Mark III
Employee Benefits

WISE COUNTY PUBLIC SCHOOLS

Plan Year:
July 1, 2020 – June 30, 2021

Employee Benefits Guide

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If you wish to add or make changes to your insurance coverage(s), please consult a Mark III Benefits Representative during your scheduled enrollment period. **You will not be able to make any changes once the enrollment period is over** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.). If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.

DISCLAIMER

This guide is a brief summary of benefits offered to your group and does not constitute a policy.

Your employer may amend the benefits program at any time. Your Summary Plan Description (SPD) will contain the actual detailed provisions of your benefits. The SPD will be available at mymarkiii.com

If there are any discrepancies between the information in this guide and the SPD, the language in the SPD will always prevail.

Important Points for 2020

Your plan year runs from July 1, 2020 to June 30, 2021. This means your benefit elections will take effect July 1, 2020 unless otherwise noted.

If you wish to add or make changes to your benefit elections, you have the options of Self-Enrolling or calling the Mark III Call Center.

Once the enrollment period is over, you will not be able to make changes unless you experience a qualified life event as outlined by the IRS.

REMEMBER: Employees **MUST re-enroll** in their Flexible Spending Account and Dependent Care Account each year! It will not automatically renew.

Qualifying Life Events

Open Enrollment selections are generally locked for the plan year, but certain exceptions called Qualifying Life Events (QLEs) can grant you a special enrollment period in which to make midyear changes. You are permitted to change benefit elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Post-Tax benefits can be changed during the plan year without a QLE. Please contact your Human Resources Department for information on cancelling post-tax benefits.

Examples of QLEs

The following events will open a special ***30-day*** enrollment period from the date of the event, allowing you to make changes to your coverage.

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Hi, Wise County Schools Employee!

Mark III Employee Benefits is here to help guide you through the benefits offered by your employer. If you have any questions regarding your benefits, please feel free to contact Mark III at:

Mark III Employee Benefits
(800) 532-1044 (toll-free)
Cindy Hayden
704-365-4280 x 217

As stated in the disclaimer, this guide is simply a brief summary of benefits offered and does not constitute a policy. Before we review benefits offered, let's look at the difference in pre-tax vs post-tax benefits.

Pre-Tax

A "pre-tax basis" means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or until you have a qualifying change in your status (i.e. birth of a child, divorce, separation, reduction in hours, etc.). If your premiums are deducted on a pre-tax basis, any benefits received under the plan could be treated as taxable income.

vs.

Post-Tax

A "post-tax basis" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. Although you do not get any savings from taxes, you have the flexibility of dropping your coverage at any time. Once a change has occurred, an employee has 30 days to notify Mark III or New Hanover County Schools to request a change in elections.

Pre-Tax Plans Offered:

FBA Health Savings Account (HSA)

FBA Flexible Spending Accounts

Allstate Cancer

Aflac Group Accident

Aflac Group Hospital Indemnity

Post-Tax Plans Offered:

Aflac Group Critical Illness

AUL Short-Term Disability

Texas Life Whole Life

Texas Life Universal Life

How to Enroll at Open Enrollment

No matter what your schedule holds, you have multiple options to enroll or elect changes to your benefits.

Call Center

You can dial the number below to speak with a Mark III Benefits Representative. They will help you get enrolled and answer any questions you might have.

Call Center: 1-833-865-1709
Monday – Friday (8:00am – 5:00pm EST)

Online Self-Enroll

Would you rather self-enroll online? No problem.
We offer online enrollment and updates on the BenSelect℠ platform.

To Start

1. Go to https://markiiieb.com/enroll/.
2. Search for **Wise County Schools**
3. Click on the link **Enroll or Make Changes Online**

See next page for step-by-step instructions on how to login and enroll.

View Your Benefits

Find details about all of your benefits, download forms, submit claims, ask questions, and more at mymarkiii.com.

- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

Available 24/7* from any internet enabled device for your convenience.

As with all technology, due to technical difficulties beyond our control there may be small windows of time the benefits website is down. In the case of outage, plan information can always be requested from your HR office or Mark III Employee Benefits

Filing a Claim

Allstate Group Cancer

Claims may be submitted online, mailed or faxed. Simply logon to https://www.allstatebenefits.com to download your claim form and submit, or you may call Customer Care Center at (800) 521-3535 to have your claim form sent by mail. If you are submitting your claim through mail send to:

American Heritage Life Insurance Company, P.O. Box 43067, Jacksonville, FL 32203-3067. If you are submitting your claim through fax send to: 1-866-427-3623.

Group Aflac

Simply logon to https://www.aflacgroupinsurance.com and click on **Customer Service** and then **File a Claim**. Choose from accident, hospital, critical illness or wellness and follow the instructions. Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information. That's it!

AUL Disability

Visit https://markiiieb.com/employees/ and click on the **Virginia** icon. You will then type in **Wise County Schools** and press search. Click on your group. This will take you to your microsite to download your claim form. There are four options for submitting your Short or Long-Term Disability claim:

1. Call the disability claim team at 1-855-517-6365. You should have all information available before calling the disability claim team
2. Email to Disability.claims@oneamerica.com
3. Fax to 1-844-287-9499
4. Mail to American United Life Insurance Company, P.O. Box 9060, Portland, ME 04104.

HEALTHY LIVING

Core Benefit options to keep you and your family healthy.

FSA vs. HSA

Know the Difference!

Below, we've outlined the key difference between an FSA and HSA so you can see which is right for you and your family, the advantages to each and why they are offered.

FSA

Type of Coverage	2020 Contribution Limit
Medical FSA	$2,750
Dependent Care FSA	$5,000 ($2,500 if married & filing taxes separately)

An FSA is an employer-owned account that employees use to set aside funds for qualified expenses. FSAs offer pre-tax savings on eligible expense like medical or dependent care services. FSAs will also save you money! For example, if an employee is enrolled in the Medical FSA, he/she reduces the taxable income, which reduces the amount subject to Social Security and Medicare. You won't have to pay Social Security or Medicare tax on funds going into an FSA.

Control - Owned by the employer
Funding - Employer and/or employee funded
Health Plan Eligibility - Must be offered a group health plan by employer
Invest Funds? - No

HSA

Type of Coverage	2020 Contribution Limit
Individual	$3,550
Family	$7,100

An HSA is an individually owned benefits plan funded by the employee. Employees must be enrolled in the High Deductible Health Plan (HDHP) to be eligible, which will lowers insurance premiums.

HSAs have a triple-tax advantage, meaning distributions for qualified medical expenses and investment returns are tax-free, and contributions are tax-deductible. They can also be invested, which lets employees grow their dollars!

