CCH HEALTHCARE

2020 Benefit Enrollment Guide

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Welcome!

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

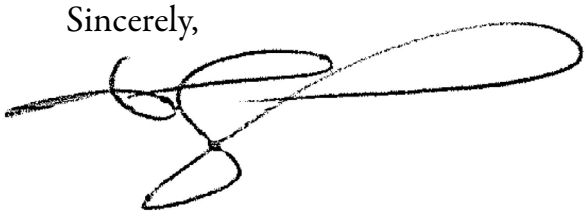
An important part of your compensation package is the employee benefits made available to all eligible employees the first of the month following 60 days of employment. This guide will give you an overview of all the available insurance benefit choices. Our H.R./ Benefits Team has worked hard to provide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

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

To make the interview process as easy as possible, we have a dedicated enrollment firm with counselors who are available to help you understand how each benefit can work for you. During the month prior to your benefit eligibility, you must find a time to call the enrollment center at (513) 785-0718. The call center is open 9 AM thru 6 PM Eastern Time. You can have your benefit interview at that time if a counselor is available, or schedule an appointment for a future time. It's that simple.

Again, welcome aboard! Wishing you much success!

Sincerely,



Jacob Stern CEO

Medical Insurance

A UnitedHealthcare Company

	Plan 1		Plan 2	
	In-network	Out-of-network	In-network	Out-of-network
Deductible (Single/Family)	$2,700/$5,200	$5,000/$10,000	$5,900/$11,800	$18,000/$36,000
Maximum amount that any one person will satisfy towards the annual family deductible	$2,700	$5,000	---	---
Out-of-Pocket Limit (Single/Family)	$3,500/$7,000	$7,000/$14,000	$6,300/$12,700	$20,000/$40,000
Maximum amount that any one person will satisfy towards the annual family out-of-network	$3,500	$7,000	---	---
Co-Insurance	---	30%	---	30%

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

Services You May Need	Plan 1 In-Network	Plan 1 Out-of-Network	Plan 2 In-Network	Plan 2 Out-of-Network
Health care provider's office or clinic visit				
Primary care visit to treat an injury or illness	No charge	30% Coinsurance	$25 Copay per visit *Deductible Waived*	30% Coinsurance
Specialist visit	No charge	30% Coinsurance	$25 Copay per visit *Deductible Waived*	30% Coinsurance
Preventive care/screening/ immunization	No charge *Deductible Waived*	30% Coinsurance	No charge *Deductible Waived*	30% Coinsurance
	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.			
Lab Tests				
Diagnostic test (x-ray, blood work)	No charge	30% Coinsurance	No charge	30% Coinsurance
Imaging (CT/PET scans, MRIs)	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*
Perscription Drugs				
Generic drugs (Tier 1)	$10 Copay per prescription (retail); $25 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	$15 Copay per prescription (retail); $37 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.
Preferred brand drugs (Tier 2)	$35 Copay per prescription (retail); $88 Copay per prescription (mail order)		Not covered	
Non-preferred brand drugs (Tier 3)	$45 Copay per prescription (retail); $175 Copay per prescription (mail order)		Not covered	
Specialty drugs (Tier 4)	25% Copay up to a Maximum of $200 per prescription		Not covered	
	Deductible and Out-of-pocket limit applies Covers up to a 30-day supply (retail & specialty); 31-90 day supply (mail order) You must pay the difference in cost between a Generic drug and a Brand-name drug, regardless of circumstances, until the out-of-pocket is met		*Out-of-pocket limit applies Covers up to a 30-day supply (retail); 31-90 day supply (mail order) Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication*	
Outpatient Surgery				
Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance	No charge	30% Coinsurance
Physician/surgeon fees	No charge	30% Coinsurance	No charge	30% Coinsurance

