.23
39	11.50	13.38	19.26	27.82	36.38	43.60	51.90	60.19	68.48	85.07	101.65
40	11.77	13.70	20.33	29.43	38.52	46.28	55.11	63.93	72.76	90.42	108.07
41	12.31	14.34	21.40	31.03	40.66	48.95	58.32	67.68	77.04	95.77	114.49
42	12.84	14.98	22.47	32.64	42.80	51.63	61.53	71.42	81.32	101.12	120.91
43	13.38	15.62	23.54	34.24	44.94	54.30	64.74	75.17	85.60	106.47	127.33
44	13.91	16.26	24.61	35.85	47.08	56.98	67.95	78.91	89.88	111.82	133.75
45	14.71	17.23	26.22	38.25	50.29	60.99	72.76	84.53	96.30	119.84	143.38
46	15.78	18.51	27.29	39.86	52.43	63.67	75.97	88.28	100.58	125.19	149.80
47	17.12	20.12	28.36	41.46	54.57	66.34	79.18	92.02	104.86	130.54	156.22
48	18.46	21.72	29.96	43.87	57.78	70.35	84.00	97.64	111.28	138.57	165.85
49	20.06	23.65	31.03	45.48	59.92	73.03	87.21	101.38	115.56	143.92	172.27
50	21.94	25.89	32.64	47.88	63.13	--	--	--	--	--	--
51	23.27	27.50	34.78	51.09	67.41	--	--	--	--	--	--
52	24.61	29.10	36.92	54.30	71.69	--	--	--	--	--	--
53	25.95	30.71	39.59	58.32	77.04	--	--	--	--	--	--
54	27.55	32.64	42.27	62.33	82.39	--	--	--	--	--	--
55	29.16	34.56	45.48	67.14	88.81	--	--	--	--	--	--
56	31.57	37.45	49.76	73.56	97.37	--	--	--	--	--	--
57	34.24	40.66	54.57	80.79	107.00	--	--	--	--	--	--
58	36.92	43.87	59.92	88.81	117.70	--	--	--	--	--	--
59	40.13	47.72	66.34	98.44	130.54	--	--	--	--	--	--
60	43.60	51.90	72.76	108.07	143.38	--	--	--	--	--	--

Spouse Coverage Available¹

This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. ¹Maximum face amount available is \$50,000.

