City of Cedar Park 2025-2026

Benefits Guide

CEDAR PARK
TEXAS

IFFGA
Benefit Solutions *Simplified*

City of Cedar Park
Human Resources
HR@cedarparktexas.gov
512-401-5000

SCAN ME

https://ffbenefits.ffga.com/cityofcedarpark

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.

Employee Benefits Center

A guide to your benefits!

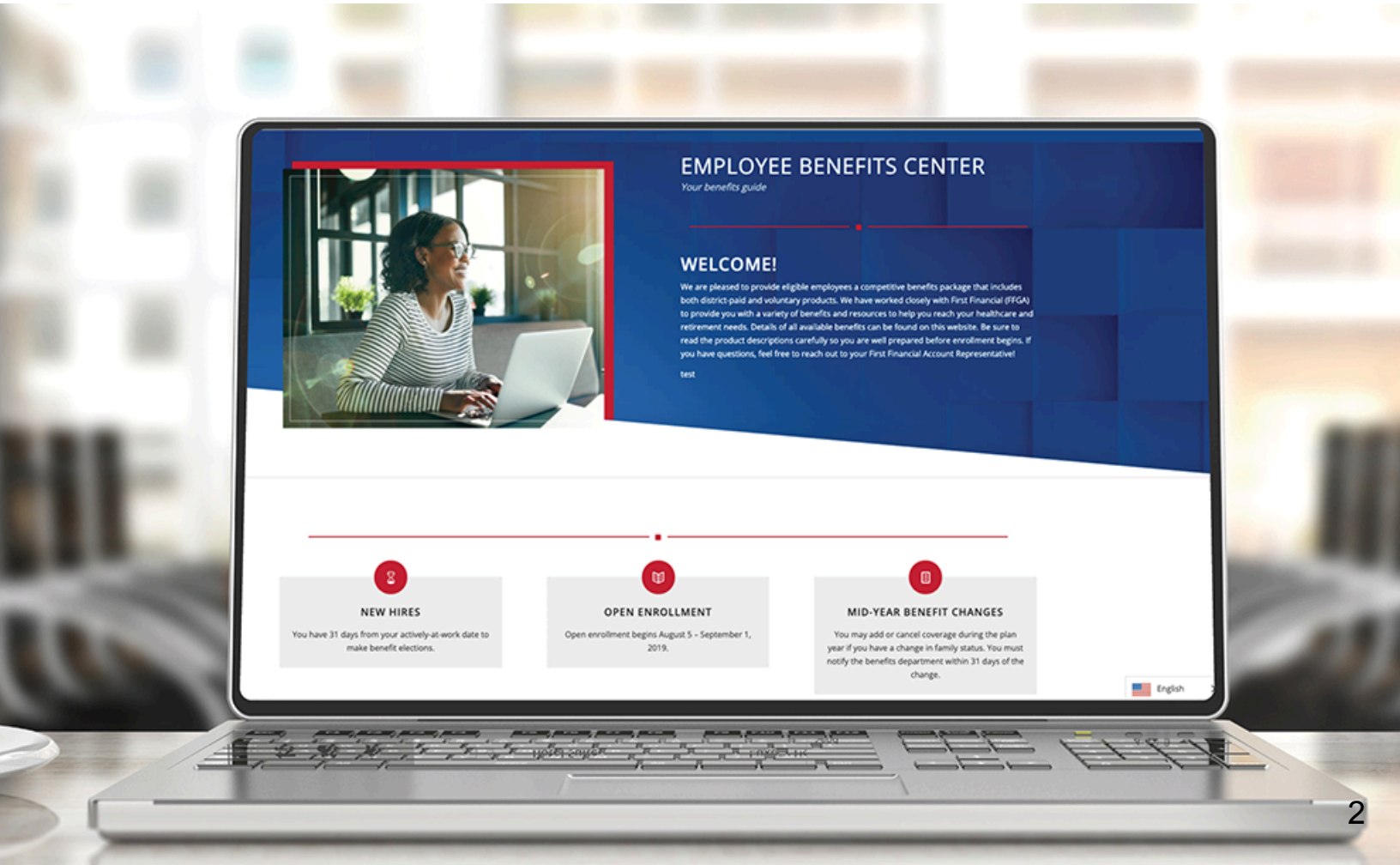
City of Cedar Park and FFGA are excited to provide you with a custom website filled with information about your benefits. Visit the Employee Benefits Center to see current benefit options for your employer as well as find claim forms, important phone numbers and enrollment information.

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

SCAN ME!

Scan the QR code to learn more about the plans that are available this year!

https://ffbenefits.ffga.com/cityofcedarpark



How to Enroll
Benefits Enrollment

On-Site Enrollment
When it's time to enroll in your benefits, your FFGA Account Representative will be on-site to assist you with making your elections. Visit your EBC for more information.

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

Enroll Now

Login & PIN
- Employee ID
  - The Employee ID is either your social security number or your Employee ID.
- PIN
  - Instructions to access your initial Personal Identification Number (PIN) will be provided to you prior to open enrollment.
  - Upon initial login, the PIN will be required to be changed.
  - Remember your PIN as you will use this to sign your enrollment confirmation form and to login in the future.

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

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

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

Benefit Eligibility & Coverage

Employee Coverage

Eligibility

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

New Employees

You have 31 days from your date of hire to make benefit elections. Insurance coverage becomes effective on the first day of the month following a 30-calendar day waiting period, after the date of hire.

Existing Employees

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

Mid-year Benefit Changes

You may add or cancel coverage during the plan year if you have a qualifying life change event. You must notify the Human Resources department within 31 days of the change.

Qualifying Life Events Include:

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

Declining Coverage

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

Section 125 Plans

Section 125 Plan Information & Rules

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

Here's How It Works

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

Is It Right For Me?

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

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

IRS specified changes in family status include:

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

Section 125 Plan Sample Paycheck		
	Without S125	With S125
Monthly Salary	$2,000	$2,000
Less Medical Deductions	-N/A	-$250
Tax Gross Income	$2,000	$1,750
Less Taxes (Fed/State at 20%)	-$400	-$350
Less Medicare (1.45%)	-$29	-$25
Less Medical Deductions	-$250	-N/A
Take Home Pay	$1,321	$1375

You could save $54 per month in taxes by paying for your benefits on a pre-tax basis!

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

Medical - United Healthcare

United Health Care | www.myuhc.com | 866-663-2446

Medical Semi-Monthly Premiums			
	HDHP	Silver PPO	Gold PPO
Employee Only	$10.00	$20.00	$50.00
Employee + Spouse	$100.00	$175.00	$250.00
Employee + Children	$87.50	$127.50	$190.00
Employee + Family	$240.00	$335.00	$405.00

UnitedHealthcare

HSA Choice Plus Base HDHP Plan

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-314-0335 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,500** Individual / **$7,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$5,250** Individual / **$10,500** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover any penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-314-0335 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Virtual Visits - $0 copay by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: 20% coinsurance Mail-Order: 20% coinsurance	Retail: 50% coinsurance	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit.
	Tier 2 - Your Mid-Range Cost Option	Retail: 20% coinsurance Mail-Order: 20% coinsurance	Retail: 50% coinsurance	
	Tier 3 - Your Mid-Range Cost Option	Retail: 20% coinsurance Mail-Order: 20% coinsurance	Retail: 50% coinsurance	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Network All Other: 0% coinsurance. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limits per calendar year: Physical/Occupational/ Speech/Cognitive: combined limit 100 visits; Cardiac, Pulmonary: Unlimited.
	Habilitative services	No Charge	50% coinsurance	None.
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or no coverage.
	Hospice services	0% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care (Adult & Child
- Routine foot care - Except as covered for Diabetes
- Weight loss programs – Except for required preventive services and Real Appeal.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits per calendar year
- Chiropractic (manipulative) care – 35 visits per calendar year
- Hearing aids - 1 hearing aid per ear, every 36 months. $2,500 limit every 36 months.
- Infertility services/treatment – Limited to the diagnosis & treatment of underlying medical condition.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare

Choice Plus Siver PPO Plan

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500** Individual / **$3,000** Family Out-of-Network: **$6,000** Individual / **$18,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,800** Individual / **$13,100** Family Out-of-Network: **$12,000** Individual / **$24,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit, deductible does not apply	50% coinsurance	Virtual Visits - $0 copay per visit by a Designated Virtual Network Provider, deductible does not apply. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$50 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: No Charge Mail-Order: No Charge Specialty Retail: $250 copay, deductible does not apply.	Retail: No Charge up to 50% coinsurance, deductible does not apply. Specialty Retail: Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply. Mail-Order: $90 copay, deductible does not apply. Specialty Retail: $250 copay, deductible does not apply.	Retail: $45 copay then 50% coinsurance Specialty Retail: Not covered	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply. Specialty Retail: $250 copay, deductible does not apply.	Retail: $75 copay then 50% coinsurance Specialty Retail: Not covered	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$400 copay per visit, then 20% coinsurance	*$400 copay per visit, then 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$75 copay per visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Network All Other: No Charge. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$50 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical/Occupational/ Speech/Cognitive: combined limit 100 visits; Cardiac, Pulmonary: Unlimited.
	Habilitative services	No Charge	50% coinsurance	None.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or no coverage.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the US
- Private duty nursing
- Routine Eye Care (Adult & Child)
- Routine foot care - Except as covered for Diabetes
- Weight loss programs – Except for required preventive services and Real Appeal.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits per calendar year for disease, injury & chronic pain.
- Chiropractic care – 35 visits per calendar year
- Hearing aids – 1 hearing aid per ear, every 36 months. $2,500 limit every 36 months.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare

Choice Plus Gold PPO Plan

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual / **$2,000** Family Out-of-Network: **$4,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,500** Individual / **$13,000** Family Out-of-Network: **$12,000** Individual / **$24,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply	50% coinsurance	Virtual Visits - $0 copay per visit by a Designated Virtual Network Provider, deductible does not apply. Office Visit cost share applies to any other Telehealth service based on provider type. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$45 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: No Charge Mail-Order: No Charge Specialty Retail: $250 copay, deductible does not apply.	Retail: No Charge up to 50% coinsurance, deductible does not apply. Specialty Retail: Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply. Mail-Order: $90 copay, deductible does not apply. Specialty Retail: $250 copay, deductible does not apply.	Retail: $45 copay then 50% coinsurance Specialty Retail: Not covered	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply. Specialty Retail: $250 copay, deductible does not apply.	Retail: $75 copay then 50% coinsurance Specialty Retail: Not covered	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$400 copay per visit, then 10% coinsurance	*$400 copay per visit, then 10% coinsurance	None
	Emergency medical transportation	10% coinsurance	*10% coinsurance	*Network deductible applies.
	Urgent Care	$75 copay per visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Physician/ surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply	50% coinsurance	Network All Other: No Charge. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	10% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$45 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical/Occupational/ Speech/Cognitive: combined limit 100 visits; Cardiac, Pulmonary: Unlimited.
	Habilitative services	No Charge	50% coinsurance	None.
	Skilled nursing care	No Charge	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	10% coinsurance	50% coinsurance	Preauthorization is required out-of-network for DME over $1,000 or no coverage.
	Hospice services	No Charge	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care (Adult & Child)
- Routine foot care - Except as covered for Diabetes
- Weight loss programs – Except for required preventive services and Real Appeal.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits per calendar year for disease, injury & chronic pain.
- Chiropractic (manipulative) care - 35 visits per calendar year
- Hearing aids – 1 hearing aid per ear, every 36 months. $2,500 limit every 36 months.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ ebsa/healthreform.
Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copay	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copay	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copay	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