A UnitedHealthcare Company

Services You May Need	Plan 1 In-Network	Plan 1 Out-of-Network	Plan 2 In-Network	Plan 2 Out-of-Network
Immediate Medical Attention				
Emergency room services	No charge True ER; Not covered Non-true ER	No charge True ER; Not covered Non-true ER *In-network deductible applies to Out-of-network benefits True ER*	No charge True ER; Not covered Non-true ER	No charge True ER; Not covered Non-true ER *In-network deductible applies to Out-of-network benefits True ER*
Emergency medical transportation	No charge ground ambulance; Not covered air ambulance	30% Coinsurance ground ambulance; Not covered air ambulance	No charge ground ambulance; Not covered air ambulance	30% Coinsurance ground ambulance; Not covered air ambulance
Urgent care	No charge	30% Coinsurance	No charge	30% Coinsurance
Hospital Stay				
Facility fee (e.g., hospital room)	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*
Physician/surgeon fee	No charge	30% Coinsurance	No charge	30% Coinsurance
Mental Health, Behavioral Health, Or Substance Abuse Needs				
Outpatient services	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*	$25 Copay per visit; *Deductible Waived office visits;* *No charge other outpatient services* *Preauthorization is required*	30% Coinsurance *Preauthorization is required*
Inpatient services	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*	No charge *Preauthorization is required*	30% Coinsurance *Preauthorization is required*
Pregnancy				
Office visits	No charge; *Deductible Waived*	30% Coinsurance	No charge; *Deductible Waived*	30% Coinsurance
Childbirth/delivery professional services	No charge	30% Coinsurance	No charge	30% Coinsurance
Childbirth/delivery facility services	No charge	30% Coinsurance	No charge	30% Coinsurance
Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).				
Recovery or Other Special Health Needs				
Home health care	No charge	30% Coinsurance	No charge	30% Coinsurance
	100 Maximum visits per calendar year; *Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.*			
Rehabilitation services	No charge *30 Maximum visits per calendar year*	30% Coinsurance *30 Maximum visits per calendar year*	$25 Copay per visit; *Deductible Waived office therapy;* *No charge hospital therapy* *30 Maximum visits per calendar year*	30% Coinsurance *30 Maximum visits per calendar year*
Habilitation services	Not covered	Not covered	Not covered	Not covered
Skilled nursing care	No charge	30% Coinsurance	No charge	
	100 Maximum days per calendar year; *Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.*		*90 Maximum days per calendar year;* *Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.*	
Durable medical equipment	No charge	30% Coinsurance	No charge	30% Coinsurance
	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchase. *If you don't get preauthorization, benefits could be reduced by 50% per occurrence.*			
Hospice service	No charge	30% Coinsurance	No charge	30% Coinsurance
	Coverage will only be provided if member is 6 months or less from the end of life.			
Children's Dental or Eye Care				
Children's eye exam	No charge; *Deductible Waived* *1 Maximum exam per calendar year*		No charge; *Deductible Waived* *1 Maximum exam per calendar year*	
Children's glasses	Not covered		Not covered	
Children's dental check-up	Not covered		Not covered	

Services Your Plan Does NOT Cover		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult)	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs
Other Covered Services *(Limitations may apply to these services)*		
• Chiropractic care	•Routine eye care (Adult)	

Teledoc Program

Teladoc® gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, web or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

Set Up Your Account	
Online	Visit the Teladoc website and click “set up account”
Mobile app	Download the app and click “Activate account”. Visit Teladoc.com/mobile to download the app
Call Teladoc	Teladoc can help you register your account over the phone

Provide Medical History
Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis

Request a Consult
Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

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Health Savings Account

(Only for Medical Enrollees in the CDHP with HSA Plan)

What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

Funds contributed to an HSA are triple-tax-advantaged.

1. Money goes in tax-free. Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited into your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.

2. Money comes out tax-free. Eligible healthcare purchases can be made tax-free when you use your HSA. Purchases can be made directly from your HSA account, either by using your benefits debit card, ACH, online bill-pay, or check – or, you can pay out-of-pocket and then reimburse yourself from your HSA.

3. Earn interest, tax-free. The interest on HSA funds grows on a tax-free basis. And, unlike most savings accounts, interest earned on an HSA is not considered taxable income when the funds are used for eligible medical expenses.

4. Additional money goes in from your employer. Your employer will match the amount you contribute monthly to HSA up to $100 per month.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, vision, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

Am I eligible to participate?

In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.

What is a high-deductible health plan?

A HDHP is a health insurance plan with deductible amounts that are greater than $1,400 for individual or $2,800 for family coverage and have an out-of-pocket maximum that does not exceed $6,900 for individual or $13,800 for family coverage.

How do I contribute money to my HSA?

Payroll deduction is offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

Can I change my contributions to my HSA during the year?

Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed $3,550 for singles or $7,100 for families in 2020. Individuals aged 55 and over may make an additional $1,000 catch-up contributions.

Do I have to spend all my contributions by the end of the plan year?

No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-deferred.

Health Savings Account – Continued

What happens if my employment is terminated?

HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.

How do I access the funds in my HSA?

Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/ or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your HSA.

Can I withdraw the money for non-healthcare purchases?

Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll pay a 20% excise tax. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.

Can I roll over or transfer funds from my HSA or Medical Savings Account (or Archer MSA) into an HSA?

Yes. Pre-existing HSA funds or MSA monies may be rolled into an HSA and will continue their tax-free status.

Can I control how the funds are invested?

Yes. Once your HSA cash account balance reaches the minimum amount required by the custodian, you can transfer funds to an HSA investment account. You can choose from a selection of mutual funds and setup and allocation model for future transfers like you would for a 401k plan.