ISSUE AGE

Premium											
Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (WP). All riders are optional.											
Death Benefit											
	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	11.50	13.38	17.66	25.41	33.17	38.25	45.48	52.70	59.92	74.37	88.81
18	11.50	13.38	17.66	25.41	33.17	38.25	45.48	52.70	59.92	74.37	88.81
19	11.50	13.38	17.66	25.41	33.17	38.25	45.48	52.70	59.92	74.37	88.81
20	11.50	13.38	17.66	25.41	33.17	38.25	45.48	52.70	59.92	74.37	88.81
21	11.50	13.38	18.19	26.22	34.24	38.25	45.48	52.70	59.92	74.37	88.81
22	11.50	13.38	18.73	27.02	35.31	39.59	47.08	54.57	62.06	77.04	92.02
23	11.50	13.38	18.73	27.02	35.31	39.59	47.08	54.57	62.06	77.04	92.02
24	11.50	13.38	19.26	27.82	36.38	40.93	48.69	56.44	64.20	79.72	95.23
25	11.50	13.38	19.80	28.62	37.45	40.93	48.69	56.44	64.20	79.72	95.23
26	11.77	13.70	20.33	29.43	38.52	42.27	50.29	58.32	66.34	82.39	98.44
27	12.04	14.02	20.87	30.23	39.59	43.60	51.90	60.19	68.48	85.07	101.65
28	12.04	14.02	21.40	31.03	40.66	43.60	51.90	60.19	68.48	85.07	101.65
29	12.31	14.34	21.94	31.83	41.73	44.94	53.50	62.06	70.62	87.74	104.86
30	12.57	14.66	22.47	32.64	42.80	46.28	55.11	63.93	72.76	90.42	108.07
31	13.11	15.30	23.54	34.24	44.94	47.62	56.71	65.81	74.90	93.09	111.28
32	13.91	16.26	25.15	36.65	48.15	50.29	59.92	69.55	79.18	98.44	117.70
33	14.45	16.91	26.22	38.25	50.29	52.97	63.13	73.30	83.46	103.79	124.12
34	15.25	17.87	27.82	40.66	53.50	54.30	64.74	75.17	85.60	106.47	127.33
35	16.05	18.83	29.43	43.07	56.71	56.98	67.95	78.91	89.88	111.82	133.75
36	17.12	20.12	31.57	46.28	60.99	60.99	72.76	84.53	96.30	119.84	143.38
37	18.19	21.40	33.71	49.49	65.27	66.34	79.18	92.02	104.86	130.54	156.22
38	19.53	23.01	36.38	53.50	70.62	70.35	84.00	97.64	111.28	138.57	165.85
39	20.87	24.61	39.06	57.51	75.97	75.70	90.42	105.13	119.84	149.27	178.69
40	22.20	26.22	42.27	62.33	82.39	82.39	98.44	114.49	130.54	162.64	194.74
41	23.81	28.14	45.48	67.14	88.81	90.42	108.07	125.73	143.38	178.69	214.00
42	25.68	30.39	49.22	72.76	96.30	101.12	120.91	140.71	160.50	200.09	239.68
43	27.82	32.96	53.50	79.18	104.86	111.82	133.75	155.69	177.62	221.49	265.36
44	30.23	35.85	57.78	85.60	113.42	123.85	148.20	172.54	196.88	245.57	294.25
45	32.64	38.73	62.60	92.82	123.05	137.23	164.25	191.26	218.28	272.32	326.35
46	35.85	42.59	65.27	96.84	128.40	143.92	172.27	200.63	228.98	285.69	342.40
47	39.32	46.76	67.95	100.85	133.75	150.60	180.30	209.99	239.68	299.07	358.45
48	43.07	51.25	71.16	105.66	140.17	158.63	189.93	221.22	252.52	315.12	377.71
49	47.35	56.39	74.37	110.48	146.59	166.65	199.56	232.46	265.36	331.17	396.97
50	52.16	62.17	77.58	115.29	153.01	--	--	--	--	--	--
51	55.91	66.66	83.46	124.12	164.78	--	--	--	--	--	--
52	59.65	71.16	89.88	133.75	177.62	--	--	--	--	--	--
53	63.93	76.29	96.30	143.38	190.46	--	--	--	--	--	--
54	68.48	81.75	103.79	154.62	205.44	--	--	--	--	--	--
55	73.30	87.53	111.82	166.65	221.49	--	--	--	--	--	--
56	80.79	96.51	120.38	179.49	238.61	--	--	--	--	--	--
57	89.08	106.47	130.01	193.94	257.87	--	--	--	--	--	--
58	98.17	117.38	140.17	209.19	278.20	--	--	--	--	--	--
59	108.34	129.58	151.41	226.04	300.67	--	--	--	--	--	--
60	119.84	143.38	163.71	244.50	325.28	--	--	--	--	--	--

Spouse Coverage Available¹

This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. ¹Maximum face amount available is \$50,000.