Control - Owned by the employee
Funding - Employer and/or employee funded
Health Plan Eligibility - Must be enrolled in a High-Deductible Health Plan
Invest Funds? - Yes

Employee FAQ:
Health Savings Accounts

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.

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 $1,300 for individual or $2,600 for family coverage and have an out-of-pocket maximum that does not exceed $6,550 for individual or $13,100 for family coverage.

How do I contribute money to my HSA?
Payroll deduction is most likely 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.

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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.

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 800-437-3539

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P.O. Box 8188 • Virginia Beach, VA 23450 • www.flex-admin.com

Flexible Spending Account

Get reimbursed for out-of-pocket healthcare & child/aged adult day care expenses with tax free dollars!!

Maximize your Income

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars!) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save approximately $27.65 to $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Eligibility

Participation in the Plan Begins on July 1, 2020 and ends on June 30, 2021. Full-time employees working at least 30 hours per week and part-time contracted employees (20 hours for bus drivers and 30 hours for Food Service only) are eligible to participate in the Plan immediately upon hire. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

The Health Care Account is a Pre-Funded Account

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions are deposited into your account throughout the Plan Year.

Contribution Limits*: *The maximum you may place in this account for the Plan Year is $2,750.

Election Changes

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers

Reimbursement Schedule

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

Online Access

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at https://fba.wealthcareportal.com/ to view the following features:

- FSA Login – view balances, check status and view claims history-download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

Health Care Reimbursement

With this account, you can pay for your out-of-pocket health care expenses for yourself, your spouse and all of your tax dependents for healthcare services that are incurred during your plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. " This is a broad definition that lends itself to creativity.

Examples of Eligible Health Care Expenses

Fees/Co-Pays/Deductibles for:

- Acupuncture|Prescription Eye glasses/Reading glasses/Contact lens and supplies|Eye Exams/Laser Eye Surgery|Physician|Ambulance|Psychiatrist|Psychologist|Anesthetist|Hospital|Chiropractor|Laboratory/Diagnostic |Fertility Treatments|Surgery|Dental/Orthodontic Fees|Obstetrician|X-Rays|Eye Exams|Prescription Drugs|Artificial limbs & teeth|Birth control pills/patches|Orthopedic shoes/inserts|Therapeutic care for drug & alcohol addiction|Vaccinations & Immunizations|Mileage|Take-home screening kits|Diabetic supplies|Routine Physicals|Oxygen|Physical Therapy|Hearing aids & batteries|Medical equipment

Over-the-Counter Expenses (Examples of medications and drugs that may be purchased in reasonable quantities with a prescription):

- Antacids|Pain relievers/aspirin|Ointments & creams for joint pain|Allergy & sinus medication|First aid creams|Cough & cold medications|Laxatives|Anti-diarrhea medicine

Day Care/Aged Adult Care Reimbursement

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
  - Disabled spouse
  - Children who became disabled prior to age 19.
  - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- ***$5,000 ($2,500 if married filing separately)***
- Your wages for the year or your spouse's if less than above
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

How to Receive Reimbursement

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you in your Employee Guide or on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by
- insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

Eligible Day Care/Aged Adult Expenses

- Au Pair|Nannies|Before & After Care|Day Camps|Babysitters|Daycare for an Elderly Dependent|Daycare for a Disabled Dependent|Nursery School|Private Pre Schools|Sick Child Center|Licensed Day Care Centers

Ineligible Expenses:

- Overnight Camps|Babysitting for Social Events|Tuition Expenses including Kindergarten|Food Expenses (if separate from dependent care expenses)|Care provided by children under 19 (or by anyone you claim as a dependent)|Days your spouse doesn't work (though you may still have to pay the provider)|Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary|Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill|Expenses incurred while on Leave of Absence or Vacation

Forfeiting Funds

Plan carefully! Unused funds will be forfeited back to your employer as governed by the IRS's "use-it-or-lose-it" rule. Please see the Employee Guide for more information.

How to Enroll in our FSA Plan

Step 1

Carefully estimate your eligible Health Care and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at https://fba.wealthcareportal.com/ to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	$2,500.00	$2,500.00
Eligible Pre-Tax employer medical insurance	$0.00	$200.00
Eligible Pre-Tax medical expenses	$0.00	$60.00
Eligible Pre-Tax dependent child care expenses	$0.00	$300.00
Taxable Income	**$2,500.00**	**$1,940.00**
Federal Tax (15%)	$375.00	$291.00
State Tax (5.75%)	$125.00	$97.00
FICA Tax (7.65%)	$191.25	$148.41
After-Tax employer medical insurance	$200.00	$0.00
After-Tax medical expenses	$60.00	$0.00
After-Tax dependent child care expenses	$300.00	$0.00
Monthly Spendable Income	**$1,248.75**	**$1,403.59**

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by $154.84 every month! This means an annual tax savings of $1,858.08. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

The FBA Benefits Card

The easy way to access all of your benefits

The benefits debit card eliminates the hassles of claim submission and waiting for a reimbursement check.

Start Saving Money by Participating in Benefit Accounts

Are your out-of-pocket healthcare, dependent care and transportation costs rising? Tax-advantaged benefit accounts are a great way for you to save your hard-earned money. These accounts can include:

- Flexible spending accounts (FSAs)
- Health reimbursement arrangements (HRAs)
- Health savings accounts (HSAs)
- Dependent care flexible spending accounts (DCAs)
- Commuter accounts (transit/parking)

Access to Funds

Your benefits debit card gives you easy access to the funds in your tax-advantaged benefit accounts by swiping the card at the point of sale. The card can be used at any qualified service provider that accepts MasterCard. Funds are automatically transferred from the benefit account directly to qualified providers with no out-of-pocket cost and no need to file a claim for reimbursement.

Your benefits debit card virtually eliminates:

- Out-of-pocket expenses
- Claim forms
- Reimbursement checks

Multiple Benefit Accounts, One Card

In the event that you have multiple benefit accounts, you need only one benefits debit card. Our technology understands which purchases should be applied to any one of your accounts. If your card is swiped at your child's daycare, the funds will be deducted from your dependent care FSA. Buy a train token automatically with funds from your transit account. It's one smart card!

Your benefits debit card is as easy as 1-2-3

1. **Check your account balance**
   You can view your transaction history, current balance, claim status, and more by logging in online, calling the phone number on the back of your card or via mobile application, if available.
2. **Swipe your benefits debit card**
   Swipe the card at the point-of-sale for eligible products and services. Most major retail chains utilize a system that will auto-substantiate the purchase, meaning it will approve eligible expenses without requiring submission of receipts. If a purchase is greater than your account balance, you can split the cost at the register or you may submit a manual claim.
3. **Keep all your receipts**
   Though the need for documentation is greatly reduced, it is a good practice to save your receipts in the rare instance documentation is requested by your administrator or in case of an IRS audit.