Can I transfer funds between the cash and investment accounts?

Yes. You can transfer money between your HSA cash and HSA investment account at any time.

For more information, call 877-943-2287

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Flexible Spending Account

Healthcare

Healthcare FSA eligible expenses:	Prescriptions, copays, coinsurance, deductibles, vision care, dental expenses for incurred by you or your eligible dependents. Over-the-Counter (OTC) medications are only eligible with a valid prescription. A complete list of expenses eligible under the medical FSA is available at www.flexfacts.com. Click on the FSA Eligible Expense Table link at the bottom of the page and enter in Access Code "flex2011".
Healthcare FSA ineligible items:	Cosmetic procedures, vitamins/supplements and food under a weight-loss program (may be reimbursable with a doctor's letter of medical necessity or prescription).*
Plan year dates: 1/1/2020 - 12/31/2020	The plan year is the time period during which you may incur your expenses.
Maximum annual election: $1,000	The maximum amount you can deduct from your paycheck over the course of the plan year. Your full annual election is available as of the first day of the plan year.
Claim run-out date: 3/31/2021	The day which all of your manual claims must be submitted. All claims must have incurred during the plan year.

Dependent Day Care

Dependent Day Care FSA eligible expenses:	Expenses incurred for the care of a child age 12 and under; or a disabled dependent incapable of self-care that allow the employee (and spouse, if applicable) to work. Additional restrictions may apply.
Dependent Day Care FSA ineligible expenses:	Overnight camp, care provided by your dependent under the age of 18, babysitting when you are not working, care of your dependent who does not spend at least 8 hours per day in your home.*
Plan year dates: 1/1/2020 - 12/31/2020	The plan year is the time period during which you may incur your expenses.
Maximum annual election: $5,000	The maximum amount you can deduct from your paycheck over the course of the plan year. Your funds will be available as they are deducted from your paycheck. Additional Restrictions may apply.
Claim run-out date: 3/31/2021	The day which all of your manual claims must be submitted. All claims must have incurred during the plan year.

Contact Us

Our customer service representatives are ready to help with any questions you may have. Please feel free to contact us using one of these methods:

- **Call our customer service department toll free at 877-94-FACTS (32287) or local at 732-640-5951 between the hours of 8:30 AM and 8:30 PM Monday through Thursday and Friday from 8:30 AM to 5:30 PM EST, excluding holidays.**
- **Send an email info@flexfacts.com**
- **Send a fax to 877-747-8564**
- **By mail at 1200 River Ave, Suite 10E, Lakewood, NJ 08701**

Filing a Claim

The easiest way to use your funds is by using your Flex Facts debit card at the point of service. The card can be used at any medical or dependent care facility that accepts MasterCard. You can also use your card at most pharmacies. When you use your card funds are automatically deducted from your account to pay for eligible expenses. Please note that you should retain all of your receipts. The IRS requires that we request copies of receipts for certain claims. If you are required to send in receipts an e-mail or letter will be sent to you the business day after you use your card.

If you are not able to use your card at the point of service you can file a claim online, by fax or by mail.

- To file electronically log into your account, click on the "Request Reimbursement" link under "My Accounts" on the top left hand side of the screen then follow the on-line instructions.
  - To file via fax or mail complete a Claim Form and send it along with a copy of the receipt/invoice to:
  - Flex Facts Claims Department, 1200 River Ave, Suite 10E, Lakewood, NJ 08701
- Fax 877-747-8564
- You can download the claim form at www.flexfacts.com or request a copy from your human resources representative.

Manual claims are reimbursed via direct deposit or manual check. To speed up the reimbursement process please sign up for direct deposit by logging into your account as described below.

If you should terminate employment for any reason your card will be deactivated. You will have 90 days following the date of termination to submit manual claims that incurred while you were an active participant in the plan.

Accessing Your Account On-Line

Once your enrollment is received and entered into the system you will be able to access your account information on-line:

5. Enter in the information requested. You will need the following information:
   a. Your employee ID is your Social Security Number(no dashes) Unless your employer uses a different type of employee identifying number
   b. Your Registration ID (Card Number from Drop Down) is your Flex Facts Debit Card Number
   c. You then must click on the link to "View Terms of Use" and it will bring up a separate page, after reviewing, mark the box to accept the terms and then click Register

Once you log into your account you can access your account information including balances and claims history.

You can download a Mobile App for your Smartphone at the Apple iTunes store (iPhone) or the Google Play Store (Android) by searching for FlexFacts. Once you download the app you can also create an online account using the above instructions. If you have already created an account online you must use the same User ID and Password. The App can be used to view account balances, view transaction history and to upload claims by taking a picture from your Smartphone.