ISSUE AGE

Premium											
<i>Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (WP). All riders are optional.</i>											
Death Benefit											
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
18	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
19	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
20	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
21	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
22	5.14	9.63	15.52	22.20	28.89	32.90	39.06	45.21	51.36	63.67	75.97
23	5.24	9.90	16.05	23.01	29.96	34.24	40.66	47.08	53.50	66.34	79.18
24	5.24	9.90	16.05	23.01	29.96	34.24	40.66	47.08	53.50	66.34	79.18
25	5.24	9.90	16.05	23.01	29.96	34.24	40.66	47.08	53.50	66.34	79.18
26	5.24	9.90	16.05	23.01	29.96	35.58	42.27	48.95	55.64	69.02	82.39
27	5.35	10.17	16.59	23.81	31.03	35.58	42.27	48.95	55.64	69.02	82.39
28	5.35	10.17	16.59	23.81	31.03	36.92	43.87	50.83	57.78	71.69	85.60
29	5.46	10.43	17.12	24.61	32.10	36.92	43.87	50.83	57.78	71.69	85.60
30	5.46	10.43	17.12	24.61	32.10	38.25	45.48	52.70	59.92	74.37	88.81
31	5.56	10.70	17.66	25.41	33.17	39.59	47.08	54.57	62.06	77.04	92.02
32	5.67	10.97	18.19	26.22	34.24	39.59	47.08	54.57	62.06	77.04	92.02
33	5.67	10.97	18.19	26.22	34.24	40.93	48.69	56.44	64.20	79.72	95.23
34	5.78	11.24	18.73	27.02	35.31	40.93	48.69	56.44	64.20	79.72	95.23
35	5.89	11.50	19.26	27.82	36.38	42.27	50.29	58.32	66.34	82.39	98.44
36	6.10	12.04	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
37	6.31	12.57	21.40	31.03	40.66	47.62	56.71	65.81	74.90	93.09	111.28
38	6.53	13.11	22.47	32.64	42.80	50.29	59.92	69.55	79.18	98.44	117.70
39	6.74	13.64	23.54	34.24	44.94	52.97	63.13	73.30	83.46	103.79	124.12
40	7.06	14.45	25.15	36.65	48.15	56.98	67.95	78.91	89.88	111.82	133.75
41	7.38	15.25	26.75	39.06	51.36	60.99	72.76	84.53	96.30	119.84	143.38
42	7.81	16.32	28.89	42.27	55.64	66.34	79.18	92.02	104.86	130.54	156.22
43	8.24	17.39	30.50	44.67	58.85	70.35	84.00	97.64	111.28	138.57	165.85
44	8.67	18.46	33.17	48.69	64.20	75.70	90.42	105.13	119.84	149.27	178.69
45	9.20	19.80	35.31	51.90	68.48	82.39	98.44	114.49	130.54	162.64	194.74
46	9.74	21.13	37.99	55.91	73.83	89.08	106.47	123.85	141.24	176.02	210.79
47	10.27	22.47	40.66	59.92	79.18	95.77	114.49	133.22	151.94	189.39	226.84
48	10.81	23.81	43.87	64.74	85.60	103.79	124.12	144.45	164.78	205.44	246.10
49	11.45	25.41	47.62	70.35	93.09	113.15	135.36	157.56	179.76	224.17	268.57
50	12.20	27.29	51.36	75.97	100.58	--	--	--	--	--	--

Spouse Coverage Available!

*This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. *Maximum face amount available is \$50,000.*

ISSUE AGE	Premium										
	Includes Policy Fee, Accidental Death & Dismemberment Rider (AD&D) and Waiver of Premium Rider (WP). All riders are optional.										
	Death Benefit										
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$250,000	\$300,000
17	6.21	12.31	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
18	6.21	12.31	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
19	6.21	12.31	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
20	6.21	12.31	20.33	29.43	38.52	44.94	53.50	62.06	70.62	87.74	104.86
21	6.31	12.57	20.87	30.23	39.59	46.28	55.11	63.93	72.76	90.42	108.07
22	6.42	12.84	21.40	31.03	40.66	47.62	56.71	65.81	74.90	93.09	111.28
23	6.53	13.11	21.94	31.83	41.73	48.95	58.32	67.68	77.04	95.77	114.49
24	6.63	13.38	22.47	32.64	42.80	50.29	59.92	69.55	79.18	98.44	117.70
25	6.74	13.64	23.01	33.44	43.87	51.63	61.53	71.42	81.32	101.12	120.91
26	6.85	13.91	23.54	34.24	44.94	52.97	63.13	73.30	83.46	103.79	124.12
27	6.96	14.18	24.08	35.04	46.01	54.30	64.74	75.17	85.60	106.47	127.33
28	7.06	14.45	24.61	35.85	47.08	55.64	66.34	77.04	87.74	109.14	130.54
29	7.17	14.71	25.15	36.65	48.15	56.98	67.95	78.91	89.88	111.82	133.75
30	7.28	14.98	25.68	37.45	49.22	58.32	69.55	80.79	92.02	114.49	136.96
31	7.70	16.05	27.82	40.66	53.50	62.33	74.37	86.40	98.44	122.52	146.59
32	8.13	17.12	29.96	43.87	57.78	66.34	79.18	92.02	104.86	130.54	156.22
33	8.67	18.46	32.64	47.88	63.13	70.35	84.00	97.64	111.28	138.57	165.85
34	9.20	19.80	35.31	51.90	68.48	75.70	90.42	105.13	119.84	149.27	178.69
35	9.74	21.13	38.52	56.71	74.90	81.05	96.84	112.62	128.40	159.97	191.53
36	10.27	22.47	41.20	60.72	80.25	86.40	103.26	120.11	136.96	170.67	204.37
37	10.91	24.08	44.41	65.54	86.67	91.75	109.68	127.60	145.52	181.37	217.21
38	11.66	25.95	47.62	70.35	93.09	98.44	117.70	136.96	156.22	194.74	233.26
39	12.41	27.82	50.83	75.17	99.51	105.13	125.73	146.32	166.92	208.12	249.31
40	13.16	29.69	54.57	80.79	107.00	111.82	133.75	155.69	177.62	221.49	265.36
41	14.02	31.83	58.85	87.21	115.56	119.84	143.38	166.92	190.46	237.54	284.62
42	14.98	34.24	63.67	94.43	125.19	127.87	153.01	178.16	203.30	253.59	303.88
43	16.05	36.92	69.02	102.45	135.89	137.23	164.25	191.26	218.28	272.32	326.35
44	17.23	39.86	74.90	111.28	147.66	147.93	177.09	206.24	235.40	293.72	352.03
45	18.51	43.07	81.32	120.91	160.50	158.63	189.93	221.22	252.52	315.12	377.71
46	19.69	46.01	84.00	124.92	165.85	165.32	197.95	230.59	263.22	328.49	393.76
47	20.97	49.22	86.67	128.94	171.20	170.67	204.37	238.08	271.78	339.19	406.60
48	22.36	52.70	89.88	133.75	177.62	178.69	214.00	249.31	284.62	355.24	425.86
49	23.86	56.44	92.56	137.76	182.97	186.72	223.63	260.55	297.46	371.29	445.12
50	25.47	60.46	95.77	142.58	189.39	--	--	--	--	--	--