How long is my card valid?

As long as you do not have a break in participation, you can use your card for three years, until the expiration date printed on it. If you are still a participant when your card expires, a new card will be automatically mailed to you.

For more information, please call 800-437-3539

P.O. Box 8188 • Virginia Beach, VA 23450 • www.flex-admin.com

Get CONNECTED with your account... Wherever, whenever.

Introducing... our convenient participant web site! With the online WealthCare Portal you can view your account status, submit claims and report your benefits card lost/stolen right from your computer.

Once your account is established, you can use the same user name and password to access your account via our Mobile App!

Follow the simple steps below to establish your secure user account.

- Get started by visiting **https://fba.wealthcareportal.com/** and click the register button in the top-right corner of the homepage.
- You will be directed to the registration page.
- Follow the prompts to create your account.
  - User Name
  - Password
  - Name
  - Email Address
  - **Employee ID** (Your SSN, no spaces/dashes)
  - Registration ID
    - **Employer ID** (FBAWISE)
    - Your Benefits Card Number
- Once completed, please proceed to your account.

Getting Started is Easy!

If you are having difficulty creating your user account or you have forgotten your password to an existing account, please contact us at 800-437-3539 or flexdivision@flex-admin.com.

FlexibleBenefit ADMINISTRATORS

Your healthcare finances are at your fingertips with the Flexible Benefit Administrators mobile app!

The Flexible Benefit Administrators mobile app provides ultimate convenience and 24/7 access directly from your tablet or mobile device.

Features

Download on iTunes

Download on Google Play

- **Access accounts** – Check balances, view transaction history, and more.
- **Manage claims** – Submit new claims, upload receipts and check claims status.
- **Track and pay expenses** – Track medical claims and other expenses, plus pay bills electronically.
- **Access cards** – Manage card details, access your PIN, and initiate card replacement for lost or stolen cards.
- **Receive alerts** – View important account messages.
- **Update your profile** – Update personal information, including your email and mobile phone.

Get Started Today!

Simply search Flexible Benefit Administrators Mobile in iTunes or Google Play store, select "Install", and log-in online if previously registered or register. Registration requires an employee ID (generally your SSN), employer ID/ benefit debit card number, and valid email address to begin.

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Managing your healthcare finances is easy with the Flexible Benefit Administrators member portal!

The Flexible Benefit Administrators member portal provides you with powerful self-service account access, plus education and decision support tools that help put you in the driver's seat with your healthcare finances.

Features

Full account details at your fingertips – intuitive online access to plan details, account balances and transaction history (including prior years)

Self-service convenience – check balances, submit claims and receipt documentation, pay bills, manage investments, and more

Comprehensive decision support tools – educational and interactive tools to help you make critical spending and saving decisions throughout the plan year

Communication when you need it – manage your preferences, with access to more than 25 alerts to keep you connected to your account

Value-add services and offers – to help you get the most value from your healthcare dollars

Get Started Today!

Take control of your healthcare finances this open enrollment season by registering for online access to your pre-tax account at fba.wealthcareportal.com.

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STAY WELL

Voluntary Benefit Options that enhance your and your family's well being.

Cancer Plan

Allstate. BENEFITS

Your Benefit Coverage

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A $100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to:
(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);
(2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery

Up to a $3,000* benefit will be paid when a covered surgery (*amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; Allstate Benefits pays the amount for the procedure with the greatest benefit. Allstate Benefits pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

Second Opinion

A $400 benefit will be paid for a second opinion, if physician recommends surgery or treatment for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

Physical or Speech Therapy

A $50 benefit will be paid per day for physical or speech therapy for restoration of normal body function.

Anesthesia

25% of the surgery benefit will be paid for anesthesia.

Ambulatory Surgical Center

A $500 benefit will be paid for a surgical procedure covered under the surgery benefit performed at an ambulatory surgical center.

Radiation/Chemotherapy for Cancer

Up to a $10,000 (Low & Mid) or $20,000 (High) benefit will be paid per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost this provision.

Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

Anti-Nausea Benefit
Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine
A $25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

Hematological Drugs
Up to a $200 (Low & Mid) or $400 (High) benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

Medical Imaging
Actual cost up to a $500 (Low & Mid) or $1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services
A $100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

New or Experimental Treatment
Actual charges up to a $5,000 benefit will be paid per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Blood, Plasma, and Platelets
Up to a $10,000 (Low & Mid) or $20,000 (High) benefit will be paid per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance
A $50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

At Home Nursing
A $100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

Prosthesis
Up to a $2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Hair Prosthesis
A $25 benefit will be paid every 2 years for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis
Up to a $50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

Ambulance

A $100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

- Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
- Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

Extended Care Facility

A $100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

Outpatient Lodging

A $50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Non-Local Transportation

$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

Family Member Lodging and Transportation

Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.
2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (employee only)

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

Bone Marrow or Stem Cell Transplant*

A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person.

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

ADDITIONAL BENEFITS

Wellness

A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

A $100 benefit will be paid per calendar year per covered person age 50 and over and for covered persons age 40 and over who are at high risk for prostate cancer for the following wellness test: PSA Testing/Digital Rectal Examinations.

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

A one-time benefit of $3,000 (Low and High) or $10,000 (Mid) benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care (Low and High Plans Only)*

A benefit will be paid for each day for the following types of intensive care confinement:

1. **Hospital Intensive Care Unit Confinement $600**** - This benefit is for hospital intensive care unit confinement for any illness or accident.
2. **Step-Down Hospital Intensive Care Unit Confinement $300**** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.
3. **Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

This benefit is not disease-specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.

****This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.***

Issue Ages: 18 and older while actively at work.

Certificates - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Eligibility - Family members eligible for coverage include: you, your legal spouse and your unmarried children including adopted children or foster children from the moment of placement in the residence, stepchildren, or legal ward who are under 26 years old, unless he or she continues to meet the definition of a dependent. Your children must be dependent on you for support or reside with you and be named on the enrollment or Evidence of Insurability Form.

Portability Privilege - Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage," we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision, the date you are no longer in an eligible class, or the date your class is no longer eligible.

Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

Pre-Existing Condition, Exclusions and Limitations - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. Your consent is not required for this. Allstate Benefits is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. This 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.

This material is valid as long as information remains current, but in no event later than August 1, 2021. 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.