**These are just select examples of ineligible expenses. Any expense not listed in the complete list of eligible expenses on the FlexFacts website may be an ineligible expense. Please see www.flexfacts.com*

Dental Insurance

Plan Features:	Low Plan Active PPO MAX With PPOII Network		High Plan Passive PPO With PPOII Network
	Participating	Non-participating	Participating & Non-participating
Annual Deductible* (Individual/Family)	$50/$150	$50/$150	$50/$150
Preventive Services	100%	80%	100%
Basic Services	80%	70%	80%
Major Services	50%	40%	50%
Annual Benefit Maximum*	$1,000	$1,000	$1,000
Office Visit Copay	N/A	N/A	N/A
Orthodontic Services**	Not Covered	Not Covered	50%**
Orthodontic Deductible	Not Covered	Not Covered	None
Orthodontic Lifetime Maximum	Not Covered	Not Covered	$1,000
**Applies to: Basic & Major services only* ***Orthodontia is covered only for children (appliance must be placed prior to age 20).*			
Reward Provisions			
Required Service for Annual Maximum Increase in the following year	Any Preventive Service	Any Preventive Service	Any Preventive Service
Annual Maximum Reward Increase	$200	$200	$200
Maximum Number of Increases	3	3	3
Annual Maximum Impact if No Visit	Reduced to original plan level	Reduced to original plan level	Reduced to original plan level
			Increase does not apply to Orthodontia
Preventive Services *(partial list)*			
Oral examinations[1]	100%	80%	100%
Cleanings[1] Adult/Child	100%	80%	100%
Fluoride[1]	100%	80%	100%
Sealants[1] (permanent molars only)	100%	80%	100%
Bitewing Images[1]	100%	80%	100%
Full mouth series Images[1]	100%	80%	100%
Space Maintainers	100%	80%	100%
Basic Services *(partial list)*			
Root canal therapy Anterior teeth / Bicuspid teeth	80%	70%	80%
Root canal therapy, molar teeth	80%	70%	80%
Scaling and root planing[1]	80%	70%	80%
Gingivectomy[2]	80%	70%	80%
Amalgam (silver) fillings	80%	70%	80%
Composite fillings (anterior teeth only)	80%	70%	80%
Stainless steel crowns	80%	70%	80%
Incision and drainage of abscess[2]	80%	70%	80%
Uncomplicated extractions	80%	70%	80%
Surgical removal of erupted tooth[2]	80%	70%	80%
Surgical removal of impacted tooth (soft tissue)[2]	80%	70%	80%
Osseous surgery[1 2]	80%	70%	80%
Surgical removal of impacted tooth (partial bony/ full bony)[2]	80%	70%	80%
General anesthesia/intravenous sedation[2]	80%	70%	80%
Crown Lengthening	80%	70%	80%

	Low Plan		High Plan
	Participating	Non-participating	Participating & Non-participating
Major Services *(partial list)*			
Inlays	50%	40%	50%
Onlays	50%	40%	50%
Crowns	50%	40%	50%
Full & partial dentures	50%	40%	50%
Pontics	50%	40%	50%
Denture repairs	50%	40%	50%
Crown Build-Ups	50%	40%	50%

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

Aetna Dental Care RewardSM Plan
The Aetna Dental Care Reward plan encourages oral and overall health by rewarding members who seek dental care. Members who receive a dental service (as outlined in their plan), in one year, will receive increased benefits in the following year. If members continue to receive dental care annually as outlined by their plan, benefits continue to increase year after year until reaching coinsurance, frequency and other maximums as described in the plan.

The benefit level is independently tracked for each member and dependent. After the first year, each family member's benefit level may vary.
If the member or dependent does not seek care in a particular year, the benefit level will either stay at current level or decrease depending on the plan selected.

Other Important Information
This Aetna Dental® Preferred Provider Organization (PPO) MAX benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) MAX plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO MAX plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Emergency Dental Care
If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.
When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:
1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
   (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
   (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
**This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.*