Spouse Coverage Available¹

This insert must be used in conjunction with SB-30357 and any state specific deviations thereof. The Waiver of Premium rider is available for issue ages 17-60. The Accidental Death and Dismemberment rider is available for issue ages 17-65. Additional optional benefit riders are available. Please contact your American Fidelity account manager for more details. This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. ¹Maximum face amount available is \$50,000.

Metlife

Term Life

Supplemental Term Life



MetLife

Plan Design for: Marshall Independent School District

Date Prepared: 01/01/2019

For All Active Full-Time Employees working at least 20 hours per week

Build Your Benefit With MetLife's Supplemental Term Life insurance, your employer gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse and your dependent children -- all at affordable group rates.

	Employee	Spouse & Child	
		Spouse ¹	Child
Life Coverage: provides a benefit in the event of death Schedules:	Increments of \$10,000	Increments of \$5,000	Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000
Non Medical Maximum	\$150,000	\$25,000	\$10,000
Overall Benefit Maximum	The lesser of 5 times Your Basic Annual Earnings, or \$500,000	\$500,000	\$10,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)
AD&D Maximum	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage
Employee Contribution	100%	100%	100%

Any purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of MetLife.

To request coverage:

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart below.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart below.
Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown below.
5. Fill in the enrollment form with the amounts of coverage you are selecting. (To request coverage over the non-medical maximum, please see your Human Resources representative for a medical questionnaire that you will need to complete.) Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse or children.

Employee Age	Employee & Spouse Coverage -- Monthly Premium For:						
	\$1,000	\$10,000	\$20,000	\$40,000	\$50,000	\$100,000	
Under 30	\$0.08	\$0.80	\$1.60	\$3.20	\$4.00	\$8.00	
30-34	\$0.09	\$0.90	\$1.80	\$3.60	\$4.50	\$9.00	
35-39	\$0.10	\$1.00	\$2.00	\$4.00	\$5.00	\$10.00	
40-44	\$0.15	\$1.50	\$3.00	\$6.00	\$7.50	\$15.00	
45-49	\$0.20	\$2.00	\$4.00	\$8.00	\$10.00	\$20.00	
50-54	\$0.33	\$3.30	\$6.60	\$13.20	\$16.50	\$33.00	
55-59	\$0.54	\$5.40	\$10.80	\$21.60	\$27.00	\$54.00	
60-64	\$0.82	\$8.20	\$16.40	\$32.80	\$41.00	\$82.00	
65-69	\$1.36	\$13.60	\$27.20	\$54.40	\$68.00	\$136.00	
70+	\$2.15	\$21.50	\$43.00	\$86.00	\$107.50	\$215.00	

Dependent Child Coverage ² Monthly Premium For:	
\$1,000	\$0.18
\$2,000	\$0.36
\$4,000	\$0.73
\$5,000	\$0.91
\$10,000	\$1.82

Due to rounding, your actual payroll deduction amount may vary slightly.

Features available with Supplemental Life

Grief Counseling³: You, your dependents, and your beneficiaries access to grief counseling sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet.³ In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-1-888-319-7819 or log on to www.metlifegc.lifeworks.com (Username: metlifearranger; Password: support).