Allstate Group Cancer 11 Month Rates

Low Option without Optional Benefits	
Employee	$21.90
Employee + Spouse	$33.78
Employee + Child(ren)	$30.24
Family	$42.08

Low Option with Optional Benefits	
Employee	$28.44
Employee + Spouse	$45.27
Employee + Child(ren)	$40.16
Family	$56.98

Mid Option with Cancer Initial Diagnosis	
Employee	$32.45
Employee + Spouse	$51.30
Employee + Child(ren)	$46.00
Family	$64.79

High Option without Optional Benefits	
Employee	$33.92
Employee + Spouse	$51.84
Employee + Child(ren)	$47.62
Family	$65.50

High Option with Optional Benefits	
Employee	$40.45
Employee + Spouse	$63.33
Employee + Child(ren)	$57.55
Family	$80.40

Allstate Benefits
1776 American Heritage Life Drive, Jacksonville, Florida 32224
Customer Care Center: 1.800.521.3535 / www.allstate.com or AllstateBenefits.com

Allstate BENEFITS

Group Accident Plan

Plan Features

- Benefits are payable regardless of any other insurance programs.
- Coverage is guaranteed-issue, provided the applicant is eligible for coverage.
- The plan features benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits are available for spouse and/or dependent children.
- There's no limit on the number of claims an insured can file.
- Premiums are paid by convenient payroll deduction.
- Immediate effective date – Coverage will be effective the date the employee signs the application
- 24-Hour Coverage.

Eligibility

Issue Ages

Employee at least age 18
Spouse at least age 18
Children under age 26

The employee may purchase Accident Insurance coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

Coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Accident Benefits – High Option

Complete Fractures		Closed Reduction Benefits
	Employee	Spouse/Child(ren)
Hip/Thigh	$4,500	$4,000
Vertebrae	$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

If the fracture requires open reduction, we will pay 150% of the amount shown. A ***fracture*** is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown. ***Multiple fractures*** refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture. However, we will pay no more than 150% of the benefit amount for the fractured bone which has the highest dollar amount. ***Chip fracture*** refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown for the affected bone. The maximum amount payable for the Fracture Benefit per covered accident is 150% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations		
	Employee Closed Reduction	Spouse/Child(ren) Closed Reduction
Hip	$4,000	$3,000
Knee (not kneecap)	$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

If the dislocation requires open reduction, we will pay 150% of the amount shown. ***Dislocation*** refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan. ***Multiple dislocations*** refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 150% of the benefit amount for the dislocated joint that has the higher dollar amount. ***Partial dislocation*** is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint. The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount. If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

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:

- The insured is 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 the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations	
Up to 2” long	$50
2”-6” long	$200
More than 6” long	$400
Lacerations not requiring stiches	$25

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration. If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment & surgery within 90 days)	$250
Removal of foreign body from eye (requiring no surgery)	$50
Tendons/Ligaments* (treatment within 60 days, surgical repair within 90 days)	
• Single	$400
• Multiple	$600
If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	
Ruptured Disc (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	$100
• Injury occurs after first certificate year	$400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year)	
• Injury occurs during first certificate year	$100
• Injury occurs after first certificate year	$400

Burns (treatment within 14 days, first degree burns not covered)	
Second Degree	
• Less than 10% of body surface covered	$100
• At least 10%, but not more than 25% of body surface covered	$200
• At least 25%, but not more than 35% of body surface covered	$500
• More than 35% of body surface covered	$1,000
Third Degree	
• Less than 10% of body surface covered	$1,000
• At least 10%, but not more than 25% of body surface covered	$5,000
• At least 25%, but not more than 35% of body surface covered	$10,000
• More than 35% of body surface covered	$20,000
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. (Note: Concussion and MTBI are used interchangeably. The concussion must be diagnosed by a doctor.)	$200
Coma (state of profound unconsciousness lasting 30 days or more)	$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	$1,000
Exploratory Surgery (without repair. i.e. arthroscopy)	$250
Emergency Dental Work (injury to sound, natural teeth)	
• Repaired with crown	$150
• Resulting in extractions	$50

Medical Fees (for each accident)	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for X-rays or doctor services. For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident. We will pay the Medical Fees Benefit:

- For treatment received due to injuries from a covered accident **and**
- For each covered accident up to one year after the accident date.

Emergency Room Treatment	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room **and**
- Receives initial treatment within 14 days 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 Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit	
Employee or Spouse	$75
Child(ren)	$45

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, **and**
- Is held in a hospital for observation for at least 24 hours, **and**
- Receives initial treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-Up Treatment	$25

We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 14 days of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy	$25

We will pay the amount shown for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 14 days 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.

Air Ambulance	$500
Ambulance	$100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

Transportation (within 90 days)	
Train or Plan	$300
Bus	$150

If hospital treatment or diagnostic study is recommended by your physician and is not available in the insured's city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood/Plasma	$100

If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	$500

If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids—including false teeth—are not covered.

Appliance	$100

We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

Family Lodging Benefit (per night)	$100

If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness	$60

This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams
- Blood screenings
- Eye examinations
- Immunizations
- Flexible sigmoidoscopies
- Ultrasounds
- Mammograms
- Pap smears
- PSA tests

Hospital Admission	$1,000

We will pay the amount shown, when because of a covered accident, the insured:

- Is injured,
- Requires hospital confinement, **and**
- Is 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.

Hospital Confinement (per day)	$200

We will pay the amount shown when, because of a covered accident, the insured:

- Is 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.

Hospital Intensive Care (per day)	$400

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same injury is 30 days. This benefit is payable in addition to the Hospital Confinement Benefit.

Accidental Death & Dismemberment (within 90 days)

	Employee	Spouse	Children
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$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 Finger(s) of Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

- Loss of a hand – The hand is cut off at or above the wrist joint; **or**
- Loss of a foot – The foot is cut off at or above the ankle; **or**
- Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**
- Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**
- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Limitations & Exclusions

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

- War - participating in war or any act of war, declared or not; 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 by this certificate when you are in such service. This does not include terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – 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. This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- Illegal Acts – participating or attempting to participate in an illegal activity or working at an illegal job.
- Sports – participating in any organized sport—professional or semiprofessional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Aflac Group Accident Rates

High Option - 24 Hour Plan	11 Pay Rates
Employee	$17.67
Employee & Spouse	$25.26
Employee & Dependent Children	$33.71
Family	$41.30

Wellness Benefit included in rates.

Group Hospital Indemnity Plan

Plan Description

The Group Supplemental Hospital Indemnity Insurance Plan provides benefits for inpatient and outpatient services as a result of covered accidents and sicknesses.

Plan Features

- Benefits available for spouse and/or dependent children.
- Pays regardless of any other insurance programs.
- Premiums are paid by convenient payroll deduction.
- Covers both injuries and sicknesses.
- Admission and per day Hospital Confinement Benefits included.
- Surgery and Anesthesia Benefits included.
- The plan is portable with certain stipulations

Eligibility

Issue Ages
Employee 18-64
Spouse 18-64
Children under age 26

Spouse & Dependent Children Coverage Available

The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate. If the employee is eligible then the employee's spouse and dependent children are eligible to participate.