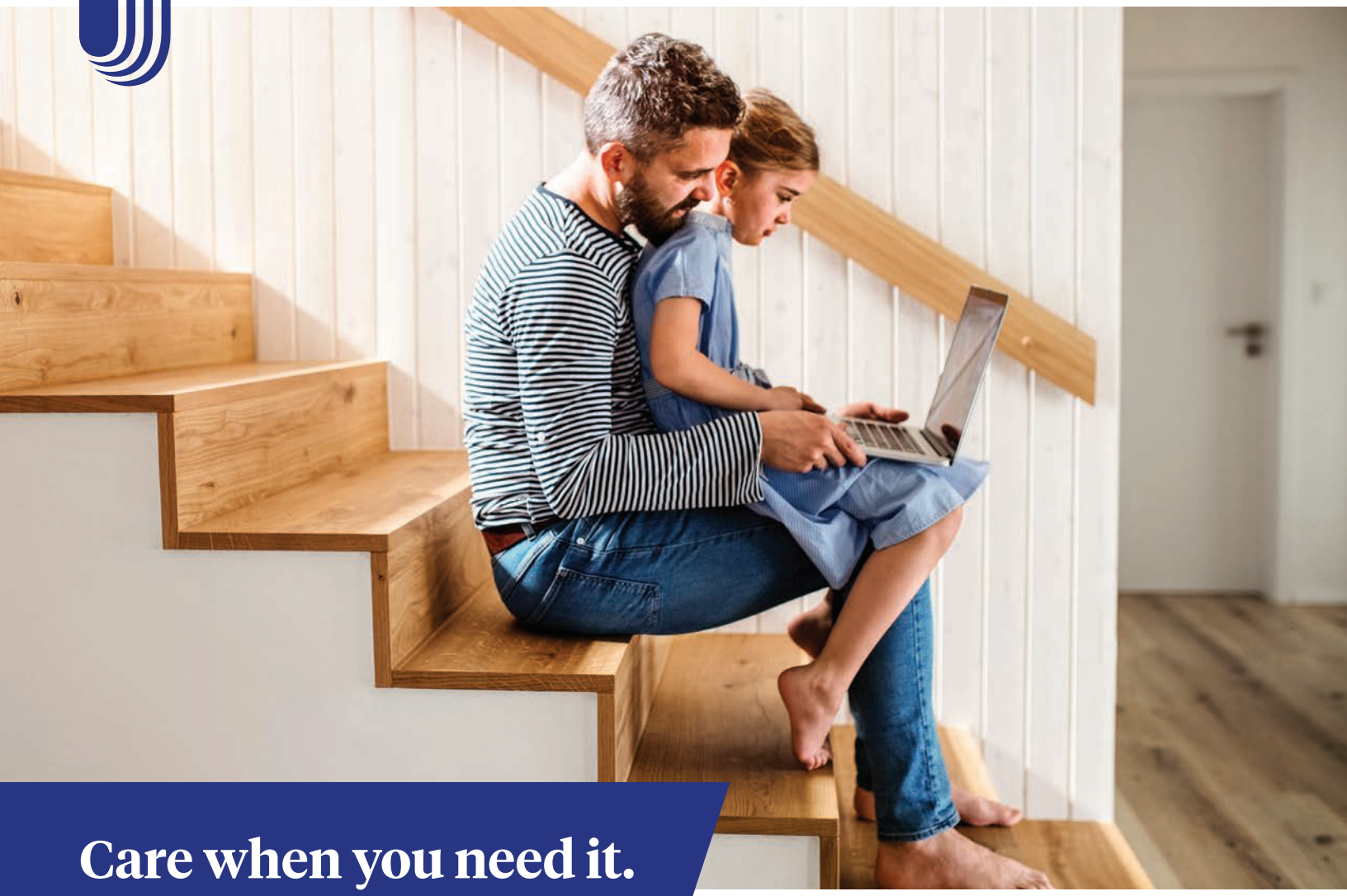
TeleHealth

United Health Care | www.myuhc.com/virtualcare

Studies show that more than 50 percent of doctor's office visits can be handled over the phone. With the Telehealth program, you can get a diagnosis quicker and spend less time in the waiting room.

Board Certified physicians will diagnose your illness, recommend treatment, and prescribe medication via telephone or video. You can contact them from anywhere – home, work, school, even while on vacation. They can treat common health issues like acid reflux, allergies, asthma, cold and flu, sinus infections, rashes, sore throat and more.

It's like having a doctor on call whenever you need medical advice. Access is only a call or click away!



Care when you need it. No shoes required.

You can make a virtual care appointment for your urgent care, primary care, mental health and specialty care needs. You may get seen faster by a provider and often, it even costs less. All from the comfort of anywhere you choose.

Get seen sooner with virtual care

On average, you can connect with a provider by video or phone* in:

15 minutes or less**
for 24/7 Virtual Visits

3 days or less
for virtual specialty care

1 week or less
for virtual primary care or virtual therapy

*Data rates may apply.
**Based on 2023-2024 analysis of provider average wait times from request to visit across UnitedHealthcare Designated Virtual Network Providers. Wait times may be impacted by volume at time of the visit.

continued

United Healthcare®

Let care come to you

Here are some of the things virtual care can help you with.

24/7 Virtual Visits

- Bronchitis
- Coughs, colds and flu
- Fevers
- Headaches
- Pinkeye
- Rashes
- Sinus problems
- Stomach pain and urinary tract infections (UTIs)

Virtual primary care

- Annual wellness visits, covered 100% just like in-person
- Lab orders
- Non-urgent needs
- Prescription refills*
- Specialist referrals

Virtual therapy

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Grief
- Mental health disorders
- Stress

Virtual specialty care

- Dental care
- Dermatology
- Gastroenterology needs
- Migraines
- Sleep apnea
- Speech therapy
- Women's health issues, like menopause, birth control and breast health

Make an appointment

Scan or visit **myuhc.com/virtualcare** to get started

United Healthcare®

*Certain prescriptions may not be available, and other restrictions may apply.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Virtual primary care are services available with a provider via video, chat, email, or audio-only where permitted under state law. Virtual primary care services are only available if the provider is licensed in the state that the member is located at the time of the appointment. Virtual primary care is not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Certain prescriptions may not be available, and other restrictions may apply.

Virtual Specialists are services available with a provider or coach via video, chat, email, or audio-only where permitted under state law. It is not an insurance product or a health plan. Virtual Specialists are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Certain prescriptions may not be available, and other restrictions may apply.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Hospital Indemnity Insurance

Aenta | www.myaetnasupplemental.com | 800-607-3366

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

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

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

Hospital Indemnity Semi-Monthly Rates		
Premium	Low Plan	High Plan
Employee	$4.67	$13.75
Employee + Spouse	$9.49	$28.12
Employee + Children	$7.40	$21.76
Family	$11.66	$34.40

Aetna Hospital Indemnity plan, administered by Aetna Life Insurance Company

Federal Disclosure

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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

Plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna) at 151 Farmington Ave., Hartford, CT, 0615.

aetna®

3562552-01-01 (11/24)

Less stress

Aetna Hospital Indemnity Plan

Be prepared for what lies ahead
Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

What is the Hospital Indemnity Plan?
The plan pays benefits when you have a planned, or unplanned hospital stay for an illness, injury, surgery or delivering a baby. It also pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to ***you***, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?
It's completely up to you. You can use the money any way you want, like paying for:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else ***you*** choose.

Easy to use
Online tools make it easy to manage your plan. File a claim in about 90 seconds or less if you have a covered stay in a hospital. And, benefits get paid directly to you by check or direct deposit.

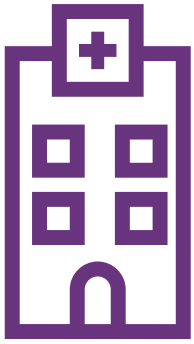
The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna).

aetna®

57.03.509.1 (02/21)

Because it happens

$1.24 trillion was spent on hospital services in 2020. **60%-65%** of all bankruptcies are related to medical expenses[1].



Ready...or not

Carter* is a hard worker, so he doesn't always slow down to listen to his body. Before he knew it, a little cough turned into pneumonia — and a hospital stay.

Good thing he had the Aetna Hospital Indemnity Plan. He filed his claim and the benefits were deposited right into his bank account.

That money helped make up for the time he missed while recovering, and paid some of his deductible. Now, he can focus more on his health.

A Simplified Claims Experience™

Register on the **My Aetna Supplemental** app or on the member portal at **Myaetnasupplemental.com** to view plan documents, submit and track claims, and sign up for direct deposit.

Filing a claim is easy! Click "Report New Claim", answer a few quick questions, and upload or take a picture of your medical bill. You can also print and mail a paper claim form to Aetna Voluntary Plans.

[1]Debt.org. Hospital and Surgery Costs. October 2021. Available at: https://www.debt.org/medical/hospital-surgery-costs/. Accessed June 3, 2022.
*This is a fictional example of how the plan could work.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. This insurance plan provides limited benefits. It pays fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. For more information about Aetna plans, refer to **Aetna.com.**

Policy forms issued in Missouri and Oklahoma include: GR-96172 01, AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.

57.03.509.1 (02/21)

Benefit Summary

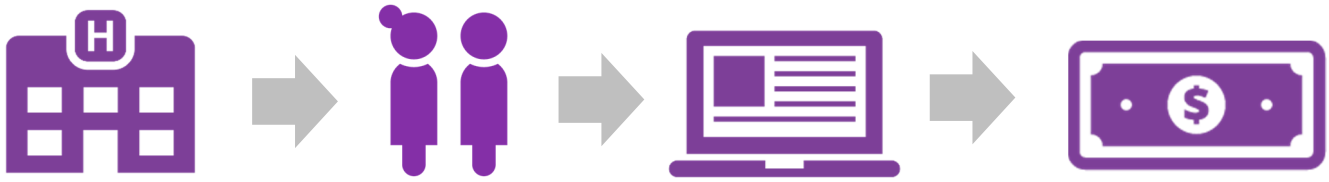
City of Cedar Park

802404

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's an example of how the plan can help you:



You have an unexpected event and have to go to the hospital.

You are admitted into the hospital and spend two days there.

You submit your hospital claim to Aetna.

Aetna pays benefits directly to you.

Unless otherwise indicated, all benefits and limitations are per covered person.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at **www.medicare.gov.**
This is a summary of your benefits. See the plan documents for a complete description of the benefits, exclusions, limitations and conditions of coverage.

The policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

Inpatient benefits	Low	High
Hospital stay - admission Provides a lump sum benefit for the initial day of your stay in a non-ICU room of a hospital. *Maximum **1 stay** per plan year*	$500	$1,500
Hospital stay - daily Pays a daily benefit, for each day of your stay in a non-ICU room of a hospital, beginning on day two. *Maximum **30 days** per plan year*	$50	$150
Hospital stay - (ICU) daily Pays a daily benefit, for each day of your stay in an ICU room of a hospital, beginning on day two. *Maximum **30 days** per plan year*	$100	$300
Newborn routine care Pays a lump sum benefit after the birth of your newborn with an inpatient stay. This would not pay for an outpatient birth.	$100	$200
Observation unit Pays a lump sum benefit for the initial day of your observation. *Maximum **1 day** per plan year*	$100	$200
Substance abuse stay - daily Pays a daily benefit for each day you have a stay in a substance abuse treatment facility, beginning on day one. *Maximum **30 days** per plan year*	$50	$150
Mental disorder stay - daily Pays a daily benefit for each day you have a stay in a mental disorder treatment facility, beginning on day one. *Maximum **30 days** per plan year*	$50	$150
Rehabilitation unit stay - daily Pays a daily benefit for each day of your stay in a rehabilitation unit immediately after your hospital stay, beginning on day one. *Maximum **30 days** per plan year*	$25	$75

Important note:
All daily stay benefits count toward the combined plan year maximum.

Portability

If your employment ends, and as a result your coverage under the policy ends, you can choose to continue your coverage by enabling the portability provision in your coverage. Such coverage will be available to you and any of your covered dependents.

Waiver of Premium

If you are in a hospital for more than 30 days in a row, we will waive the premium beginning on the first premium due date that occurs after the 30th day of your stay, through the next 6 months of coverage. During your stay, you must remain employed with the policyholder.