Funeral Discounts and Planning Services⁴: As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using a Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you and your family in making confident decisions when planning ahead as well as bereavement travel services - available 24 hours, 7 days a week, 365 days a year - to assist with time-sensitive travel arrangements to be with loved ones.

Will Preparation⁵: Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have in person access to Hyatt Legal Plans' network of 14,000+ participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney. To obtain the legal plan's toll-free number and your company's group access number, contact your employer or your plan administrator for this information.

MetLife Estate Resolution Services (ERS)⁵: is a valuable service offered under the group policy. A Hyatt Legal Plan attorney will consult with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator.. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

Portability⁶: If your present employment ends, you can choose to continue your current life benefits.

What Is Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally

sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99 or G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases, when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the certificate.

If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

1. Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit.
2. Child benefits for children under 6 months old are limited.
3. Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
4. Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.
5. Will Preparation and MetLife Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Will Preparation and Estate Resolution Services are subject to regulatory approval and currently available in all states. For New York sitused cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Please note that certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.
6. Subject to state availability. To take advantage of this benefit, coverage of at least \$20,000 must be elected.

Texas Life

LIFE INSURANCE HIGHLIGHTS

For the employee

*Flexible Premium Life Insurance to Age 121
Policy Form PRFNG-NI-10*

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. This voluntary 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, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually cost more and decline in death benefit.

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

- **High Death Benefit.** With one of the highest death benefits available at the worksite,¹ PURELIFE-plus gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.
- **Refund of Premium.** Unique in the marketplace, PURELIFE-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy 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 in most states. This valuable living benefit gives 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 ICCo7-ULABR-07 or Form Series ULABR-07)*
- **Accelerated Death Benefit for Chronic Illness Rider.** Included for employees at a small extra cost, this rider will be triggered by the loss of two activities of daily living² or permanent cognitive impairment. It pays the insured 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)*

(over)



TEXASLIFE

INSURANCE COMPANY

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

See the PURELIFE-plus brochure for details.

PURELIFE-plus is not available in NJ, NY or PA.

Additional Features

- **Minimal Cash Value.** Designed to provide a high death benefit at a reasonable premium, PURELIFE-plus provides 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.**³ Enjoy the assurance of a policy 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).



You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse/domestic partner, children and grandchildren by answering just 3 questions:⁴

During the last six months, has the proposed insured:

- a. Been actively at work on a full time basis, performing usual duties?
- b. Been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- c. 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 therapy, dialysis treatment, or treatment for alcohol or drug abuse?

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative for costs and complete details.

¹ Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2012

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: (1) short or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning.

³ Guarantees are subject to product terms, exclusions and limitations and the insurer's claims-paying ability and financial strength.

⁴ Coverage and spouse/domestic partner eligibility may vary by state. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships. Coverage not available on children and grandchildren in Washington.