Guaranteed-Issue

During the initial enrollment, coverage is guaranteed-issue, which means you may not have to answer health questions to be eligible for coverage. Subsequent to the initial enrollment, evidence of insurability may be required.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Benefits

	Hospital Confinement (per day)
Plan I	$100
Plan II	$150

We will pay the amount shown when an insured is confined to a hospital as a resident bed patient as the result of an injury or because of a covered sickness. To receive this benefit for injuries received in an injury, the insured must be confined to a hospital within six months of the date of the covered accident.

The maximum period for which a covered person can collect benefits for hospital confinements resulting from covered sickness or from injuries received in the same covered accident is 180 days.

This benefit is payable for only one hospital confinement at a time—even if the confinement is a result of more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.

Hospital Admission (per confinement)	
Plan I	$500
Plan II	$1,500

We will pay the amount shown when an insured is admitted to a hospital and confined as a resident bed patient because of an injury or because of a covered sickness. To receive this benefit for injuries received in a covered accident, an insured 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, for emergency room treatment, or for outpatient treatment. We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

This benefit option will be based on the insured's current major medical plan's deductible to assist the insured in meeting the out-of-pocket liability.

Residents of Massachusetts are not eligible for Hospital Admission Benefit amounts in excess of $500

Surgical Benefit (per procedure)	
Plan I	Up to $750
Plan II	Up to $1,500

If an insured has surgery performed by a physician due to an injury or because of a covered sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a hospital (on an inpatient or outpatient basis), in an ambulatory surgical center, or in a physician's office.

If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations (the operation that is nearest in severity and complexity).

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.

Anesthesia Benefits	
Plan I	Up to $188
Plan II	Up to $375

When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.

Wellness (per calendar year)	
Plan I & II	$50

We will pay the amount shown when an insured visits a doctor and he is neither injured nor sick. This benefit is payable once per calendar year per insured.

Limitations & Exclusions

Pre-Existing Condition Limitation

A ***pre-existing condition*** means, within the 12-month period prior to the insured's effective date, conditions for which medical advice or treatment was received or recommended. We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured's effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition—whichever is less. A claim for benefits for loss starting after 12 months from the effective date of the insured's certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition. Pregnancy will not be covered if conception was before the Effective Date of the Insured Person's Certificate. Pregnancy will be covered as any other sickness when date of conception is after the Insured Person's Effective Date of coverage. Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines. If the certificate is issued as a replacement for a certificate previously issued under this plan, then the pre-existing condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining pre-existing condition limitation period of the prior certificate continues to apply to the prior level of benefits.

Exclusions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above).

We will not pay benefits for loss contributed to by, caused by, or resulting from:

1. War – 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 by this certificate when the insured is in such service.
2. Suicide – Committing or attempting to commit suicide, while sane or insane.
3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.
4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.
6. Aviation – Operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft, including those, which are not motor–driven.
7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts – Participating or attempting to participate in an illegal activity or working at an illegal job.
9. Sports – Participating in any organized sport: professional or semi–professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

Aflac Group Hospital Indemnity Rates

Plan I	11 Pay Rates
Employee	$15.11
Employee + Spouse	$31.00
Employee + Child(ren)	$26.24
Family	$42.13

Plan II	11 Pay Rates
Employee	$32.10
Employee + Spouse	$65.89
Employee + Child(ren)	$56.50
Family	$90.29

Group Critical Illness Plan

without Cancer

Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $25,000 for spouses
- Dependent children are covered at 50% of the primary insured's amount at no additional charge
- Guaranteed-Issue coverage is available for employee and spouse
- Coverage is portable, with certain stipulations
- Annual health screening benefit is included
- Premiums are paid through convenient payroll deduction
- Includes an Additional Benefits Rider with benefits for the following: Coma, Paralysis, Severe Burn, Loss of Sight, Loss of Hearing, Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed- Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available:
Up to **$20,000** for employees and up to **$10,000** for spouses with no participation requirement.

For employee amounts over **$20,000** and spouse amounts over **$10,000:**
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18-69
- Spouse 18-69
- Children under age 26

Benefit-eligible employees who work at least **35 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **100%** of the employee amount, not to exceed the $25,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $25,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Children-only coverage is not available.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Group Critical Illness Benefits

First Occurrence Benefit - After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Critical Illnesses Covered Under Plan	Percentage of Face Amount/Benefit
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End-Stage)	100%
Stroke	100%
Coronary Artery Bypass Surgery +	25%

Additional Occurrence Benefit - We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

Reoccurrence Benefit - We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months.

+Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.

Health Screening Benefit - $100

After the Waiting Period, an Insured may receive a maximum of **$100** for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains enforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

- Stress test on a bicycle or treadmill
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL
- Thermography

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe Burns	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1	
Coronary Artery Bypass Surgery	100%
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

Limitations & Exclusions

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium. The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description. Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane;
- Illegal activities or participation in an illegal occupation;
- War, participating in way or any act of war, declared or not, or participating in the armed forces of or contracting with country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the Effective Date. No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the Effective Date resulted in the insured receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the Effective Date.

Additional Benefit Rider Limitation & Exclusions

All limitations and exclusions that apply to the Critical Illness plan also apply to the rider. The Waiting Period and Pre-existing condition limitation apply from the date the rider is effective. No benefits will be paid for loss which occurred prior to the effective date of the rider. Benefits are not payable for loss if these conditions result from another Critical Illness. The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months. The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the rider is in force; and the cause of the illness is not excluded by name or specific description.

Heart Event Rider Limitation & Exclusions

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium.

Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness.

Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

Pre-Existing Conditions Limitation

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from an insured's effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date. Any benefits for coronary artery bypass surgery denied under the coverage due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

Exclusions

No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for loss which occurred prior to the effective date of coverage.

Diagnosis must be made and treatment received in the United States.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions. 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.

Aflac Group Accident, Critical Illness & Hospital Indemnity are underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company, Columbia, South Carolina.