Hospital Indemnity Exclusions & Limitations

This plan has exclusions and limitations. Refer to the actual policy and booklet certificate to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. **However, the plan may contain exceptions to this list based on state mandates or the plan design purchased. Benefits will not be paid for any service for an illness or accidental injury related to the following:**

1. Certain competitive or recreational activities, including but not limited to: ballooning, bungee jumping, parachuting, skydiving
2. Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment
3. Act of war, riot, war
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not
5. Assault, felony, illegal occupation or other criminal act
6. Care provided by a spouse, parent, child, sibling or any other household member
7. Cosmetic services and plastic surgery, with certain exceptions
8. Custodial care
9. Hospice services, except as specifically provided in the benefits under your plan section of the certificate
10. Self-harm, suicide, except when resulting from a diagnosed disorder
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle
12. Care or services received outside the United States or its territories
13. Education, training or retraining services or testing
14. Accidental injury sustained while intoxicated or under the influence of any drug intoxicant
15. Exams except as specifically provided in the Benefits under your plan section of the certificate
16. Dental and orthodontic care and treatment
17. Family planning services
18. Any care, prescription drugs and medicines related to infertility
19. Nutritional supplements, including but not limited to: food items, infant formulas, vitamins
20. Outpatient cognitive rehabilitation, physical therapy, occupational therapy or speech therapy for any reason
21. Vision-related care

Frequently asked questions (FAQs) about the Hospital Indemnity plans

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?

Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?

A stay is a period during which you are admitted as an inpatient; and are confined in a hospital, non-hospital residential facility, or rehabilitation facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.

What happens if I lose my employment? Can I take the Hospital Indemnity Plan with me?

Yes, you are able to continue coverage under the portability provision; however, you will need to pay premiums directly to Aetna.

How do I file a claim?

Go to **www.aetnavoluntaryforms.com** to find your benefit claim form. Use the "Online claims process" link to fill out the form and submit your claim. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail a printed form.

What should I do in an emergency?

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

What if I don't understand something I've read here, or have more questions?

We want you to understand these benefits before you decide to enroll. Reach out to us. Call toll-free at **1-800-607-3366**, Monday through Friday, 8 a.m. to 6 p.m. We're here to answer questions before and after you enroll.

Health Savings Account

HSA Bank | www.hsabank.com | 1.800.357.6246

A Health Savings Account (HSA) is a great way to help you control your healthcare costs. It works in conjunction with a qualified High Deductible Health Plan (HDHP) to combine tax-free savings earmarked for qualified medical expenses. An HSA allows you to set aside money to pay for higher deductibles associated with a lower monthly premium HDHP. The money you save in monthly insurance premiums is reserved for eligible medical expenses you incur in the future. Eligible expenses include things like co-pays and deductibles, prescriptions, vision expenses, dental care, therapy and medical supplies.

Health Savings Account Highlights

- Balances roll over from year to year and earn interest along the way.
- Portable – you keep it even after you leave employment.
- Tax advantages – invest money in mutual funds to grow your tax savings for either future healthcare costs or retirement.
- Pay for expenses with a benefits debit card that gives you immediate access to your money at the time of purchase.
- Expenses also can be reimbursed through our online portal, online bill pay directly to your provider or submitting a distribution request form.
- Receipts are not required for reimbursement but be sure to save them for tax purposes.

Who Can Participate in an HSA?

- 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.

	2025	2026
HSA Contribution Limits	• Self: $4,300 • Family: $8,550	• Self Only: $4,400 • Family: $8,750
Health Insurance Deductible Limits	• Self Only: $1,650 • Family: $3,300	• Self Only: $1,700 • Family: $3,400
$1,000 catch-up contributions (age 55 or older)		

Flexible Spending Accounts

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

Medical FSA

A Medical Flexible Spending Account (Medical FSA) is an IRS-approved program to help you save taxes and reimburse yourself for out-of-pocket medical expenses not covered under your medical plan. FSA Funds are only carried over up to $660, if you enroll for the new plan year. If you do not enroll in the FSA and have remaining funds after the end of the runoff period, funds will be limited to a one-year carryover period. Any remaining funds over the IRS indexed allowable carry over amount in the FSA at the end of the runoff period will be forfeited.

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

Medical FSA Highlights

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

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

Dependent Care FSA

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

You may allocate up to $5,000 per tax year for reimbursement of dependent care services.
If you are married and file a separate tax return, the limit is $2,500.

Dependent Care FSA Highlights

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

FSA Resources

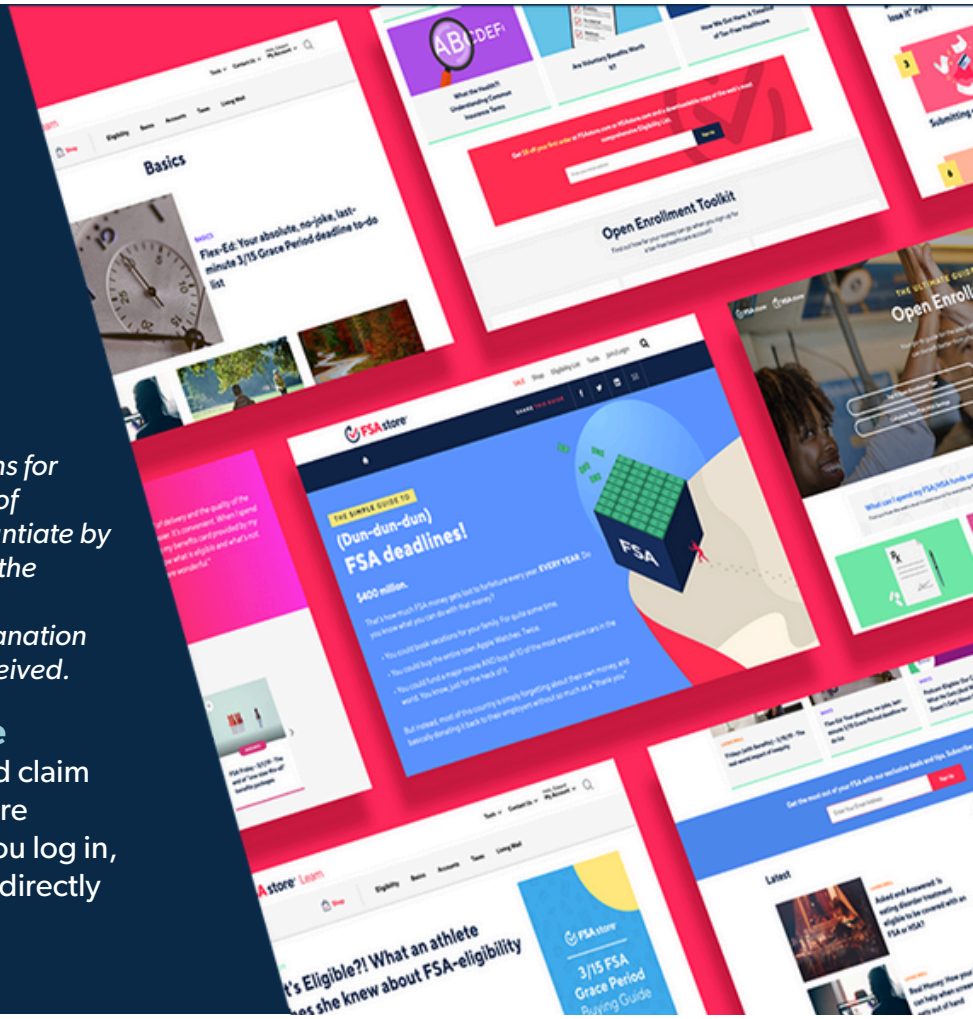
Benefits Card

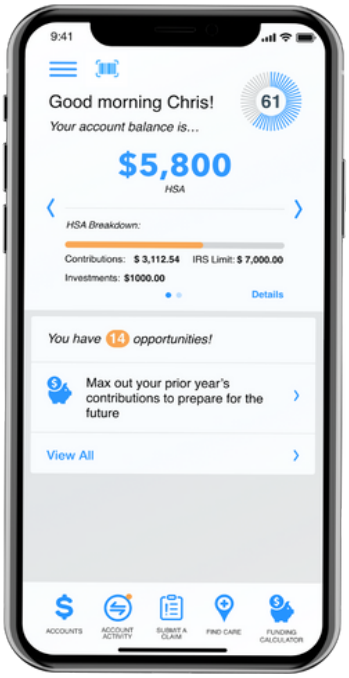
The FFGA Benefits Card is available to all employees that participate in a Medical FSA. The Benefits Card gives you immediate access to your money at the point of purchase. Cards are available for participating employees, their spouse and any eligible dependents who are at least 18 years old.

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

View Your Account Details Online

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





FF Mobile Account App

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

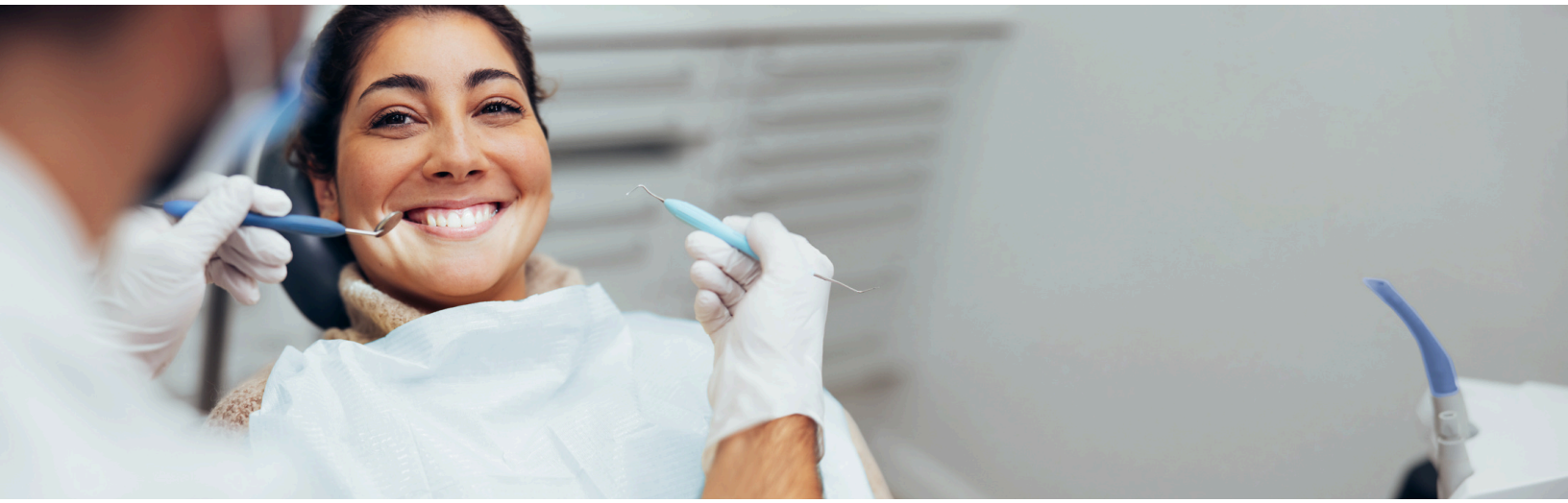
FSA Store

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

FSA store®
Everything Flex Spending.

Dental Insurance

Plan Choices



Delta Dental | www.deltadental.com | 800-521-2651

Taking care of your oral health is not a luxury, it is a necessity to long-term optimal health. Dental insurance can greatly reduce your costs when it comes to preventative, restorative, and emergency procedures. Review the plan benefits to see which option is best for you and your family's dental needs. A range of procedures may be covered, such as:

- Comprehensive Exams
- Cleanings
- X-Rays
- Fillings
- Tooth Extractions
- General Anesthesia
- Crown
- Root Canals

Dental Monthly Premiums	
Employee Only	$0.00
Employee + Spouse	$19.28
Employee + Children	$30.59
Employee + Family	$48.82

DELTA DENTAL

Keep smiling

DPO

Save with DPO

Visit a dentist in the DPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a DPO dentist at **deltadentalins.com**.

Set up an online account

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

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

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

Understand transition of care

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

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a DPO dentist

DPO

NON-DPO

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

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

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

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

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

Benefit Highlights: DPO from Delta Dental

Plan Benefit Highlights for: City of Cedar Park
Group Number: 23095 **Effective Date:** 11/1/2024

Benefits	Delta Dental DPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Deductibles per member / per family each calendar year	$50/ $150	$50/ $150	$50/ $150
Deductibles waived for Diagnostic & Preventive?	Yes, for all Dentists		
Deductibles waived for Orthodontics?	Yes, for all Dentists		
Maximums Per member each calendar year	$1,500	$1,500	$1,500
D&P counts toward maximum?	Yes, for all Dentists		

Covered Services*	Delta Dental DPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D&P) Exams, Cleanings, X-Rays, Sealants and Space Maintainers	100%	100%	100%
Basic Services Fillings, Simple Extractions and Posterior Composites	80%	80%	80%
Endodontics Root Canals	80%	80%	80%
Periodontics Surgical and Non-Surgical Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services Crowns, Inlays, Onlays and Cast Restorations	50%	50%	50%
Prosthodontics Bridges, Dentures and Denture Repair/Reline/Rebase	50%	50%	50%
Orthodontic Services Adults and Dependent Children	50%	50%	50%
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime	$1,500 Lifetime

For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).