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
15D-10		8.38	15.25							75
11-16		8.65	15.80							70
17-20		10.65	19.80	28.95	38.10	56.40	74.70	93.00	111.30	66
21		10.93	20.35	29.78	39.20	58.05	76.90	95.75	114.60	66
22		10.93	20.35	29.78	39.20	58.05	76.90	95.75	114.60	65
23-25		11.20	20.90	30.60	40.30	59.70	79.10	98.50	117.90	63
26		11.48	21.45	31.43	41.40	61.35	81.30	101.25	121.20	63
27		11.75	22.00	32.25	42.50	63.00	83.50	104.00	124.50	63
28		11.75	22.00	32.25	42.50	63.00	83.50	104.00	124.50	62
29		12.03	22.55	33.08	43.60	64.65	85.70	106.75	127.80	62
30-31		12.30	23.10	33.90	44.70	66.30	87.90	109.50	131.10	60
32		12.85	24.20	35.55	46.90	69.60	92.30	115.00	137.70	61
33		13.40	25.30	37.20	49.10	72.90	96.70	120.50	144.30	62
34		13.95	26.40	38.85	51.30	76.20	101.10	126.00	150.90	62
35		14.78	28.05	41.33	54.60	81.15	107.70	134.25	160.80	64
36		15.33	29.15	42.98	56.80	84.45	112.10	139.75	167.40	64
37		15.88	30.25	44.63	59.00	87.75	116.50	145.25	174.00	64
38		16.70	31.90	47.10	62.30	92.70	123.10	153.50	183.90	65
39		17.80	34.10	50.40	66.70	99.30	131.90	164.50	197.10	66
40	8.46	18.90	36.30	53.70	71.10	105.90	140.70	175.50	210.30	67
41	9.01	20.28	39.05	57.83	76.60	114.15	151.70	189.25	226.80	68
42	9.78	22.20	42.90	63.60	84.30	125.70	167.10	208.50	249.90	70
43	10.55	24.13	46.75	69.38	92.00	137.25	182.50	227.75	273.00	72
44	11.32	26.05	50.60	75.15	99.70	148.80	197.90	247.00	296.10	73
45	12.20	28.25	55.00	81.75	108.50	162.00	215.50	269.00	322.50	74
46	13.08	30.45	59.40	88.35	117.30	175.20	233.10	291.00	348.90	75
47	13.85	32.38	63.25	94.13	125.00	186.75	248.50	310.25	372.00	76
48	14.73	34.58	67.65	100.73	133.80	199.95	266.10	332.25	398.40	77
49	15.72	37.05	72.60	108.15	143.70	214.80	285.90	357.00	428.10	78
50	16.93	40.08	78.65	117.23	155.80					79
51	18.36	43.65	85.80	127.95	170.10					80
52	20.12	48.05	94.60	141.15	187.70					82
53	21.88	52.45	103.40	154.35	205.30					83
54	23.64	56.85	112.20	167.55	222.90					85
55	25.18	60.70	119.90	179.10	238.30					86
56	26.28	63.45	125.40	187.35	249.30					85
57	27.05	65.38	129.25	193.13	257.00					84
58	27.93	67.58	133.65	199.73	265.80					84
59	29.03	70.33	139.15	207.98	276.80					84
60	29.88	72.45	143.40	214.35	285.30					84
61	32.41	78.78	156.05	233.33	310.60					85
62	35.49	86.48	171.45	256.43	341.40					87
63	38.90	95.00	188.50	282.00	375.50					89
64	43.41	106.28	211.05	315.83	420.60					93
65	46.60	114.25	227.00	339.75	452.50					94
66	49.68									95
67	52.43									96
68	55.29									96
69	58.37									96
70	61.67									95

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".

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
15D-10										75
11-16		8.65	15.80							70
17-20		15.33	29.15	42.98	56.80	84.45	112.10	139.75	167.40	66
21		15.88	30.25	44.63	59.00	87.75	116.50	145.25	174.00	66
22		15.88	30.25	44.63	59.00	87.75	116.50	145.25	174.00	65
23-25		16.70	31.90	47.10	62.30	92.70	123.10	153.50	183.90	63
26		16.98	32.45	47.93	63.40	94.35	125.30	156.25	187.20	63
27		17.25	33.00	48.75	64.50	96.00	127.50	159.00	190.50	63
28		17.53	33.55	49.58	65.60	97.65	129.70	161.75	193.80	62
29		17.80	34.10	50.40	66.70	99.30	131.90	164.50	197.10	62
30-31		20.00	38.50	57.00	75.50	112.50	149.50	186.50	223.50	60
32		20.55	39.60	58.65	77.70	115.80	153.90	192.00	230.10	61
33		20.83	40.15	59.48	78.80	117.45	156.10	194.75	233.40	62
34		21.10	40.70	60.30	79.90	119.10	158.30	197.50	236.70	62
35		22.48	43.45	64.43	85.40	127.35	169.30	211.25	253.20	64
36		23.30	45.10	66.90	88.70	132.30	175.90	219.50	263.10	64
37		24.68	47.85	71.03	94.20	140.55	186.90	233.25	279.60	64
38		25.50	49.50	73.50	97.50	145.50	193.50	241.50	289.50	65
39		27.15	52.80	78.45	104.10	155.40	206.70	258.00	309.30	66
40	12.75	29.63	57.75	85.88	114.00	170.25	226.50	282.75	339.00	67
41	13.52	31.55	61.60	91.65	121.70	181.80	241.90	302.00	362.10	68
42	14.51	34.03	66.55	99.08	131.60	196.65	261.70	326.75	391.80	70
43	16.05	37.88	74.25	110.63	147.00	219.75	292.50	365.25	438.00	72
44	16.93	40.08	78.65	117.23	155.80	232.95	310.10	387.25	464.40	73
45	18.14	43.10	84.70	126.30	167.90	251.10	334.30	417.50	500.70	74
46	19.24	45.85	90.20	134.55	178.90	267.60	356.30	445.00	533.70	75
47	20.34	48.60	95.70	142.80	189.90	284.10	378.30	472.50	566.70	76
48	21.44	51.35	101.20	151.05	200.90	300.60	400.30	500.00	599.70	77
49	23.20	55.75	110.00	164.25	218.50	327.00	435.50	544.00	652.50	78
50	24.41	58.78	116.05	173.33	230.60					79
51	26.28	63.45	125.40	187.35	249.30					80
52	28.59	69.23	136.95	204.68	272.40					82
53	30.46	73.90	146.30	218.70	291.10					83
54	32.77	79.68	157.85	236.03	314.20					85
55	34.42	83.80	166.10	248.40	330.70					86
56	35.85	87.38	173.25	259.13	345.00					85
57	36.95	90.13	178.75	267.38	356.00					84
58	38.93	95.08	188.65	282.23	375.80					84
59	40.58	99.20	196.90	294.60	392.30					84
60	41.76	102.15	202.80	303.45	404.10					84
61	44.62	109.30	217.10	324.90	432.70					85
62	48.25	118.38	235.25	352.13	469.00					87
63	51.99	127.73	253.95	380.18	506.40					89
64	56.06	137.90	274.30	410.70	547.10					93
65	58.81	144.78	288.05	431.33	574.60					94
66	61.89									95
67	64.97									96
68	68.38									96
69	71.90									96
70	75.75									95