Vision Insurance

Vision care services	IN-NETWORK	OUT-OF-NETWORK
Exam		
Use your Exam coverage once every calendar year		
Routine/Comprehensive Eye Exam	$0 Copay	$40 Reimbursement
Standard Contact lens Fit/Follow up	Member pays discounted fee of $40	Not covered
Premium Contact Lens Fit/Follow-Up	Member pays 90% of retail	Not covered
Eyeglass Lenses /Lens options		
Use your Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single Vision lenses	$20 Copay	$40 Reimbursement
Bifocal Vision lenses	$20 Copay	$60 Reimbursement
Trifocal Vision lenses	$20 Copay	$80 Reimbursement
Lenticular Vision lenses	$20 Copay	$120 Reimbursement
Standard Progessive Vision lenses	$85 Copay	$80 Reimbursement
Premium Progressive Vision lenses[1]	20% Discount off retail minus $120 plan allowance plus $85 Copay = member out-of-pocket	$80 Reimbursement
UV Treatment	Member pays discounted fee of $15	Not Covered
Tint (Solid and Gradient)	Member pays discounted fee of $15	Not Covered
Standard Plastic Scratch Coating	$0 Copay	Not Covered
Standard Polycarbonate Lenses - Adults	Member pays discounted fee of $40	Not Covered
Standard Polycarbonate Lenses - children <19	$0 Copay	Not Covered
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Photochromic/Transitions plastic	Member pays 80% of Retail	Not Covered
Polarized	Member pays 80% of Retail	Not covered
Contact Lenses		
Use your Contact Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional contact lenses	$160 Allowance** Additional 15% off balance over the allowance	$160 Reimbursement
Disposable contact lenses	$160 Allowance	$160 Reimbursement
Medically necessary contact lenses	$0 Copay	$320 Reimbursement
Frames		
Use your Frame coverage once every 2 calendar years		
Any Frame available, including frames for prescription sunglasses	$160 Allowance Additional 20% off balance over the Allowance	$50 Reimbursement
Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands		
Additional pairs of eyeglasses or prescription sunglasses. *Discount applies to purchases made after the plan allowances** have been exhausted.*	Up to a 40% Discount	No Discount
Non-covered items such as cleaning cloths and contact lens solution[2]	20% Discount	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] **only. Call 1-800-422-6600**	15% discount off retail or 5% discount off the promotional price	No Discount
Retinal Imaging[4]	Member pays a discounted fee up to $39	No Discount
Replacement contact lenses	Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit www.aetnavision.com for details	No Discount

Partial list of exclusions and limitations

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

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

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

Key Definitions

Copayment - The fixed amount paid by the member under the plan. Providers should collect all copayments
Allowance - Dollar amount to be applied toward the cost of materials or a service
Reimbursement - Dollar amount to be paid to the member from Aetna up to the providers' billed charge
Out-of-Pocket - The amount the member must pay after benefits have been applied
Discount - Percentage off the providers billed charge or retail cost Standard Polycarbonate - 1.5 mm center thickness with spherical curves
Standard Scratch-Resistant Coating - Front-side factory scratch coat
Standard Progressive Lens - Multi-focal design that produce a gradual change in focus without lines or junctions
Conventional Contact Lens - Lenses intended for ongoing, daily-wear use; rigid gas-permeable lenses are included
Disposable Contact Lens - Lenses that are designed and labeled to be replaced at specified time intervals (e.g., daily, weekly, monthly)
Medically Necessary Contact Lenses - To correct visual acuity to 20/40 or better if such correction is not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.
Coverage is not provided for the following:

- Special vision procedures, such as orthoptics, vision therapy, or vision training.
- Vision services that are covered in whole or in part; under any other part of this plan; or under any other plan of group benefits provided by the policyholder; or under any workers' compensation law or any other law of like purpose.
- For an eye exam which is required by an employer as a condition of employment; or an employer is required to provide under a labor agreement; or is required by any law of a government.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- Replacement of lost, stolen or broken prescription lenses or frames.
- Any exams given during a stay in a hospital or other facility for medical care.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.
This quote is based on a contract situs of New Jersey. Extraterritorial state requirements may apply to members residing in specific States.
If your plan covers members in other states, impacts to your plan of benefits and rates adjustments (if any) will be evaluated and communicated to you at the point of sale.
This material is for information only, and is not an offer or invitation to contract.

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

CHUBB®

Lifetime Benefit Life Insurance

Life Insurance – Valuable protection for your loved ones

You work hard to provide a good life for your family. However, what if something happens to you? Chubb LifeTime Benefit Term provides the help you and your family needs to help pay for:

- Mortgage and Rent
- College and Education
- Retirement
- Household Expenses
- Long Term Care
- Childcare
- Family Debt
- Burial

Lifetime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living or nursing care. For about the same premium, Lifetime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Lifetime Benefit Term Solutions

Guaranteed Issue – Purchase up to $100,000 with no medical questions or exams.*

Guaranteed Premiums - Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue.

Guaranteed Benefits During Working Years - Death Benefit is guaranteed 100% when it is needed most during your working years when your family is relying on your income. While the policy is in force, the death benefit is 100% guaranteed for the longer of 25 years or age 70.

Guaranteed Benefits After Age 70 - Even after age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50% of the original death benefit. And based on current interest rates the full death benefit is designed to last a lifetime.

Paid-up Benefits - After 10 years, paid up benefits begin to accrue. At any point thereafter, if premiums stop, a reduced paid up benefit is guaranteed. Flexibility is perfect for retirement.