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

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

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

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

Vision Insurance

Eyemed | www.eyemed.com | 8666-723-0513

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

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

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

Vision Monthly Premium	
Employee Only	$2.43
Employee + Spouse	$4.61
Employee + Children	$4.84
Employee + Family	$7.13

City of Cedarpark

Insight network

40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Frequency

Exam
once every calendar year

Frame
once every other calendar year

Lens
once every calendar year

Contact Lens
once every calendar year

(Plan allows member to receive either contacts and frame, or frames and lens services)

SCHEDULE OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$20 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal/Lenticular	$20 copay	Up to $70
Progressive - Standard	$75 copay	Up to $50
Progressive - Premium Tier 1 - 4	$105 - 235	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $23
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 100	Up to $23
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Std < 19 years of age	$0 copay	Up to $20
Scratch Coating	$0 copay	Up to $8
Tint	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $65
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $65
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

Log into eyemed.com/member to see all plans included with your benefits. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 76% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1]*Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$150 frame or contact lens allowance. 2021 EyeMed Commercial BOB stats.*

Create a member account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Disability Insurance

Madison Life Group | www.madisonlife.com | 800-356-9601 ext. 2410

Why Do I Need Disability Insurance?

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

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

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

Group Long Term Disability Insurance: Benefit Summary

Prepared for: City of Cedar Park – Class 02: All Eligible Employees Excluding Executives

Eligibility
To be eligible, you must be an active Employee working a minimum number of hours as agreed to and outlined in the signed documents between your Employer and Madison National Life Insurance Company, Inc.

Benefit Amount
60% of your Pre-disability Earnings, to a Maximum Monthly Benefit of $5,000.

Pre-existing Conditions
Definition: A Pre-existing Condition is a mental or physical condition whether or not diagnosed or misdiagnosed for which you have consulted a Physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken prescribed drugs or medications at any time during the 3 month period prior to your effective date of coverage.

Coverage under this plan: You cannot receive benefits due to a Pre-existing Condition until you have not received treatment or services for that condition for 12 consecutive months from the effective date of your insurance; or until you have been continuously covered under the group policy for at least 12 months and have been Actively at Work for at least one full day after the end of the 12 months.

Earning Income While Disabled
Benefits are reduced by other income you may receive during a Disability, including Social Security or a State Retirement or Disability benefit plan. See your certificate of insurance for details.

Minimum Monthly Benefit
Greater of $100 or 10% of Gross Monthly Benefit

Elimination Period
Benefits will begin 90 consecutive calendar days after you become Disabled.

How Long Benefits Will Be Paid
If you are Disabled prior to age 62, benefits may continue to the later of age 65 or the Social Security Normal Retirement Age. If Disabled on or after age 62, refer to Maximum Benefit Period in the Schedule of Benefits of the certificate of insurance.

QUESTIONS
Contact Ochs
ochs@ochsinc.com
651.665.3789 ● 800.392.7295

Group Long Term Disability Insurance: Benefit Summary

Prepared for: City of Cedar Park – Class 01: Executives

Eligibility
To be eligible, you must be an active Employee working a minimum number of hours as agreed to and outlined in the signed documents between your Employer and Madison National Life Insurance Company, Inc.

Benefit Amount
60% of your Pre-disability Earnings, to a Maximum Monthly Benefit of $7,500.

Pre-existing Conditions

Definition: A Pre-existing Condition is a mental or physical condition whether or not diagnosed or misdiagnosed for which you have consulted a Physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken prescribed drugs or medications at any time during the 3 month period prior to your effective date of coverage.

Coverage under this plan: You cannot receive benefits due to a Pre-existing Condition until you have not received treatment or services for that condition for 12 consecutive months from the effective date of your insurance; or until you have been continuously covered under the group policy for at least 12 months and have been Actively at Work for at least one full day after the end of the 12 months.

Earning Income While Disabled
Benefits are reduced by other income you may receive during a Disability, including Social Security or a State Retirement or Disability benefit plan. See your certificate of insurance for details.

Minimum Monthly Benefit
Greater of $100 or 10% of Gross Monthly Benefit

Elimination Period
Benefits will begin 90 consecutive calendar days after you become Disabled.

How Long Benefits Will Be Paid
If you are Disabled prior to age 62, benefits may continue to the later of age 65 or the Social Security Normal Retirement Age. If Disabled on or after age 62, refer to Maximum Benefit Period in the Schedule of Benefits of the certificate of insurance.

QUESTIONS
Contact Ochs
ochs@ochsinc.com
651.665.3789 ● 800.392.7295

Exclusions Include But Are Not Limited To *

- War or Act of War.
- Criminal Conduct.
- Military Leave.
- Imprisonment.
- Intentionally Self-Inflicted Injury or attempted Suicide.

Limitations *

- Mental Disorders and Substance Abuse. Benefit payments based on a Mental Disorder or Substance Abuse are limited to 24 months during your lifetime. Other limitations may apply.
- Foreign Residency. Payment of Benefits is limited while you reside outside of the United States or Canada. Please refer to the certificate of insurance
- Payment Limit. In no event will the LTD Benefit plus Deductible Income plus Work Earnings exceed 100% of Predisability Earnings. In the event your LTD Benefit plus Deductible Income plus Work Earnings exceeds 100% of Predisability Earnings, the LTD Benefit will be reduced by the amount in excess of 100% of Predisability Earnings.

*** This brochure is not the insurance contract. It is a brief description of your insurance underwritten by Madison National Life Insurance Company, Inc. GLDI-C200-(12/06) For complete details including all benefits, exclusions and limitations, contact your Employer or Ochs, Inc.**

Founded in 1961, Madison National Life Insurance Company, Inc. is headquartered in Madison, the rapidly growing capital city of Wisconsin. Madison National Life is licensed in 49 states and specializes in group life, disability and specialty health insurance. The company is a wholly owned subsidiary of Horace Mann Educators Corporation (NYSE:HMN), the largest financial services company focused on providing America's educators and school employees with insurance and retirement solutions.

Term Life & AD&D

Employer-Paid & Voluntary

Securian Financial Group | www.lifebenefits.com | 800-392-7295

Employer-Paid Term Life & AD&D Insurance

Life insurance provides a financial benefit to beneficiaries upon death; AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. The City of Cedar Park has partnered with Securian to provide group life and accidental death and dismemberment (AD&D) Insurance for each eligible employee at no additional cost. We have included the Line of Duty AD&D additional benefit as an enhancement to your current basic AD&D plan. Line of Duty provides an additional benefit of 100% of the basic AD&D principal sum up to $100,000 for public safety officers (police and fire) that suffer a loss while he or she is performing his or her customary duties for the employer.

Voluntary Term Life Insurance

Voluntary life insurance is term life coverage you can purchase in addition to the basic life plan provided by your employer. It will cover you for a specific period of time while you are employed. Plan amounts are offered in tiers so you can choose the amount of coverage that works best for you and your family. Because it's a group plan, premiums are typically lower, so it's more affordable to gain the peace of mind that life insurance provides. Limitations apply, please see policy for details. Visit the Employee Benefits Center for more details.

securian FINANCIAL | Ochs

City of Cedar Park

Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Insurance products issued by Minnesota Life Insurance Company or Securian Life Insurance Company and administered by Ochs.

Life Insurance Coverage Available - No Health Questions!

There are many reasons to consider Supplemental Life Insurance and there are certain times in which you can enroll for coverage without answering health questions. **Below is a summary of those options.**

Looking for a higher amount of coverage? A full list of your life Insurance coverage options is outlined on the following pages. To apply for coverage other than the amounts listed below, health questions and underwriting approval is required.

NEW HIRE OPPORTUNITY

New hire eligibility refers to when you are hired and become eligible for benefits.

- ✓ **Employee** - up to **$250,000**
- ✓ **Spouse** - up to **$25,000**
- ✓ **Child - all coverage**
- ✓ **Voluntary AD&D - all coverage**

ANNUAL ENROLLMENT OPPORTUNITY

Available during your employer's annual enrollment period.

- ✓ **Child** - **all coverage**
- ✓ **Voluntary AD&D - all coverage**

QUALIFIED STATUS CHANGE

If you experience an employment or family status change, check with your employer within 31 days to confirm guaranteed coverage availability.

Your Basic and Supplemental Life and Voluntary AD&D Insurance Coverages:

Basic Life Coverage - 100% employer paid & automatically enrolled		
Basic term life	**Amount varies** According to job classification Maximum **$300,000**	✓ Includes a matching AD&D benefit ✓ Includes a line of duty benefit ✓ Coverage reduces beginning at age 70
Supplemental Life Coverage - 100% employee paid		
Supplemental term life	Elect in **$10,000** increments Maximum **$750,000**	
Spouse term life	Elect in **$5,000** increments Maximum **$250,000**	
Child term life	Elect **$5,000, $10,000** or **$15,000**	✓ Available to elect without health questions each annual enrollment
Voluntary AD&D (employee or family)	Elect in **$10,000** increments Maximum **$300,000**	✓ Available to elect without health questions each annual enrollment ✓ Family benefit is a percentage of the employee's elected AD&D amount: Spouse w/children - 40%; Spouse no children - 50% Each child w/spouse - 10%; Each child no spouse - 15%

If your spouse or child is eligible for employee coverage, they cannot be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

Monthly Cost:

Employee or Spouse Supplemental Life	
Employee Age*	**Rate per $1,000**
<25	$0.07
25-29	$0.07
30-34	$0.09
35-39	$0.09
40-44	$0.15
45-49	$0.25
50-54	$0.45
55-59	$0.75
60-64	$0.83
65-69	$1.63
70-74	$2.97
75*	$2.97

Note: Spouse rates are based on employee's age.
*Rates beyond age 75 are available upon request.
Rates increase with age and all rates are subject to change.

Here's how to calculate your monthly premium:

Total supplemental term life coverage amount	$_____
÷ 1,000	$_____
× your rate (based on your age)	$_____
= Monthly premium	**$_____**

Here's how Riley calculated their monthly premium:

Riley elected a total supplemental term life coverage amount of	$150,000
÷ 1,000	$150.00
× Riley's rate (based on their age of 42)	$0.15
= Riley's monthly premium	**$22.50**

Child Life		
$5,000	**$10,000**	**$15,000**
$0.43	$0.86	$1.29

One premium covers all eligible children from live birth to age 26

Voluntary AD&D	
Employee	**Family**
$0.035 per $1,000	$0.060 per $1,000

One premium covers all eligible children from live birth to age 26

Why Life Insurance?

No matter where you are in life, there are many reasons to consider Life Insurance. Group Life Insurance protects you and your family from the unexpected loss of life and income during working years. AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. Life and AD&D Insurance benefits are disbursed to you and/or your beneficiaries to help pay for things like:

- ✓ Your mortgage or rent
- ✓ Childcare or education costs
- ✓ Medical bills or other expenses
- ✓ Funeral and burial costs

How much Life Insurance do I need?

To estimate the amount of Life Insurance you need, you'll want to determine what you must protect in the event of your death. Determine your needs today.

Check out our Life Insurance calculator: click here.

Or scan here:

Naming a Beneficiary:

Naming a beneficiary is an important right of Life Insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your beneficiaries periodically. Events such as marriage, birth/adoption of children, divorce or death may change how you want your Life Insurance benefit paid.

Continuation:

If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage after employment. No health questions are needed and rates are generally higher than active rates. If you would like to continue your coverage, be sure to enroll within 31 days of your current coverage ending.