AGC00031 EXP (3/21)

Wise County Schools – 11 Pay Rates

NON-TOBACCO: Employee

	$5000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$4.91	$7.09	$9.28	$11.46	$13.64	$15.82	$18.00	$20.18	$22.37	$24.55
30-39	$6.44	$10.15	$13.86	$17.57	$21.28	$24.98	$28.69	$32.40	$36.11	$39.82
40-49	$10.26	$17.78	$25.31	$32.84	$40.37	$47.89	$55.42	$62.95	$70.48	$78.00
50-59	$15.17	$27.60	$40.04	$52.48	$64.91	$77.35	$89.78	$102.22	$114.66	$127.09
60 - 69	$26.51	$50.29	$74.08	$97.86	$121.64	$145.42	$169.20	$192.98	$216.77	$240.55

NON-TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*
18-29	$4.91	$6.00	$7.09	$8.18	$9.28	$10.37	$11.46	$12.55	$13.64
30-39	$6.44	$8.29	$10.15	$12.00	$13.86	$15.71	$17.57	$19.42	$21.28
40-49	$10.26	$14.02	$17.78	$21.55	$25.31	$29.08	$32.84	$36.60	$40.37
50-59	$15.17	$21.38	$27.60	$33.82	$40.04	$46.26	$52.48	$58.69	$64.91
60 - 69	$26.51	$38.40	$50.29	$62.18	$74.08	$85.97	$97.86	$109.75	$121.64

TOBACCO: Employee

	$5000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*
18-29	$6.11	$9.49	$12.88	$16.26	$19.64	$23.02	$26.40	$29.78	$33.17	$36.55
30-39	$8.57	$14.40	$20.24	$26.08	$31.91	$37.75	$43.58	$49.42	$55.26	$61.09
40-49	$17.62	$32.51	$47.40	$62.29	$77.18	$92.08	$106.97	$121.86	$136.75	$151.64
50-59	$28.04	$53.35	$78.66	$103.97	$129.28	$154.58	$179.89	$205.20	$230.51	$255.82
60 - 69	$48.28	$93.82	$139.37	$184.91	$230.46	$276.00	$321.55	$367.09	$412.64	$458.18

TOBACCO: Spouse

	$5,000	*$7,500*	*$10,000*	*$12,500*	*$15,000*	*$17,500*	*$20,000*	*$22,500*	*$25,000*
18-29	$6.11	$7.80	$9.49	$11.18	$12.88	$14.57	$16.26	$17.95	$19.64
30-39	$8.57	$11.48	$14.40	$17.32	$20.24	$23.16	$26.08	$28.99	$31.91
40-49	$17.62	$25.07	$32.51	$39.96	$47.40	$54.85	$62.29	$69.74	$77.18
50-59	$28.04	$40.69	$53.35	$66.00	$78.66	$91.31	$103.97	$116.62	$129.28
60 - 69	$48.28	$71.05	$93.82	$116.59	$139.37	$162.14	$184.91	$207.68	$230.46

Aflac
Continental American Insurance Company
Columbia, South Carolina
Toll Free: 800.433.3036
Website: aflacgroupinsurance.com

Short-Term Disability Plan

Class Description
All Eligible Employees working a minimum of 35 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

Disability
You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly benefit is $500.

Elimination Period
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Benefit Duration
The is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) weeks.

Basis of Coverage
24 Hour Coverage, on or off the job

Maternity Coverage
Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date.

Recurrent Disability
If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may e eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318. The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment
Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1,000 monthly benefit without medical questions. Employees may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

Exclusions and Limitations
This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group.

AUL Short-Term Disability Rates

Benefit Duration 13 weeks

Monthly Benefit	11 Pay Premium
$500	$11.30
$600	$13.56
$700	$15.82
$800	$18.07
$900	$20.33
$1000	$22.59
$1100	$24.85
$1200	$27.11
$1300	$29.37
$1400	$31.63
$1500	$33.89
$1600	$36.15
$1700	$38.41
$1800	$40.67
$1900	$42.93
$2000	$45.19

Benefit Duration 26 weeks

Monthly Benefit	11 Pay Premium
$500	$16.36
$600	$19.64
$700	$22.91
$800	$26.18
$900	$29.45
$1000	$32.73
$1100	$36.00
$1200	$39.27
$1300	$42.55
$1400	$45.82
$1500	$49.09
$1600	$52.36
$1700	$55.64
$1800	$58.91
$1900	$62.18
$2000	$65.45

Benefit Duration 52 weeks

Monthly Benefit	11 Pay Premium
$500	$21.51
$600	$25.81
$700	$30.11
$800	$34.41
$900	$38.71
$1000	$43.01
$1100	$47.32
$1200	$51.62
$1300	$55.92
$1400	$60.22
$1500	$64.52
$1600	$68.82
$1700	$73.12
$1800	$77.43
$1900	$81.73
$2000	$86.03

Customer Service
800-553-5318

Disability Claims
855-517-6365
Fax: 844-287-9499

Disability Claims Email: Disability.Claims@oneamerica.com
www.employeebenefits.aul.com

ONEAMERICA®

AMERICAN UNITED LIFE INSURANCE COMPANY®
a ONEAMERICA® *company*

Whole Life Plan

TEXASLIFE INSURANCE COMPANY

Common Issue Date: September 1, 2020

An ideal complement to any group term and optional term life insurance your employer might provide, Texas Life's SOLUTIONS 121 is the life insurance you keep, even when you change jobs or retire, as long as you pay the premiums. It will help protect your family, both today and, more importantly, tomorrow. Even better, after age 65 (or 20 years if you purchased the policy after age 45), it's guaranteed to be paid up.

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements. [1]

As an employee, you are eligible to apply once you have satisfied your employer's eligibility period.

Why Voluntary Coverage?

- Most employees typically depend on group term life insurance.
- Adults covered by both group and individual life insurance replace more of their income upon death than adults having group term alone.[2]
- Term policies are created to last for a finite period of time, i.e., 10, 20 or 30 years.
- When do you want a life insurance policy in force? --Answer: When you die.
- Term is for IF you die, permanent is for WHEN you die.

The SOLUTIONS Advantage

Individual Protection SOLUTIONS 121 is a permanent life insurance policy that you own; it can never be canceled, as long as you pay the guaranteed level premiums due, even if your health changes. Because you own it, you can take SOLUTIONS 121 with you when you change jobs or retire, with no change in the premium.

Coverage for Your Family You may also apply for an individual SOLUTIONS 121 policy for your spouse, dependent children ages 15 days-26 years and grandchildren ages 15 days-18 years, even if you do not apply for coverage.[1]

Paid Up Insurance SOLUTIONS 121 has premiums that are guaranteed to remain level until you're age 65, or for 20 years if you purchase the policy after age 45. At that time, the policy becomes **fully paid up; no further premiums are due**, and the death benefit does not reduce. This gives you the peace of mind that comes with life insurance that's paid for as your income changes in retirement.

Convenience of payroll deduction Thanks to your employer, SOLUTIONS 121 premiums are paid through convenient payroll deductions and sent to Texas Life by your employer.