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".

TEXASLIFE INSURANCE COMPANY SPOUSE/CHILD MONTHLY PREMIUMS

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	Includes Added Cost for Accidental Death Benefit (Ages 17-59)									
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
15D-10		7.75	14.00							75
11-16		8.00	14.50							70
17-20		10.00	18.50	27.00	35.50	52.50	69.50	86.50	103.50	66
21		10.25	19.00	27.75	36.50	54.00	71.50	89.00	106.50	66
22		10.25	19.00	27.75	36.50	54.00	71.50	89.00	106.50	65
23-25		10.50	19.50	28.50	37.50	55.50	73.50	91.50	109.50	63
26		10.75	20.00	29.25	38.50	57.00	75.50	94.00	112.50	63
27		11.00	20.50	30.00	39.50	58.50	77.50	96.50	115.50	63
28		11.00	20.50	30.00	39.50	58.50	77.50	96.50	115.50	62
29		11.25	21.00	30.75	40.50	60.00	79.50	99.00	118.50	62
30-31		11.50	21.50	31.50	41.50	61.50	81.50	101.50	121.50	60
32		12.00	22.50	33.00	43.50	64.50	85.50	106.50	127.50	61
33		12.50	23.50	34.50	45.50	67.50	89.50	111.50	133.50	62
34		13.00	24.50	36.00	47.50	70.50	93.50	116.50	139.50	62
35		13.75	26.00	38.25	50.50	75.00	99.50	124.00	148.50	64
36		14.25	27.00	39.75	52.50	78.00	103.50	129.00	154.50	64
37		14.75	28.00	41.25	54.50	81.00	107.50	134.00	160.50	64
38		15.50	29.50	43.50	57.50	85.50	113.50	141.50	169.50	65
39		16.50	31.50	46.50	61.50	91.50	121.50	151.50	181.50	66
40	7.90	17.50	33.50	49.50	65.50	97.50	129.50	161.50	193.50	67
41	8.40	18.75	36.00	53.25	70.50	105.00	139.50	174.00	208.50	68
42	9.10	20.50	39.50	58.50	77.50	115.50	153.50	191.50	229.50	70
43	9.80	22.25	43.00	63.75	84.50	126.00	167.50	209.00	250.50	72
44	10.50	24.00	46.50	69.00	91.50	136.50	181.50	226.50	271.50	73
45	11.30	26.00	50.50	75.00	99.50	148.50	197.50	246.50	295.50	74
46	12.10	28.00	54.50	81.00	107.50	160.50	213.50	266.50	319.50	75
47	12.80	29.75	58.00	86.25	114.50	171.00	227.50	284.00	340.50	76
48	13.60	31.75	62.00	92.25	122.50	183.00	243.50	304.00	364.50	77
49	14.50	34.00	66.50	99.00	131.50	196.50	261.50	326.50	391.50	78
50	15.60	36.75	72.00	107.25	142.50					79
51	16.90	40.00	78.50	117.00	155.50					80
52	18.50	44.00	86.50	129.00	171.50					82
53	20.10	48.00	94.50	141.00	187.50					83
54	21.70	52.00	102.50	153.00	203.50					85
55	23.10	55.50	109.50	163.50	217.50					86
56	24.10	58.00	114.50	171.00	227.50					85
57	24.80	59.75	118.00	176.25	234.50					84
58	25.60	61.75	122.00	182.25	242.50					84
59	26.60	64.25	127.00	189.75	252.50					84
60	27.30	66.00	130.50	195.00	259.50					84
61	29.60	71.75	142.00	212.25	282.50					85
62	32.40	78.75	156.00	233.25	310.50					87
63	35.50	86.50	171.50	256.50	341.50					89
64	39.60	96.75	192.00	287.25	382.50					93
65	42.50	104.00	206.50	309.00	411.50					94
66	45.30									95
67	47.80									96
68	50.40									96
69	53.20									96
70	56.20									95