Questions **ochs@ochsinc.com** **800-392-7295**

Ochs, Inc.
A Securian Financial Company
400 Robert Street N, Ste. 1880, St. Paul, MN 55101

Texas Life

Permanent Life

Texas Life | www.texaslife.com | 800-283-9233

Texas Life Insurance - Permanent, Portable Life Insurance

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

Texas Life - Permanent Life Highlights

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

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

Life insurance can be an ideal way to provide money for your family when they need it most. PURELIFE-PLUS is permanent life insurance which features long guarantees[1] and one of the highest death benefits per payroll-deducted dollar offered at the worksite.[2] PURELIFE-PLUS is an ideal complement to any group term and optional life insurance your employer might provide, and it has the following features:

- **YOU OWN IT THE COST IS REASONABLE**
- **YOU CAN TAKE IT WITH YOU WHEN YOU CHANGE JOBS OR RETIRE[4]**
- **YOU PAY FOR IT THROUGH CONVENIENT PAYROLL DEDUCTIONS**
- **YOU CAN COVER YOUR SPOUSE, CHILDREN AND GRANDCHILDREN, TOO[3]**
- **YOU CAN GET A LIVING BENEFIT IF YOU BECOME TERMINALLY ILL[5]**
- **YOU CAN GET CASH TO COVER LIVING EXPENSES IF YOU BECOME CHRONICALLY ILL[6]**

3 QUICK QUESTIONS

You can qualify by answering just 3 questions.[7]

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

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

TEXASLIFE INSURANCE COMPANY

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

First Financial Group of America
First in Service and Expertise

1 Guarantees are subject to product terms, limitations, exclusions and the insurer's claims paying ability and financial strength. Current average premium guarantee is 45 years.
2 Voluntary Universal and Whole Life Products, Eastbridge Consulting Group, Inc. (2022)
3 Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
4 As long as the necessary premiums are paid.
5 Conditions apply. Accelerated Death Benefit Due to Terminal Illness Rider Form ICC07-ULABR-07 or Form Series ULABR-07
6 Chronic Illness Rider available for an additional cost for employees and their spouses. Conditions apply. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15
7 Issuance of coverage will depend on answers to these questions.

23M021-C FFGA 1019 (exp0325) Not for use in CA, FL or NH.

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

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

SEMI-MONTHLY NON-TOBACCO PREMIUMS
EMPLOYEE & SPOUSE *with Accidental Death & Chronic Illness Riders*

TEXASLIFE INSURANCE COMPANY

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

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

CHILDREN AND GRANDCHILDREN (NON-TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

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

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

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

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

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

Indicates Spouse Coverage Available

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

SEMI-MONTHLY TOBACCO PREMIUMS
EMPLOYEE & SPOUSE *with Accidental Death & Chronic Illness Riders*

TEXASLIFE INSURANCE COMPANY

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

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

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

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

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

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

CHILDREN AND GRANDCHILDREN (TOBACCO)

with Accidental Death Rider

Grandchild coverage available through age 18.

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

Indicates Spouse Coverage Available

Cancer Insurance

Allstate | www.allstatebenefits.com/mybenefits | 800-521-3535

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

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

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

Cancer Semi-Monthly Rates			
Premium	**Plan 1**	**Plan 2**	**Plan 3**
Employee	$8.45	$15.97	$22.40
Employee + Family	$14.37	$26.98	$37.84

Allstate BENEFITS

Protection for the treatment of cancer and 29 specified diseases

Cancer Insurance

Receiving a cancer diagnosis can be one of life's most frightening events. Unfortunately, statistics show you probably know someone who has been in this situation.

With Cancer insurance from Allstate Benefits, you can rest a little easier. Our coverage pays you a cash benefit to help with the costs associated with treatments, to pay for daily living expenses, and more importantly, to empower you to seek the care you need.

Here's How It Works

You choose the coverage that's right for you and your family. Our Cancer insurance pays cash benefits for cancer and 29 specified diseases to help with the cost of treatments and expenses as they happen. Benefits are paid directly to you unless otherwise assigned. With the cash benefits you can receive from this coverage, you may not need to use the funds from your Health Savings Account (HSA) for cancer or specified disease treatments and expenses.

Meeting Your Needs

- Includes coverage for cancer and 29 specified diseases
- Benefits are paid directly to you unless otherwise assigned
- Coverage available for dependents
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts (employee only)
- Coverage may be continued; refer to your certificate for details
- Additional benefits have been added to enhance your coverage

With Allstate Benefits, you can protect your finances if faced with an unexpected cancer or specified disease diagnosis. **Practical benefits for everyday living.®**

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.

[1]Life After Cancer: Survivorship by the Numbers, American Cancer Society, 2017.
[2]Cancer Treatment & Survivorship Facts & Figures, 2019-2021

DID YOU KNOW?

Early detection, improved treatments and access to care are factors that influence cancer survival[1]

22.1 million

The number of cancer survivors in the U.S. is increasing, and is expected to jump to nearly 22.1 million by 2030[2]

POD106684

Meet TJ

TJ is like anyone else who has been diagnosed with cancer. He is concerned about his wife and how she will cope with his disease and its treatment. Most importantly, he worries about how he will pay for his treatment.

Here is what weighs heavily on his mind:

- Major medical only pays a portion of the expenses associated with my treatment
- I have copays I am responsible for until I meet my deductible
- If I am not working due to treatments, I must cover my bills, rent/mortgage, groceries and other daily expenses
- If the right treatment is not available locally, I will have to travel to get the treatment I need

Here's how TJ's story of diagnosis and treatment turned into a happy ending, because he had supplemental Cancer Insurance to help with expenses.

CHOOSE

TJ chooses benefits to help protect himself and his wife if diagnosed with cancer or a specified disease

USE

TJ undergoes his annual wellness test and is diagnosed for the first time with prostate cancer. His doctor reviews the results with him and recommends pre-op testing and surgery.

Here's TJ's treatment path:

- TJ travels to a specialized hospital 400 miles from where he lives and undergoes pre-op testing
- He is admitted to the hospital for laparoscopic prostate cancer surgery
- TJ undergoes surgery and spends several hours in the recovery waiting room
- He is transferred to his room where he is visited by his doctor during a 2-day hospital stay
- TJ is released under doctor required treatment and care during a 2-month recovery period

TJ continues to fight his cancer and follow his doctor recommended treatments.

CLAIM

TJ's Cancer claim paid him cash benefits for the following:

Wellness
Cancer Initial Diagnosis
Continuous Hospital Confinement
Non-Local Transportation
Surgery
Anesthesia
Medical Imaging
Inpatient Drugs and Medicine
Physician's Attendance
Anti-Nausea

For a listing of benefits and benefit amounts, see your company's rate insert.

Cancer Insurance (GVCP3)

Includes coverage for 29 Specified Diseases

from **Allstate Benefits**

Offered to the employees of:

City of Cedar Park

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 1	PLAN 2
Continuous Hospital Confinement (daily)	$100	$300
Government or Charity Hospital (daily)	$100	$300
Private Duty Nursing Services (daily)	$100	$300
Extended Care Facility (daily)	$100	$300
At Home Nursing (daily)	$100	$300
Hospice Care Center (daily) or	$100	$300
Hospice Care Team (per visit)	$100	$300
RADIATION/CHEMOTHERAPY/RELATED BENEFITS	**PLAN 1**	**PLAN 2**
Radiation/Chemotherapy for Cancer[1] (every 12 months)	$7,500	$15,000
Blood, Plasma, and Platelets[1] (every 12 months)	$7,500	$15,000
Hematological Drugs[1] (every 12 months)	$150	$300
Medical Imaging[1] (every 12 months)	$375	$750
SURGERY AND RELATED BENEFITS	**PLAN 1**	**PLAN 2**
Surgery[2]	$1,500	$3,000
Anesthesia (% of surgery benefit)	25%	25%
Bone Marrow or Stem Cell Transplant (once/year)		
1. Autologous	$500	$1,000
2. Non-autologous (cancer or specified disease treatment)	$1,250	$2,500
3. Non-autologous (Leukemia)	$2,500	$5,000
Ambulatory Surgical Center (daily)	$250	$500
Second Opinion	$200	$400
MISCELLANEOUS BENEFITS	**PLAN 1**	**PLAN 2**
Inpatient Drugs and Medicine (daily)	$25	$25
Physician's Attendance (daily)	$50	$50
Ambulance (per confinement)	$100	$100
Non-Local Transportation[1]		
(coach fare or amount shown per mile*)	0.40/Mile	0.40/Mile
Outpatient Lodging (daily; limit $2,000/12 mo. period)	$50	$50
Family Member Lodging (daily per trip; max. 60 days)	$50	$50
and Transportation (coach fare or amount shown per mile**)	0.40/Mile	0.40/Mile
Physical or Speech Therapy (daily)	$50	$50
New or Experimental Treatment[3] (every 12 months)	$5,000	$5,000
Prosthesis[3] (per amputation)	$2,000	$2,000
Hair Prosthesis (every 2 years)	$25	$25
Nonsurgical External Breast Prosthesis[1]	$50	$50
Anti-Nausea Benefit[1] (once per calendar year)	$200	$200
Waiver of Premium (employee only)	Yes	Yes
OPTIONAL/ADDITIONAL BENEFITS	**PLAN 1**	**PLAN 2**
Cancer Initial Diagnosis (one-time benefit)	$2,000	$3,000
Intensive Care (ICU)		
ICU (daily)	$200	$300
Step-Down (daily)	$100	$150
Ambulance	Actual Charges	Actual Charges
Wellness Benefit	$50	$75

[1]Pays actual cost up to amount listed. [2]Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. [3]Pays actual charges up to amount listed. *At least 70 miles away, up to 700 miles. **Transportation up to 700 miles per continuous hospital confinement.

PLAN 1 PREMIUMS

MODE	EE	F
Semi-Monthly	$8.45	$14.37

PLAN 2 PREMIUMS

MODE	EE	F
Semi-Monthly	$15.97	$26.98

Issue ages: 18 and over if actively at work

EE=Employee; F-Family

FOR HOME OFFICE USE ONLY - GVCP3

Opt 1-1Hosp; 3Rad; 1Surg; 1Misc; 2Init; 2ICU; 2Well; 0Prog

Opt 2-3Hosp; 6Rad; 2Surg; 1Misc; 3Init; 3ICU; 3Well; 0Prog

V.2021.08.31 FA Rate Insert Creation Date: 9/10/2021

ABJ30590-3 - Insert - 34259

Cancer Insurance (GVCP3)

Includes coverage for 29 Specified Diseases

from **Allstate Benefits**

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 3
Continuous Hospital Confinement (daily)	$400
Government or Charity Hospital (daily)	$400
Private Duty Nursing Services (daily)	$400
Extended Care Facility (daily)	$400
At Home Nursing (daily)	$400
Hospice Care Center (daily) or	$400
Hospice Care Team (per visit)	$400
RADIATION/CHEMOTHERAPY/RELATED BENEFITS	**PLAN 3**
Radiation/Chemotherapy for Cancer[1] (every 12 months)	$20,000
Blood, Plasma, and Platelets[1] (every 12 months)	$20,000
Hematological Drugs[1] (every 12 months)	$400
Medical Imaging[1] (every 12 months)	$1,000
SURGERY AND RELATED BENEFITS	**PLAN 3**
Surgery[2]	$6,000
Anesthesia (% of surgery benefit)	25%
Bone Marrow or Stem Cell Transplant (once/year)	
1. Autologous	$2,000
2. Non-autologous (cancer or specified disease treatment)	$5,000
3. Non-autologous (Leukemia)	$10,000
Ambulatory Surgical Center (daily)	$1,000
Second Opinion	$800
MISCELLANEOUS BENEFITS	**PLAN 3**
Inpatient Drugs and Medicine (daily)	$25
Physician's Attendance (daily)	$50
Ambulance (per confinement)	$100
Non-Local Transportation[1]	
(coach fare or amount shown per mile*)	0.40/Mile
Outpatient Lodging (daily; limit $2,000/12 mo. period)	$50
Family Member Lodging (daily per trip; max. 60 days)	$50
and Transportation (coach fare or amount shown per mile**)	0.40/Mile
Physical or Speech Therapy (daily)	$50
New or Experimental Treatment[3] (every 12 months)	$5,000
Prosthesis[3] (per amputation)	$2,000
Hair Prosthesis (every 2 years)	$25
Nonsurgical External Breast Prosthesis[1]	$50
Anti-Nausea Benefit[1] (once per calendar year)	$200
Waiver of Premium (employee only)	Yes
OPTIONAL/ADDITIONAL BENEFITS	**PLAN 3**
Cancer Initial Diagnosis (one-time benefit)	$4,000
Intensive Care (ICU)	
ICU (daily)	$400
Step-Down (daily)	$200
Ambulance	Actual Charges
Wellness Benefit	$100

[1]Pays actual cost up to amount listed. [2]Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. [3]Pays actual charges up to amount listed. *At least 70 miles away, up to 700 miles. **Transportation up to 700 miles per continuous hospital confinement.