Long Term Care *(LTC is not available in NY) - If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Terminal Illness Benefit - After your coverage has been in force for two years, you can receive 50% of your death benefit, up to $100,000, if you are diagnosed as terminally ill.

Fully Portable and Guaranteed Renewable for Life - Your coverage cannot be canceled as long as premiums are paid as due.

Child Term - Death Benefits of $10,000 available. Guaranteed conversion to individual coverage at age 26—up to 5 times the benefit amount.

Waiver of Premium - Waives premium if you become totally disabled.

Payer Waiver of Premium - Waives premium of your spouse, if you become totally disabled.

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

Accident Insurance

Plan Description

The Aflac Group Accident plan provides cash benefits directly to you (unless otherwise assigned) that help with out-of-pocket expenses - medical and nonmedical - associated with treatment in the event of a covered accident.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Coverage	24 Hour
Covered Insureds	Available for all family members Spouses-only and Child-only coverage is not available

HOSPITAL BENEFITS	Employee – Spouse – Child
HOSPITAL ADMISSION We will pay the amount shown, when because of a covered accident, you are injured, require hospital confinement, and are confined to a hospital for at least 24 hours within 6 months after the accident date. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$1,000
HOSPITAL CONFINEMENT (per day) We will pay the amount shown when, because of a covered accident, you are injured and those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date. The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$200
HOSPITAL INTENSIVE CARE (per day) We will pay the amount shown when, because of a covered accident, you are injured, and those injuries cause confinement to a hospital intensive care unit. This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.	$400
MEDICAL FEES (for each accident) We will pay up to the amount shown for X-rays and doctor services when, because of a covered accident, you are injured and those injuries cause you to receive initial treatment from a doctor within 72 hours after the accident. If you do not exhaust the maximum benefit paid during the initial treatment, we will pay the remainder of this benefit for treatment received due to injuries from a covered accident and for each covered accident up to one year after the accident date.	$125 – $125 – $75
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days) Quadriplegia Paraplegia Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, you are injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the accident. The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.	$10,000 $5,000

ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)	Employee	Spouse	Child
Accidental - Death	$50,000	$25,000	$5,000
Accidental Common - Carrier Death (plane, train, boat, or ship)	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
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	$100	$100	$100

Fractures – once per accident, within 90 days of the accident Fractures Scheduled	Closed Reduction Employee – Spouse – Child
Hip/Thigh	$4,000
Vertebrae (except processes)	$3,600
Pelvis	$3,200
Skull (depressed)	$3,000

Fractures Scheduled (Continued)	Closed Reduction Employee – Spouse – Child
Leg	$2,400
Forearm/Hand/Wrist	$2,000
Foot/Ankle/Kneecap	$2,000
Shoulder Blade/Collar Bone	$1,600
Lower Jaw (mandible)	$1,600
Skull (simple)	$1,400
Upper Arm/Upper Jaw	$1,400
Facial Bones (except teeth)	$1,200
Vertebral Processes	$800
Coccyx/Rib/Finger/Toe	$320
Dislocations – once per accident, within 90 days of the accident	
Dislocation Scheduled	**Closed Reduction Employee – Spouse – Child**
Hip	$3,000
Knee	$1,950
Shoulder	$1,500
Foot/Ankle	$1,200
Hand	$1,050
Lower Jaw	$900
Wrist	$750
Elbow	$600
Finger/Toe	$240
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 (treatment within 60 days; surgical repair within 90 days)	
If you tear, sever, or rupture a tendon or ligament in a covered accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for tendons and ligaments repaired.	$600 (Multiple) $400 (Single)
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 nonsurgically, with or without anesthesia	$50
CONCUSSION A concussion or mild traumatic brain injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head.	$200
COMA Coma means a state of profound unconsciousness caused by a covered accident. If you are in a coma lasting 30 days or more as the result of a covered accident, we will pay the benefit shown.	$10,000
EMERGENCY DENTAL WORK (per accident; injury to sound, natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50