Permanent You may continue the peace of mind SOLUTIONS 121 provides, even when you change jobs or retire. Once your policy is issued, the coverage is yours to keep. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to Texas Life by automatic bank draft or monthly bill (for monthly bill we may add a billing fee not to exceed $2.00). Premiums are guaranteed to remain level to your age 65, or for 20 years if you purchase the policy after age 45. At that time, the policy becomes fully paid up; no further premiums are due.

Coverage begins immediately Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two-year suicide and contestability provisions apply (one year in ND). Interim Insurance is not available for a policy issued in KS. For KS, see Temporary Insurance Coverage Agreement and Receipt, Form 16M056.

Additional Policy Benefits

- **Accelerated Death Benefit due to Terminal Illness** For no additional premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92.6% (92% in CA, DC, DE, FL, ND & SD) of the death benefit, minus a $150 ($100 in Florida) administrative fee in lieu of the insurance proceeds otherwise payable at death. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. (Conditions apply) (Policy Form ICC-ULABR-11 or Form Series ULABR-11)
- **Accelerated Death Benefit due to Chronic Illness** Included in the policy at the option of the employer, the Accelerated Death Benefit for Chronic Illness rider covers all applicants. If an insured becomes permanently chronically ill, meaning that he/she is unable to perform two of six Activities of Daily Living (such as bathing, continence, or dressing), or is severely cognitively impaired (such as Alzheimer's), he/she may elect to claim an accelerated death benefit in lieu of the insurance proceeds payable at death. The single sum payment is 92% of the death benefit less an administrative fee of $150 ($100 in FL). The Accelerated Death Benefit for Chronic Illness Rider premiums are 8% of the base policy premium. Conditions and limitations apply. See the SOLUTIONS 121 Pamphlet for details. Not Available in CA. (Policy form ULABR-CI-14 or ICC14-ULABR-CI-14.)
- **Waiver of Premium Rider** This benefit to age 65 (issue ages 17-59) waives the premium after six months of the insured's total disability and will even refund the prior six months' premium. Benefits continue payable until the earlier of the end of the insured's total disability or age 65. Cost is an additional 10% of the basic monthly premium. Self-inflicted or war-related disability is excluded. Notice, proof and waiting period provisions apply. Not available in CA. (Policy Form ICC07-ULCL-WP-07 or Form Series ULCL-WP-07).

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire, as long as you pay premiums due
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Rates include Accelerated Death Benefit for Chronic Illness on all policies
- Rates shown include Waiver of Premium for ages 17-59
- If desired, you may apply for higher amounts of coverage by answering additional underwriting questions[3]
- Coverage available for spouse, children and grandchildren[1]

Limited payment whole life insurance. Some limitations apply. Texas Life is licensed to do business in the District of Columbia and every state but NY.

See the SOLUTIONS brochure for complete details. Policy Form Series WLOTO-NI-11 or ICC11-WLOTO-NI-11

[1] Coverage not available on children in Washington or on grandchildren in Washington and Maryland. In Maryland, child must reside with the applicant to be eligible for coverage.
[2] LIMRA; Life Insurance Ownership Focus – 2016
[3] Answers to these questions will determine coverage.

19M055-C MO 1097 (exp0521)

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

SOLUTIONS WHOLE LIFE

TEXAS LIFE SOLUTIONS 121

ELEVENTHLY PREMIUMS
LIFE WITH WVR & CI

TIER 1/TIER 2 COMBO — ELEVENTHLY PREMIUMS

Issue Age (ALB)	Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages)								PAID UP At Attained Age
	$ 10,000		$ 15,000		$ 25,000		$ 30,000		
	Non-Tobacco	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	
17	10.55	12.23	14.03	16.54	20.98	25.17	24.46	29.48	65
18	10.95	12.62	14.61	17.12	21.95	26.13	25.62	30.64	65
19	10.95	12.75	14.61	17.32	21.95	26.46	25.62	31.02	65
20	11.20	13.13	15.00	17.90	22.60	27.42	26.39	32.19	65
21	11.33	13.39	15.19	18.28	22.91	28.06	26.78	32.95	65
22	11.59	13.64	15.57	18.67	23.56	28.71	27.55	33.72	65
23	11.97	14.03	16.16	19.25	24.53	29.68	28.71	34.88	65
24	12.10	14.42	16.35	19.83	24.84	30.64	29.09	36.05	65
25	12.35	14.81	16.74	20.40	25.49	31.61	29.86	37.20	65
26	12.88	15.19	17.50	20.98	26.78	32.57	31.41	38.36	65
27	13.26	15.70	18.09	21.76	27.75	33.86	32.57	39.91	65
28	13.77	16.22	18.87	22.53	29.03	35.14	34.12	41.45	65
29	14.28	16.86	19.64	23.50	30.32	36.76	35.66	43.38	65
30	14.55	17.50	20.02	24.46	30.96	38.36	36.43	45.31	65
31	15.32	18.28	21.18	25.62	32.90	40.29	38.74	47.63	65
32	16.10	19.05	22.34	26.78	34.83	42.22	41.07	49.95	65
33	16.74	19.96	23.30	28.13	36.43	44.48	43.00	52.65	65
34	17.12	20.72	23.88	29.30	37.40	46.41	44.15	54.96	65
35	17.76	21.76	24.84	30.83	39.00	48.99	46.08	58.05	65
36	18.67	22.78	26.20	32.38	41.26	51.56	48.79	61.15	65
37	19.70	23.94	27.75	34.12	43.84	54.45	51.88	64.62	65
38	20.60	25.23	29.09	36.05	46.08	57.67	54.58	68.48	65
39	22.14	26.78	31.41	38.36	49.95	61.53	59.22	73.12	65
40	22.91	28.06	32.57	40.29	51.88	64.75	61.53	76.98	65
41	24.20	29.73	34.50	42.81	55.10	68.94	65.39	82.00	65
42	25.36	31.54	36.24	45.51	58.00	73.44	68.87	87.41	65
43	26.64	33.47	38.18	48.40	61.22	78.27	72.74	93.20	65
44	28.44	35.79	40.88	51.88	65.72	84.06	78.14	100.15	65
45	30.26	38.23	43.58	55.55	70.23	90.18	83.55	107.49	65
46	31.41	39.91	45.31	58.05	73.12	94.36	87.02	112.51	66
47	32.70	41.58	47.24	60.57	76.34	98.55	90.88	117.53	67
48	34.12	43.38	49.37	63.28	79.88	103.05	95.13	122.94	68
49	35.66	45.18	51.69	65.98	83.74	107.56	99.77	128.34	69
50	36.81	45.95	53.43	67.14	86.63	109.49	103.24	130.66	70
51	38.23	48.02	55.55	70.23	90.18	114.64	107.49	136.84	71
52	39.78	49.95	57.87	73.12	94.04	119.46	112.12	142.63	72
53	41.45	52.14	60.38	76.40	98.22	124.94	117.15	149.20	73
54	43.25	54.58	63.08	80.07	102.72	131.04	122.55	156.53	74
55	44.02	56.00	64.24	82.19	104.66	134.59	124.87	160.78	75
56	45.57	58.18	66.55	85.48	108.52	140.06	129.50	167.35	76
57	48.02	60.51	70.23	88.95	114.64	145.85	136.84	174.30	77
58	50.21	63.33	73.50	93.20	120.10	152.93	143.40	182.80	78
59	52.01	66.42	76.20	97.84	124.61	160.65	148.80	192.06	79
60	50.40	64.19	73.97	94.64	121.10	155.56	144.66	186.02	80
61	53.11	67.49	78.04	99.59	127.87	163.80	152.79	195.91	81
62	55.71	71.37	81.92	105.43	134.35	173.52	160.56	207.57	82
63	58.18	75.50	85.63	111.62	140.54	183.83	167.98	219.94	83
64	61.60	79.62	90.76	117.80	149.08	194.14	178.24	232.31	84
65	64.66	84.10	95.35	124.51	156.74	205.34	187.42	245.74	85
66	68.79	89.40	101.54	132.46	167.04	218.59	199.79	261.65	86
67	72.91	94.71	107.72	140.42	177.35	231.84	212.16	277.55	87
68	77.74	100.48	114.96	149.08	189.43	246.28	226.66	294.88	88
69	82.92	107.43	122.74	159.51	202.39	263.66	242.21	315.74	89
70	88.58	114.86	131.23	170.63	216.53	282.21	259.18	338.00	90