PLAN 3 PREMIUMS

MODE	EE	F
Semi-Monthly	$22.40	$37.84

Issue ages: 18 and over if actively at work

EE=Employee; F-Family

FOR HOME OFFICE USE ONLY - GVCP3

Opt 3-4Hosp; 8Rad; 4Surg; 1Misc; 4Init; 4ICU; 4Well; 0Prog

V.2021.08.31 FA Rate Insert Creation Date: 9/10/2021

Allstate BENEFITS

For use in enrollments situsued in: TX. This rate insert is part of the approved brochure for City of Cedar Park and is not to be used on its own.

Using your cash benefits
Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits
An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Wellness Benefit
Biopsy for skin cancer; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer), PSA (prostate cancer); Bone Marrow Testing; Chest X-ray; Colonoscopy; Doppler screening for carotids or peripheral vascular disease; Echocardiogram; EKG; Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening for abdominal aortic aneurysms.

Benefits (subject to maximums as listed on the attached rate insert)

HOSPITAL CONFINEMENT AND RELATED BENEFITS

Continuous Hospital Confinement - inpatient admission and confinement

Government or Charity Hospital - confinements in lieu of all other benefits, except Waiver of Premium

Private Duty Nursing Services - full-time nursing services authorized by attending physician

Extended Care Facility - within 14 days of a hospital stay; payable up to the number of days of the hospital stay

At Home Nursing - private nursing care must begin within 14 days of a covered hospital stay; payable up to the number of days of the previous hospital stay

Hospice Care Center or Team - terminal illness care in a facility or at home; one visit per day

RADIATION/CHEMOTHERAPY AND RELATED BENEFITS

Radiation/Chemotherapy for Cancer - covered treatments to destroy or modify cancerous tissue

Blood, Plasma and Platelets - transfusions, administration, processing, procurement, cross matching

Hematological Drugs - boosts cell lines for white/red cell counts and platelets; payable when Radiation/Chemotherapy for Cancer benefit is paid

Medical Imaging - initial diagnosis or follow-up evaluation based on covered imaging exam

SURGERY AND RELATED BENEFITS

Surgery* - based on Certificate Schedule of Surgical Procedures

Anesthesia - 25% of Surgery benefit for anesthesia received by an anesthetist

Bone Marrow or Stem Cell Transplant - autologous, non-autologous for treatment of cancer or specified disease other than Leukemia, or non-autologous for treatment of Leukemia

Ambulatory Surgical Center - payable only if Surgery benefit is paid

Second Opinion - second opinion for surgery or treatment by a doctor not in practice with your doctor

MISCELLANEOUS BENEFITS

Inpatient Drugs and Medicine - not including drugs/medicine covered under the Radiation/Chemotherapy for Cancer or Anti-Nausea benefits

Physician's Attendance - one inpatient visit by one physician

Ambulance - transfer to or from hospital where confined by a licensed service or hospital-owned ambulance

Non-Local Transportation - obtaining treatment not available locally

Outpatient Lodging - more than 100 miles from home

Family Member Lodging and Transportation - adult family member travels with you during non-local hospital stays for specialized treatment. Transportation not paid if Non-Local Transportation benefit is paid

Physical or Speech Therapy - to restore normal body function

New or Experimental Treatment - payable if physician judges to be necessary and only for treatment not covered under other policy benefits

Prosthesis - surgical implantation of prosthetic device for each amputation

Hair Prosthesis - wig or hairpiece every two years due to hair loss

Nonsurgical External Breast Prosthesis - initial prosthesis after a covered mastectomy

Anti-Nausea Benefit - prescribed anti-nausea medication administered on outpatient basis

Waiver of Premium -** must be disabled 90 days in a row due to cancer, as long as disability lasts

OPTIONAL/ADDITIONAL BENEFITS

Cancer Initial Diagnosis - for first-time diagnosis of cancer other than skin cancer

Intensive Care (ICU)
a. **ICU Confinement -** illness or accident confinements up to 45 days/stay
b. **Step-Down ICU Confinement -** confinements up to 45 days/stay
c. **Ambulance -** licensed air or surface ambulance service to ICU

Wellness Benefit - once per year for one of 23 exams. See left for list of wellness tests

SPECIFIED DISEASES

29 Specified Diseases Covered - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis, Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease, Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or C), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis

*Two or more surgeries done at the same time are considered one operation. The operation with the largest benefit will be paid. Outpatient is paid at 150% of the amount listed in the Schedule of Surgical Procedures. Does not pay for other surgeries covered by other benefits **Premiums waived for employee only

DEFINITIONS

Actual Charges vs. Actual Cost

Actual Charge – Amount billed for a treatment or service before any insurance discounts or payments.

Actual Cost – Amount actually paid by or on behalf of you, accepted as full payment by the provider of goods or services.

CERTIFICATE SPECIFICATIONS

Eligibility

Coverage may include you, your spouse or domestic partner, and children under age 26.

Termination of Coverage

Coverage under the policy ends on the date the policy is canceled; the last day premium payments were made; the last day of active employment, unless coverage is continued due to Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence; the date you or your class is no longer eligible.

Spouse/domestic partner coverage ends upon divorce/termination of partnership or your death. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Portability Privilege

Coverage may be continued under the Portability Provision when coverage under the policy ends. Refer to your Certificate of Insurance for details.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation

We do not pay benefits for a pre-existing condition during the 12-month period beginning on the date that person's coverage starts. A pre-existing condition is a disease or condition for which medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date.

Exclusions and Limitations

We do not pay for any loss except for losses due to cancer or a specified disease. Benefits are not paid for conditions caused or aggravated by cancer or a specified disease. Treatment and services must be needed due to cancer or a specified disease and be received in the United States or its territories.

Hospice Care Team Limitation: Services are not covered for food or meals, well-baby care, volunteers or support for the family after covered person's death.

Blood, Plasma and Platelets Limitation: Does not include immunoglobulins or blood replaced by donors.

For the **Surgery, New or Experimental Treatment** and **Prosthesis** benefits, we pay 50% of the applicable maximum when specific charges are not obtainable as proof of loss.

For the **Radiation/Chemotherapy for Cancer** benefit, we do not pay for: any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; treatment planning, consultation or management; the design and construction of treatment devices; basic radiation dosimetry calculation; any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; the diagnostic tests related to these treatments; or any devices or supplies including intravenous solutions and needles related to these treatments.

Intensive Care Exclusions and Limitations

Benefits are not paid for attempted suicide or intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed by a physician, or alcoholism or drug addiction. Benefits are not paid for confinements to a care unit that does not qualify as a hospital intensive care unit, including progressive care, subacute intensive care, intermediate care, private rooms with monitoring, or step-down and other lesser care units. Benefits are not paid for step-down confinements in the following units: telemetry or surgical recovery rooms; post-anesthesia care; progressive care; intermediate care; private monitored rooms; observation units in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms; emergency, labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. Benefits are not paid for continuous confinements occurring during a hospitalization prior to the effective date. Children born within 10 months of the effective date are not covered for confinement occurring or beginning during the first 30 days of the child's life. We do not pay for ambulance if paid under the Cancer and Specified Disease Ambulance benefit.

Allstate BENEFITS

This brochure is for use in enrollments sitused in TX and is incomplete without the accompanying rate insert. This advertisement is a solicitation of insurance; contact may be made by an Allstate Benefits Agent, Agency, or Representative.

This material is valid as long as information remains current, but in no event later than September 10, 2024.
Group Cancer benefits are provided under policy form GVCP3, or state variations thereof.

The coverage provided is limited benefit supplemental cancer and specified disease insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. There may be instances when a law requires that benefits under this coverage be paid to a third party, rather than to you. If you or a dependent have coverage under Medicare, Medicaid, or a state variation, please refer to your health insurance documents to confirm whether assignments or liens may apply.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Critical Illness Insurance

AFLAC | www.aflacgroupinsurance.com | 800-433-3036

Prepare For the Unexpected

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

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

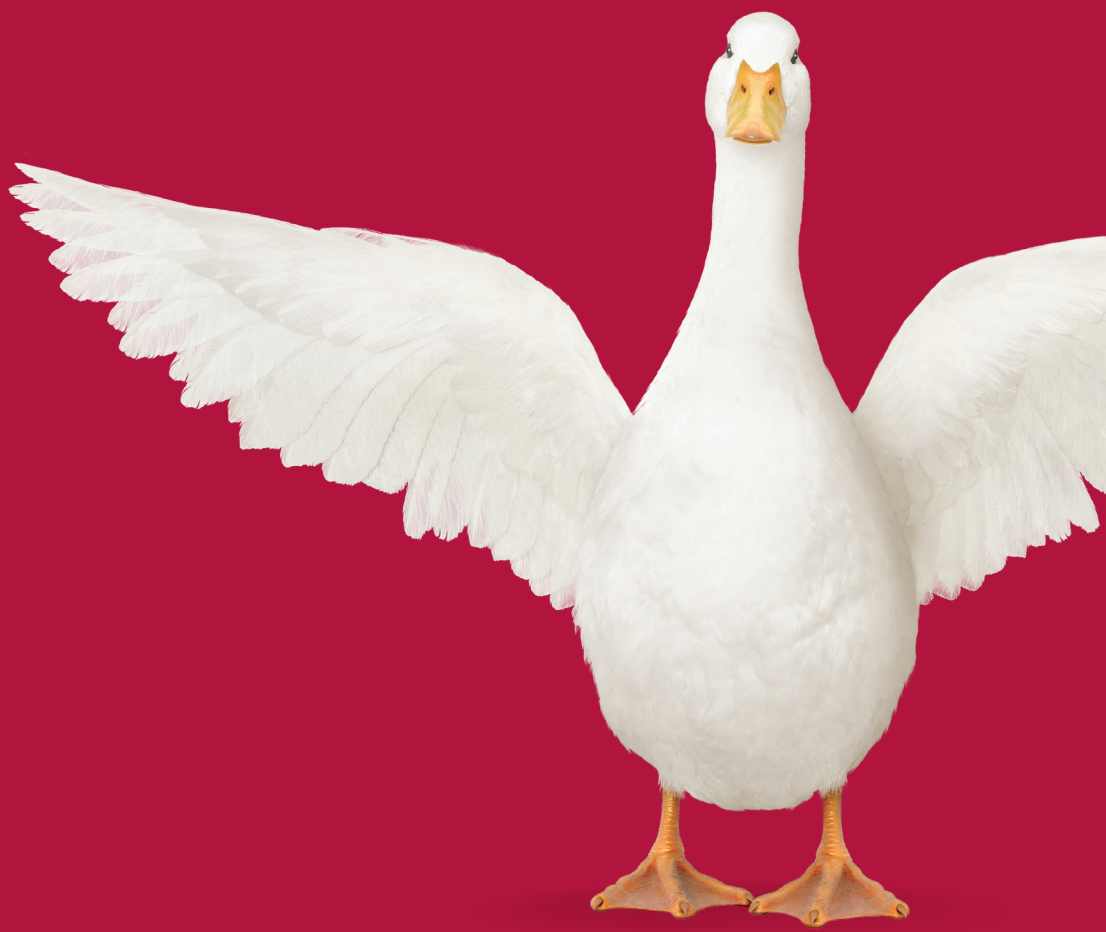
Prepare now for the unexpected with a critical illness insurance plan. The plan helps you focus on getting well rather than worrying about finances. Visit the Employee Benefits Center and view policy for more details.

Aflac

Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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



Aflac®

AFLAC GROUP CRITICAL ILLNESS

CI G

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.