SPECIFIC INJURIES (Continued)	Employee – Spouse – Child
BURNS (treatment within 72 hours and based on percentage 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%	$1,000
At least 10%, but less than 25%	$5,000
At least 25%, but less than 35%	$10,000
35% or more	$20,000
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.	
EMERGENCY ROOM TREATMENT We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room and receive initial treatment within 72 hours after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident. We will not pay the Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.	$200
EMERGENCY ROOM OBSERVATION We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room, are held in a hospital for observation for at least 24 hours, and receive initial treatment within 72 hours after the accident. This benefit is payable only once per 24-hour period and only once per covered accident. This benefit is payable in addition to Emergency Room Treatment Benefit.	$100
MAJOR DIAGNOSTIC TESTING We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG). These exams must be performed in a hospital or a doctor’s office. This benefit is limited to one payment per covered accident.	$200
POST TRAUMATIC STRESS DISORDER DIAGNOSIS Post-traumatic Stress Disorder (PTSD) is a mental health condition triggered by a covered accident. We will pay the amount shown if you are diagnosed with post-traumatic stress disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist. This benefit is payable only once per covered accident.	$200
AMBULANCE / **AIR AMBULANCE** If you require 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.	$200 – ambulance $1,000 – air ambulance
BLOOD/PLASMA If you are injured, and receive blood or plasma within 90 days after the covered accident, we will pay the benefit shown.	$100
APPLIANCES If a doctor advises you to use a medical appliance, we will pay the benefit shown. Medical appliance means crutches, wheelchairs, leg braces, back braces, and walkers.	$100
INTERNAL INJURIES (resulting in open abdominal or thoracic surgery) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$1,000

ACCIDENT FOLLOW-UP TREATMENT We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. You 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.	$30
SPECIFIC INJURIES (Continued)	**Employee – Spouse – Child**
EXPLORATORY SURGERY WITHOUT REPAIR (i.e., arthroscopy) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$250
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 each covered person) for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.	$50
PROSTHESIS We will pay this benefit if you require the use of a prosthetic device due to injuries received in a covered accident. We will pay this benefit for each prosthetic device you use. Hearing aids, wigs, dental aids, and false teeth are not covered.	$500
PHYSICAL THERAPY We will pay this benefit for up to six doctor-prescribed physical therapy treatments per covered accident. You must have received initial treatment within 72 hours of the covered accident. The physical therapy treatment must begin within 30 days after the covered accident or discharge from the hospital and must take place within six months of the covered accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$30
TRANSPORTATION We will pay this benefit if a doctor-recommended hospital treatment or diagnostic study is not available in your resident city. 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) We will pay this benefit for each night's lodging, up to 30 days, for an adult immediate family member's lodging if you are required to travel more than 100 miles from your resident home due to confinement in a hospital for treatment of an injury from a covered accident. This benefit is only payable while you remain confined to the hospital, and treatment must be prescribed by your local doctor.	$100
REHABILITATION UNIT BENEFIT (per 12-month period) We will pay the amount shown for injuries received in a covered accident if you are admitted for a hospital confinement, are transferred to a bed in a rehabilitation unit of a hospital, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.	$75

Critical Illness Insurance

Plan Description
The Aflac Group Critical Illness Plan provides cash benefits when an insured person is diagnosed with a covered critical illness-and these benefits are paid directly to you (unless otherwise assigned). The plan proves a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. It is also H.S.A.-compatible. --

Features and Plan Provisions (specific benefit provisions may vary by situs state)		
Employee Coverage	$5,000 – $20,000	
Spouse Coverage	Up to 50% of the face amount elected by the employee	
Guaranteed Issue Amounts	Employee: Spouse:	Up to $50,000 Up to $25,000
Based Benefits		
Heart Attack (Myocardial Infarction)		100%
Sudden Cardiac Arrest		100%
Coronary Artery Bypass Surgery		25%
Major Organ Transplant		100%
Bone Marrow Transplant (Stem Cell Transplant)		100%
Kidney Failure (End-Stage Renal Failure)		100%
Stroke (Ischemic or Hemorrhagic)		100%
Cancer Benefits		
Cancer (Internal or Invasive)		100%
Non-Invasive Cancer		25%
Skin Cancer		$250 per calendar year
Health Screening Benefits		
Health Screening (payable for employee and spouse only)		$50 per calendar year
Additional Benefits		
Coma		100%
Severe Burns		100%
Paralysis		100%
Loss of Sight		100%
Loss of Speech		100%
Loss of Hearing		100%

Please Request a sample policy for full benefit provisions and descriptions.

Hospital Indemnity Insurance

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

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Coverage	Available for all family members "Coverage on employee is required to add child or spouse"
Guaranteed Issue Amounts	Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first anniversary, late enrolls are eligible to enroll on a guaranteed-issue basis.