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".

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	Includes Added Cost for Accidental Death Benefit (Ages 17-59)									
	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	
15D-10										75
11-16		8.00	14.50							70
17-20		14.25	27.00	39.75	52.50	78.00	103.50	129.00	154.50	66
21		14.75	28.00	41.25	54.50	81.00	107.50	134.00	160.50	66
22		14.75	28.00	41.25	54.50	81.00	107.50	134.00	160.50	65
23-25		15.50	29.50	43.50	57.50	85.50	113.50	141.50	169.50	63
26		15.75	30.00	44.25	58.50	87.00	115.50	144.00	172.50	63
27		16.00	30.50	45.00	59.50	88.50	117.50	146.50	175.50	63
28		16.25	31.00	45.75	60.50	90.00	119.50	149.00	178.50	62
29		16.50	31.50	46.50	61.50	91.50	121.50	151.50	181.50	62
30-31		18.50	35.50	52.50	69.50	103.50	137.50	171.50	205.50	60
32		19.00	36.50	54.00	71.50	106.50	141.50	176.50	211.50	61
33		19.25	37.00	54.75	72.50	108.00	143.50	179.00	214.50	62
34		19.50	37.50	55.50	73.50	109.50	145.50	181.50	217.50	62
35		20.75	40.00	59.25	78.50	117.00	155.50	194.00	232.50	64
36		21.50	41.50	61.50	81.50	121.50	161.50	201.50	241.50	64
37		22.75	44.00	65.25	86.50	129.00	171.50	214.00	256.50	64
38		23.50	45.50	67.50	89.50	133.50	177.50	221.50	265.50	65
39		25.00	48.50	72.00	95.50	142.50	189.50	236.50	283.50	66
40	11.80	27.25	53.00	78.75	104.50	156.00	207.50	259.00	310.50	67
41	12.50	29.00	56.50	84.00	111.50	166.50	221.50	276.50	331.50	68
42	13.40	31.25	61.00	90.75	120.50	180.00	239.50	299.00	358.50	70
43	14.80	34.75	68.00	101.25	134.50	201.00	267.50	334.00	400.50	72
44	15.60	36.75	72.00	107.25	142.50	213.00	283.50	354.00	424.50	73
45	16.70	39.50	77.50	115.50	153.50	229.50	305.50	381.50	457.50	74
46	17.70	42.00	82.50	123.00	163.50	244.50	325.50	406.50	487.50	75
47	18.70	44.50	87.50	130.50	173.50	259.50	345.50	431.50	517.50	76
48	19.70	47.00	92.50	138.00	183.50	274.50	365.50	456.50	547.50	77
49	21.30	51.00	100.50	150.00	199.50	298.50	397.50	496.50	595.50	78
50	22.40	53.75	106.00	158.25	210.50					79
51	24.10	58.00	114.50	171.00	227.50					80
52	26.20	63.25	125.00	186.75	248.50					82
53	27.90	67.50	133.50	199.50	265.50					83
54	30.00	72.75	144.00	215.25	286.50					85
55	31.50	76.50	151.50	226.50	301.50					86
56	32.80	79.75	158.00	236.25	314.50					85
57	33.80	82.25	163.00	243.75	324.50					84
58	35.60	86.75	172.00	257.25	342.50					84
59	37.10	90.50	179.50	268.50	357.50					84
60	38.10	93.00	184.50	276.00	367.50					84
61	40.70	99.50	197.50	295.50	393.50					85
62	44.00	107.75	214.00	320.25	426.50					87
63	47.40	116.25	231.00	345.75	460.50					89
64	51.10	125.50	249.50	373.50	497.50					93
65	53.60	131.75	262.00	392.25	522.50					94
66	56.40									95
67	59.20									96
68	62.30									96
69	65.50									96
70	69.00									95

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".

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