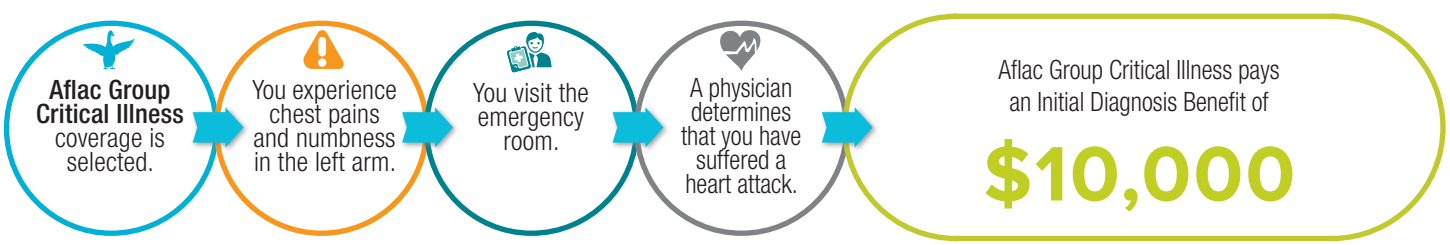
The Aflac Group Critical Illness plan benefits include:

- 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%

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

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

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

*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.

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

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

SUCCESSOR INSURED WAIVER OF PREMIUM RIDER BENEFIT
If you die, and your spouse is also insured under this plan at the time of your death, then your surviving spouse may apply to become the primary insured. This would include continuation of any dependent child coverage that is in force at that time. (In Illinois: Spouse and dependent child coverage will continue for a period of 90 days after your death.)

We will waive premiums once the successor insured has applied to keep the coverage in force for your surviving spouse and for any dependent child coverage that is in force at the time of your death. Premiums will be waived for a period of six months from the date of your death, or until the date coverage ends, whichever comes first.

HEALTH SCREENING BENEFIT (Employee and Spouse only)
We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

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.

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.

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 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.	25%

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
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.

State references refer to the state of your group and not your resident state.

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

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

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

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
  - 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
- 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

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

Date of Diagnosis is defined as follows:

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

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 physphokinase (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) images, or
- Magnetic Resonance Imaging (MRI).

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

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

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.
  - 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,
- Loss of coordination,
- Speech disturbances, or
- 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 - Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and
- Require substantial physical assistance from another adult to perform at least three ADLs.

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

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

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

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

CHILDHOOD CONDITIONS RIDER

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

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.

Accident Insurance

AFLAC | www.aflacgroupinsurance.com | 800-433-3036

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

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

Accident Semi-Monthly Rates	
Employee	$8.10
Employee + Spouse	$11.58
Employee + Children	$15.45
Family	$18.93

Peace of Mind *and* Real Cash Benefits

GROUP ACCIDENT INSURANCE

AC1G

Aflac®

We've got you under our wing.®

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. Definitions, Pre-Existing Condition limitation, limitations and exclusions, benefits, termination, portability, etc., may vary based on your employer's home office. Please see your agent for the plan details specific to your employer. This product is not available in all states.

GROUP ACCIDENT INSURANCE

Policy Series CA7700-MP This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

AC1G

Do you know how much a trip to the emergency room could cost you?

An accident insurance plan provides benefits to help cover the costs associated with unexpected bills. You don't budget for accidents if you're like most people. When a Covered Accident occurs, the last thing on your mind is the charges that may be accumulating while you're at the emergency room, including:

- The ambulance ride
- Use of the emergency room
- Surgery and anesthesia
- Stitches
- Casts
- Wheelchairs
- Crutches
- Bandages

You get the picture. These costs add up—fast. You hope they never happen, but at some point you may take a trip to your local emergency room. If that time comes, wouldn't it be nice to have an insurance plan that pays benefits regardless of any other insurance you have? This group accident plan does just that.

FEATURES

- 24-hour coverage
- No limit on the number of claims
- Pays regardless of any other insurance plans you may have
- Benefits available for your Spouse and/or Dependent Children
- Benefits for both inpatient and outpatient treatment of Covered Accidents
- Guaranteed issue (No underwriting is required to qualify for coverage.)
- Payroll deduction (Premiums are paid by convenient payroll deduction.)
- Portable coverage (You can continue coverage when you leave employment; see back of brochure for guidelines.)

80.1 MILLION

People sought medical attention for an injury.*

* *All Injuries, 2014*, Centers for Disease Control and Prevention.

HOSPITAL BENEFITS

	EMPLOYEE	SPOUSE	CHILD
HOSPITAL ADMISSION We will pay this benefit when an insured is admitted to a hospital and confined as a resident bed patient because of injuries received in a Covered Accident (within six months of the date of the accident). We will pay this benefit once per calendar year, per Covered Accident. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.	$1,000	$1,000	$1,000
HOSPITAL CONFINEMENT (per day) We will provide this benefit on the first day of hospital confinement for up to 365 days per Covered Accident when an insured is confined to a hospital due to a Covered Accident. Hospital confinement must begin within 90 days from the date of the accident.	$200	$200	$200
HOSPITAL INTENSIVE CARE (per day) This benefit is paid up to 30 days per Covered Accident. Benefits are paid in addition to the Hospital Confinement Benefit.	$400	$400	$400
MEDICAL FEES (for each accident) If an insured is injured in a Covered Accident and receives treatment within one year after the accident, we will pay up to the applicable amount for physician charges, emergency room services, supplies, and X-rays. The total amount payable will not exceed the maximum shown per accident. Initial treatment must be received within 60 days after the accident.	$125	$125	$75
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)			
Quadriplegia	$10,000	$10,000	$10,000
Paraplegia	$5,000	$5,000	$5,000

ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)

	EMPLOYEE	SPOUSE	CHILD
ACCIDENTAL-DEATH	$50,000	$10,000	$5,000
ACCIDENTAL COMMON-CARRIER DEATH (plane, train, boat, or ship)	$100,000	$50,000	$15,000
SINGLE DISMEMBERMENT	$6,250	$2,500	$1,250
DOUBLE DISMEMBERMENT	$25,000	$10,000	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	$1,250	$500	$250
PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)	$100	$100	$100

If the Accidental Common-Carrier Death Benefit is paid, we will not pay the Accidental-Death Benefit.

Accidental Injury means bodily injury caused solely by or as the result of a Covered Accident.

Covered Accident means an accident that occurs on or after the Effective Date, while the certificate is in force, and that is not specifically excluded.

MAJOR INJURIES (diagnosis and treatment within 90 days)

	EMPLOYEE	SPOUSE//CHILD
FRACTURES (closed reduction):		
Hip/Thigh	$4,500	$4,000
Vertebrae (except processes)	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (depressed)	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand/Wrist	$2,250	$2,000
Foot/Ankle/Knee Cap	$2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (mandible)	$1,800	$1,600
Skull (simple)	$1,575	$1,400
Upper Arm/Upper Jaw	$1,575	$1,400
Facial Bones (except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320
DISLOCATIONS (closed reduction):		
Hip	$3,600	$2,700
Knee (not knee cap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

- Open reduction is paid at 150% of closed reduction.
- Multiple fractures and dislocations are paid at 150% of the benefit amount for open or closed reduction.
- Chip fractures are paid at 10% of the fracture benefit.
- Partial dislocations are paid at 25% of the dislocation benefit.

SPECIFIC INJURIES

	EMPLOYEE//SPOUSE//CHILD
RUPTURED DISC	
(treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
TENDONS/LIGAMENTS	
(within 60 days; surgical repair within 90 days). If the insured fractures a bone or dislocates a joint, the amount paid will be based on the number (single or multiple) of tendons or ligaments repaired. We will only pay one benefit.	$400 (Single) $600 (Multiple)
TORN KNEE CARTILAGE	
(treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
EYE INJURIES	
Treatment and surgical repair within 90 days	$250
Removal of foreign body	$50
CONCUSSION	
(a head injury resulting in electroencephalogram abnormality)	$200
COMA (lasting 30 days or more)	$10,000

	EMPLOYEE//SPOUSE//CHILD
EMERGENCY DENTAL WORK (per accident)	
Repaired with crown	$150
Resulting in extraction	$50
BURNS (treatment within 72 hours and based on percent of body surface burned):	
Second-Degree Burns	
Less than 10%	$100
At least 10%, but less than 25%	$200
At least 25%, but less than 35%	$500
35% or more	$1,000
Third-Degree Burns	
Less than 10%	$500
At least 10%, but less than 25%	$3,000
At least 25%, but less than 35%	$7,000
35% or more	$10,000
First-degree burns are not covered.	
LACERATIONS (treatment and repair within 72 hours):	
Under 2" long	$50
2" to 6" long	$200
Over 6" long	$400
Lacerations not requiring stitches	$25

Multiple Lacerations: We will pay for the largest single laceration requiring stitches.

ADDITIONAL BENEFITS

	EMPLOYEE//SPOUSE//CHILD
AMBULANCE	$100
AIR AMBULANCE If an insured requires transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a Covered Accident, we will pay the amount shown.	$500
BLOOD/PLASMA If the insured receives blood or plasma within 90 days following a Covered Accident, we will pay the amount shown.	$100
APPLIANCES We will pay this benefit when an insured is advised by a physician to use a medical appliance due to injuries received in a Covered Accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.	$100
INTERNAL INJURIES (resulting in open abdominal or thoracic surgery)	$1,000
ACCIDENT FOLLOW-UP TREATMENT We will pay this benefit for up to six treatments per Covered Accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the Covered Accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.	$25
EXPLORATORY SURGERY [without repair (i.e., arthroscopy)]	$250
PROSTHESIS If an insured requires the use of a prosthetic device due to injuries received in a Covered Accident, we will pay this benefit. Hearing aids, wigs, or dental aids, including but not limited to false teeth, are not covered.	$500
PHYSICAL THERAPY We will pay this benefit for up to six treatments per Covered Accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the Covered Accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$25
TRANSPORTATION If hospital treatment or diagnostic study is recommended by the insured's physician and is not available in the insured's city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the Covered Accident. The distance to the hospital must be greater than 50 miles from your residence.	**$300** (train/plane) **$150** (bus)
FAMILY LODGING BENEFIT (per night) If an insured is required to travel more than 100 miles from his or her home for inpatient treatment of injuries received in a Covered Accident, we will pay this benefit for an immediate adult family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital. The treatment must be prescribed by the insured's local physician.	$100
WELLNESS BENEFIT (per 12-month period) After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.	$60

LIMITATIONS AND EXCLUSIONS

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.

WE WILL NOT PAY BENEFITS FOR LOSS, INJURY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those that are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, the Virgin Islands, Bermuda, and Jamaica, except under the Accidental Common-Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Participating in any professional or semiprofessional organized sport.
- Being legally intoxicated or under the influence of any narcotic, unless taken under the direction of a physician.
- Driving any taxi, or intrastate or interstate long-distance vehicle for wage, compensation, or profit.
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment, except as a result of a covered accident.

A doctor or physician does not include you or a member of your immediate family.

A hospital is not a nursing home, an extended-care facility, a convalescent home, a rest home or a home for the aged, a place for alcoholics or drug addicts, or a mental institution.

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for a loss that is caused by, that is contributed to, or that results from a Pre-Existing Condition for 12 months after the Effective Date of your certificate and attached riders, as applicable.

Pre-Existing Condition means within the 12-month period prior to the Effective Date of a certificate and attached riders, as applicable: (1) those conditions for which medical advice or treatment was received or recommended, or (2) the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

A claim for benefits for loss starting after 12 months from the Effective Date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures, and taking prescribed drugs and medicines.

A certificate may have been issued as a replacement for a certificate previously issued under the plan. If so, then the Pre-Existing Condition Limitation provision of the certificate applies only to any increase in benefits over the prior certificate. Any remaining period of the Pre-Existing Condition Limitation of the prior certificate will continue to apply to the prior level of benefits.

You and **Your** refer to an employee as defined in the plan.

Spouse means the person married to you on the Effective Date of the rider. The rider may only be issued to your Spouse if your Spouse is between ages 18 and 64, inclusive. Coverage on your Spouse terminates when your Spouse attains age 70.

Dependent Children means your natural children, stepchildren, foster children, legally adopted children, or children placed for adoption, who are under age 26.

Your natural Children born after the Effective Date of the rider will be covered from the moment of live birth. No notice or additional premium is required.

Coverage on Dependent Children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on his or her parent(s) for support, the above age 26 limitation shall not apply. Proof of such incapacity and dependency must be furnished to the company within 31 days following such child's 26th birthday.

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION

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.