Hospitalization Benefits	Employee – Spouse – Child
Hospital Admission Benefit The benefit is paid when a Covered Person is admitted to a hospital and confined as a resident bed patient because of Injuries received in a Covered Accident or because of a Covered Sickness. In order to receive this benefit for Injuries received in a Covered Accident, the Covered Person must be admitted to a hospital within six months of the date of the Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency treatment or outpatient treatment. We will pay this benefit once for a period of confinement. We will only pay this benefit once for each Covered Accident or Covered Sickness. If a Covered Person is confined to the hospital because of the same or related Injury or Sickness, we will not pay this benefit again.	$500 per admission
Hospital Confinement (up to 180 days per confinement) This benefit is paid when a covered person is confined to a hospital as a resident bed patient because of a covered sickness or as the result of injuries received in a covered accident. To receive this benefit for injuries received in a covered accident, the covered person must be confined to a hospital within six months of the date of the covered accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.	$200 per day confined
Hospital Intensive Care (30-day maximum for any one period of confinement) This benefit is paid when a covered person is confined in a hospital intensive care unit because of a covered sickness or due to an injury received from a covered accident. To receive this benefit for injuries received in a covered accident, the covered person must be admitted to a hospital intensive care unit within six months of the date of the covered accident. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness. If we pay benefits for confinement in a hospital intensive care unit and a covered person becomes confined to a hospital intensive care unit again within six months because of the same or a related condition, we will treat this confinement as the same period of confinement.	$200 per day confined
Surgical and Anesthesia Benefits These benefits are paid when a covered person has surgery performed by a physician due to an injury received in a covered accident or because of a covered sickness. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided. Surgical and Anesthesia Benefits are available subject to plan definitions and the Surgical Schedule. (The Anesthesia Benefit will be 25 percent of the Surgical Benefit paid.)	Surgery up to $2,000 Anesthesia up to $500
Out-Of-Hospital Prescription Drug Benefit (5 prescriptions max per year per covered person) We will pay an indemnity benefit, based on the plan definitions, for each prescription filled for a covered person. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the patient. This benefit is subject to the Out-Of-Hospital Prescription Drug Benefit maximum. This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; =(c) drugs, medicines, or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home, or similar institution; (d) immunization agents, biological sera, blood, or blood plasma; or (e) contraceptive materials, devices, or medications or infertility medication, except where required by law.	$10
Intermediate Intensive Care Step-Down Unit (per day) If a covered person is injured in a covered accident or has treatment as the result of a covered sickness, we will pay the benefit as shown for a maximum benefit of $50 based on the following: $50 – Physician (per visit) / X-ray (per visit) $25 – Laboratory fees (per visit) / Injections/medications (per visit) Not to exceed a maximum of $50 per visit.	Up to a maximum of $50 per visit Maximum $250 per covered person per calendar year Maximum $1,000 per Family per calendar year
Well Baby Care Benefit We will pay the Well Baby Care Benefit amount associated with each benefit plan option when an insured baby receives well baby care (four visits per calendar year, per insured baby). For this plan, a baby is a dependent child 12 months of age or younger. This benefit is payable only if coverage is issued with the Dependent Children Benefit Rider.	$25 per visit

Short-Term Disability Insurance

Plan Description

The Aflac Group Disability Advantage Insurance Plan provides for payment of a monthly disability benefit when a covered employee is disabled and unable to work due to an injury or sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit period.

Why enroll in Group Disability Advantage Insurance?
Group Disability Advantage is like insurance for your paycheck. The plan insures a portion of your monthly salary in the event you become disabled and are unable to work due to injury or sickness.

Plan Features

Premiums are paid through **convenient payroll deduction**.

Coverage is **non-occupational**. This means the plan covers disability due to off-the-job injuries and sicknesses.

A Partial Disability Benefit allows for a transition period before returning to full-time employment.

Employees can **continue coverage** when they leave employment (with certain stipulations).

The **minimum and Maximum monthly disability benefit range is $300 to $6,000.**

The **maximum income replacement** is 60% of the employee's salary. The **maximum income replacement** for states with state disability benefits is 40%

Premium payments are **waived** after 90 days of total disability.

Benefits Overview

TOTAL DISABILITY
This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. Total disability benefits will be payable monthly once the elimination period has been satisfied.

PARTIAL DISABILITY
The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If you remain partially disabled and are only able to work earning less than 80 percent of your pre-disability income at any job, this plan will still pay you 50 percent of your selected monthly benefit for up to the maximum partial disability benefit period of 3 months after the elimination period. You do not have to have received the Total Disability benefit to receive the Partial Disability benefit.

WAIVER OF PREMIUM
Premiums are waived after 90 days of Total Disability. After Total Disability benefits end, any premiums which become due must be paid in order to keep your insurance in force. This benefit is not available on plans with a 3-month benefit period.

PORTABILITY
If you cease employment with your employer, you may elect to continue your coverage. In order to continue your coverage you must meet all of the requirements listed below.

- You must work full-time for another employer.
- You must make a written application and pay the required premium to us within 31 days after the date your insurance would otherwise terminate.
- You must continue to pay any required premiums.

The coverage you may continue is that which you had on the date your employment terminated. If you qualify for this portability privilege as described, then the same benefits, plan provisions, and premium rate shown in your certificate as previously issued will apply. Coverage may not be continued if you fail to pay any required premium or if the master policy terminates. Instructions for continuing coverage will be provided within your certificate of coverage.