EFFECTIVE DATE

The **Effective Date** for an employee is as follows: (1) An employee's insurance will be effective on the date shown on the Certificate Schedule, provided the employee is then actively at work. (2) If an employee is not actively at work on the date coverage would otherwise become effective, the Effective Date of his or her coverage will be the date on which such employee is first thereafter actively at work.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

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.

Legal Plan

Securian Financial Group | www.http://lifebenefits.com/lfg | 877-849-6034

Have you ever found yourself in need of legal advice, but aren't sure where to go? A voluntary group legal plan helps fill that need. It provides you with access to professional lawyers at a low monthly rate. For just a few dollars a month, you can consult with a lawyer about having your will prepared, reviewing documents, contesting a traffic ticket, lawsuits, divorce and so much more. Expert legal advice is available at your fingertips.

Automatic access to Lifestyle Benefits

Your employer's group insurance programs help protect your financial wellness. And you and your family can rely on a suite of additional tools, support, guidance and services to help make life a little easier.

There is no additional fee or enrollment for these resources. Just access the services you need, whenever you need them. Lifestyle Benefits are automatically available to active U.S. employees insured with Securian Financial. Your spouse and insurance-eligible children can also use these resources, even if they're not covered under the insurance program.

Lifestyle Benefits available to you include:

- Legal, Financial and Grief Resources
- Travel Assistance
- Legacy Planning Resources

Legal, Financial and Grief Resources
from TELUS Health

Professional services for a variety of needs - from legal matters and financial situations to coping with loss - through comprehensive web and mobile resources, as well as consultations

Legal: Includes resources such as will prep templates - and a free, 30-minute consultation per issue, by phone or in an attorney's office (additional services available at 25 percent discount)

Funeral planning: Resources to make funeral arrangements, including a final wishes and funeral planning form and guidebooks, as well as a 10 percent discount on prearrangements and immediate-need end-of-life services

Financial: Includes telephone consults or 45-minute counseling session per issue on many topics — from budget analysis to tax planning. Includes online access to a financial fitness assessment

Grief support: Access master's-level consultants by phone for any stage of grief and referrals for loss support

Well-being: Includes a total well-being index with personalized recommendations for lifestyle changes, access to online self-guided programs to help with anxiety, depression and stress, as well as personalized fitness journeys based on personal goals

How to access:

LifeBenefits.com/Lfg
username: lfg
password: resources

1-877-849-6034

Travel Assistance
from RedpointWTP LLC

24/7 online, pre-trip resources and support for emergency travel assistance and other services when traveling 50+ miles from home

Pre-trip planning and trip support: Passport, visa, immunization and currency conversion information

Medical evacuation services: Pre-hospital and rental vehicle assistance, transportation to nearest appropriate medical facility once hospitalized, mortal remains repatriation, return of dependent children/pets, family member visitation, and travel companion transport

Security evacuation services: Transfer to nearest safe area, ID theft support and assistance replacing lost/stolen luggage

How to access:

LifeBenefits.com/travel

U.S./Canada:
1-855-516-5433

All other locations:
1-415-484-4677

Legacy Planning Resources
from Securian Financial

Online information and resources to help with multiple aspects of legacy planning — from end-of-life and funeral planning, final arrangements, directives and survivor assistance

Funeral concierge: Allows for coverage verification and direct payment to a funeral home so services can be provided before insurance payment is made

Express Assignment™: Same-day funeral home assignment service reduces concern about paying funeral expenses by working with the funeral home or lending agency

How to access:

securian.com/legacy

Employee Assistance Program

Neely | neelyeap.helpwhereyouare.com | 866-212-6096

Life pulls us in many different directions. Between kids, personal relationships, extracurricular activities, and family time, it seems like we don't have enough time in a day to fit it all in. When life gets you stressed, call the employee assistance line provided by your employer. It offers 24/7 access to professionals who can help you successfully face emotional issues.

An employee assistance program, or EAP, is a free, voluntary program offered by your employer. With one phone call, you will have access to short-term counseling and confidential assessments whenever you have a personal or work-related problem.

Employee assistance programs address a wide range of issues including mental and emotional well-being, substance abuse and grief. Counselors are held to the highest ethical standard and are trained to keep your situation confidential. They work with you to determine the best way to address your needs and move you in a positive direction.

WHAT DOES MY EAP INCLUDE?

ACCESS TO 24/7: Our team is staffed to support incoming calls day and night, weekends, and holidays in English and Spanish, offering In The Moment Counseling for urgent issues, with an ADA-compliant phone line available at all times.

Counseling Services: Employees and household family members receive 1 to 6 free, confidential, structured counseling sessions per employee or family member per issue annually; available modes include telephonic, face-to-face, in-person, or online video counseling.

Legal and Financial Support: Unlimited access to certified financial advisors and attorneys for assistance, plus free wills and legal document services.

Member Website: Our website features comprehensive resource articles, self-assessments, and audio/video files covering emotional well-being, health and wellness, workplace issues, child and elder care, adoption, and educational content; offers support in Spanish, multiple languages, online seminars and assessments, legal forms, and LiveCONNECT live chat access.

Newsletters: Monthly employee and supervisor newsletter with wellness articles and other resources, upcoming event information, and direct registration options.

Secure the Wheel: Emergency cab fare reimbursement for situations when you're unable to drive yourself.

Wellness App: iConnectYou, allows users to engage with a counselor via phone, video, instant messaging, or SMS text, serving as both an access and delivery tool.

Wellness Training/Development: Onsite and live online training sessions for employees and supervisors based on seven core workplace well-being themes, including leadership and development, with closed captions on all video content.

ACCESS NEELY EAP SERVICES

All benefits can be accessed by calling our 24/7 helpline

866-212-6096 | 800-735-2989 (TDD)

neelyeap.helpwhereyouare.com

Company Code:cedar

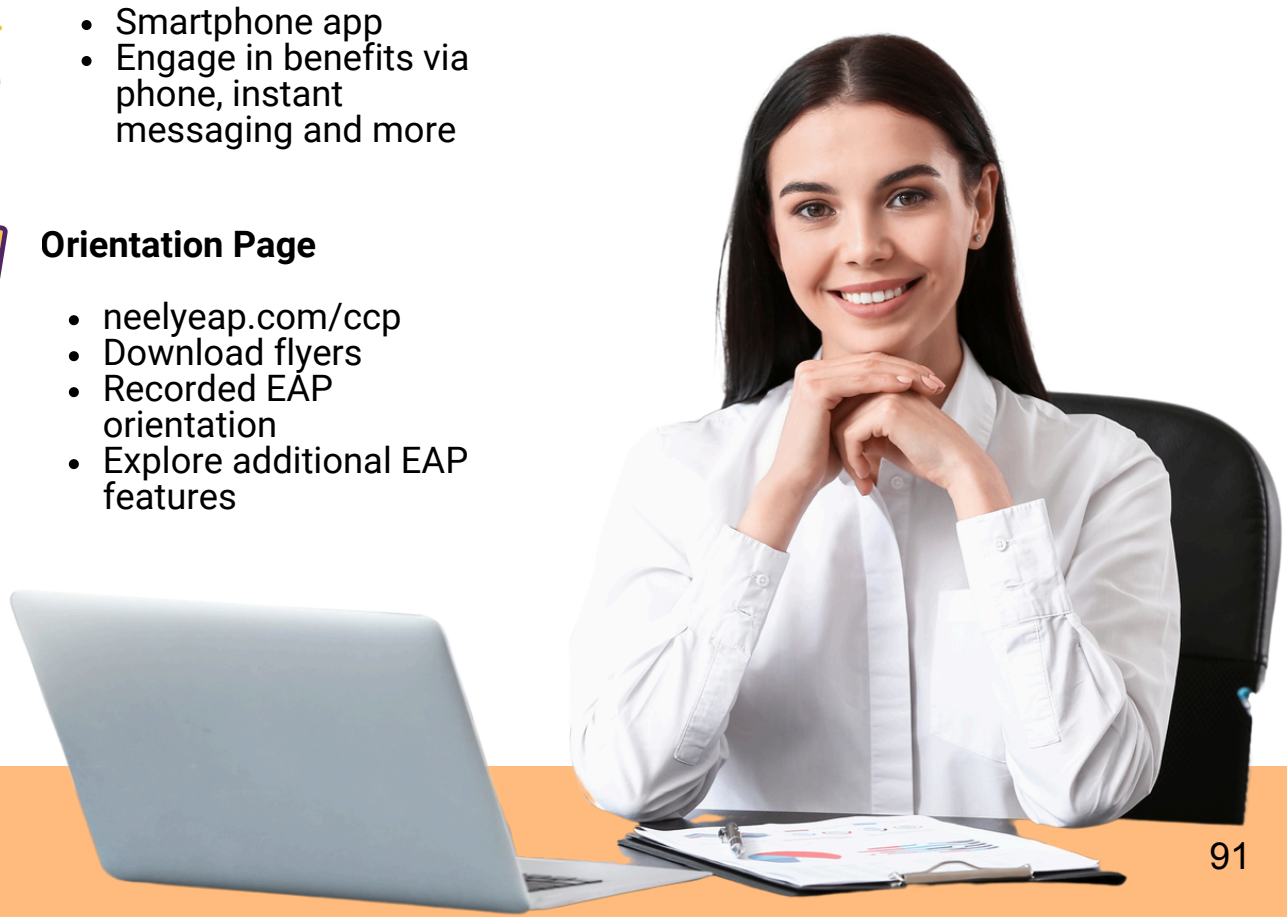
- Register for Seminars and view On-Demand content
- Download forms and read articles
- LiveCONNECT, Real Messaging Service, response within 2 hours

iConnectYou

- Smartphone app
- Engage in benefits via phone, instant messaging and more

Orientation Page

- neelyeap.com/ccp
- Download flyers
- Recorded EAP orientation
- Explore additional EAP features

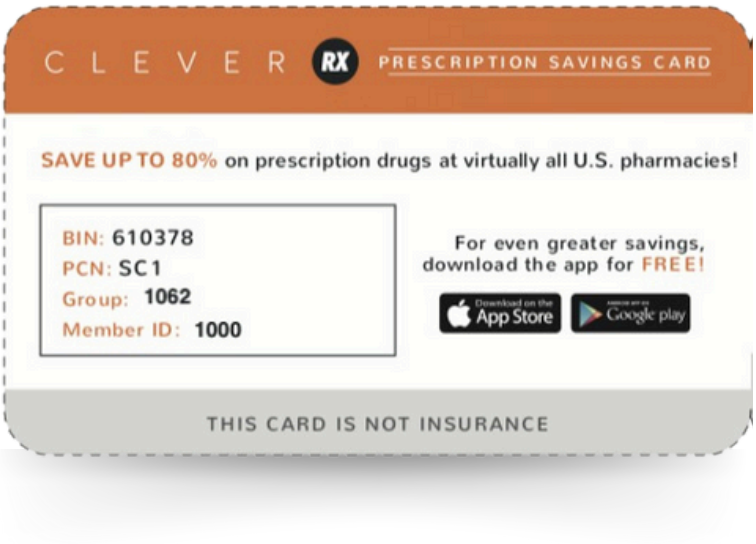


Clever RX

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

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

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



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

Clever RX Highlights

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

Carrier Contact Information

Product	Carrier	Website	Phone
Medical	United Health Care	www.myuhc.com	866-633-2446
HSA	HSA Bank	www.hsabank.com	800-357-6246
Dental	Delta Dental	www.detladental.com	800-521-2651
Vision	Eyemed	www.eyemed.com	866-723-0513
Basic Life and AD&D	Securian Financial Group	www.lifebenefits.com	800-392-7295
Disability	Madison Life Group	www.madisonlife.com	800-356-9601 ext. 2410
Legal	Securian Financial Group	www.lifebenefits.com/lgf	877-849-6034
EAP	Neely	www.neelyeap.helpwhereyouare.com	86-212-6096
Medical FSA and Dependent Care	First Financial Administrators, INC	www.ffga.com	866-853-3539
Permanent Life	Texas Life	www.texaslife.com	800-283-9233
Cancer	Allstate	www.allstatebenefits.com	800-521-3535
Critical Illness	Aflac	www.aflacgroupinsurance.com	800-433-3036
Accident	Aflac	www.aflacgroupinsurance.com	800-433-3036
Hospital Indemnity	Aetna	www.myaetnasupplemental.com	800-607-336