Underwriting requirements will vary depending on plan year, participation rates and other factors.
For more information see Group Enrollment Guide.

Form: 19M019EGS-ICC-B-L-3WP-D-NCV

TEXASLIFE INSURANCE COMPANY

SOLUTIONS WHOLE LIFE

TEXAS LIFE SOLUTIONS 121

ELEVENTHLY PREMIUMS
LIFE WITH WVR & CI

TIER 1/TIER 2 COMBO — ELEVENTHLY PREMIUMS

Issue Age (ALB)	Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages)								PAID UP At Attained Age
	$ 50,000		$ 75,000		$ 100,000		$ 150,000		
	Non-Tobacco	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	
17	38.36	46.73	55.74	68.30	73.12	89.85	107.87	132.98	65
18	40.29	48.66	58.64	71.19	76.98	93.71	113.67	138.77	65
19	40.29	49.30	58.64	72.16	76.98	95.00	113.67	140.70	65
20	41.58	51.23	60.57	75.05	79.55	98.86	117.53	146.49	65
21	42.22	52.52	61.53	76.98	80.84	101.44	119.46	150.35	65
22	43.51	53.81	63.46	78.91	83.42	104.01	123.32	154.22	65
23	45.44	55.74	66.36	81.81	87.28	107.87	129.11	160.01	65
24	46.08	57.67	67.32	84.70	88.56	111.74	131.04	165.80	65
25	47.37	59.60	69.26	87.60	91.14	115.60	134.91	171.59	65
26	49.95	61.53	73.12	90.50	96.29	119.46	142.63	177.39	65
27	51.88	64.11	76.02	94.36	100.15	124.61	148.42	185.11	65
28	54.45	66.68	79.88	98.22	105.30	129.76	156.15	192.83	65
29	57.03	69.90	83.74	103.05	110.45	136.19	163.87	202.49	65
30	58.31	73.12	85.67	107.87	113.02	142.63	167.73	212.14	65
31	62.18	76.98	91.47	113.67	120.75	150.35	179.32	223.73	65
32	66.04	80.84	97.26	119.46	128.47	158.08	190.90	235.31	65
33	69.26	85.35	102.08	126.22	134.91	167.09	200.56	248.83	65
34	71.19	89.21	104.98	132.02	138.77	174.81	206.35	260.42	65
35	74.40	94.36	109.80	139.74	145.20	185.11	216.00	275.86	65
36	78.91	99.51	116.57	147.46	154.22	195.41	229.52	291.31	65
37	84.06	105.30	124.29	156.15	164.51	206.99	244.97	308.69	65
38	88.56	111.74	131.04	165.80	173.52	219.87	258.48	328.00	65
39	96.29	119.46	142.63	177.39	188.97	235.31	281.66	351.17	65
40	100.15	125.90	148.42	187.04	196.70	248.19	293.24	370.48	65
41	106.59	134.26	158.08	199.60	209.57	264.92	312.55	395.58	65
42	112.38	143.27	166.77	213.11	221.15	282.94	329.93	422.61	65
43	118.82	152.93	176.43	227.59	234.03	302.25	349.24	451.58	65
44	127.83	164.51	189.94	244.97	252.05	325.42	376.27	486.33	65
45	136.84	176.74	203.46	263.32	270.07	349.88	403.30	523.02	65
46	142.63	185.11	212.14	275.86	281.66	366.62	420.68	548.12	66
47	149.07	193.48	221.80	288.42	294.53	383.35	439.99	573.22	67
48	156.15	202.49	232.42	301.94	308.69	401.37	461.23	600.26	68
49	163.87	211.50	244.01	315.45	324.14	419.39	484.40	627.29	69
50	169.66	215.36	252.69	321.24	335.72	427.12	501.78	638.87	70
51	176.74	225.66	263.32	336.69	349.88	447.71	523.02	669.77	71
52	184.47	235.31	274.90	351.17	365.33	467.02	546.19	698.73	72
53	192.83	246.26	287.45	367.59	382.06	488.91	571.29	731.56	73
54	201.84	258.48	300.96	385.92	400.08	513.36	598.32	768.24	74
55	205.71	265.56	306.76	396.55	407.81	527.52	609.91	789.48	75
56	213.43	276.51	318.34	412.96	423.26	549.41	633.08	822.31	76
57	225.66	288.09	336.69	430.34	447.71	572.58	669.77	857.07	77
58	236.60	302.25	353.10	451.58	469.60	600.90	702.59	899.55	78
59	245.61	317.70	366.62	474.75	487.62	631.79	729.63	945.89	79
60	238.91	307.84	356.73	460.12	474.55	612.40	710.19	916.96	80
61	252.46	324.33	377.06	484.86	501.65	645.39	750.83	966.44	81
62	265.42	343.77	396.50	514.02	527.57	684.27	789.71	1,024.76	82
63	277.79	364.39	415.05	544.95	552.31	725.50	826.83	1,086.62	83
64	294.88	385.01	440.68	575.87	586.48	766.74	878.08	1,148.47	84
65	310.19	407.39	463.65	609.45	617.11	811.51	924.03	1,215.63	85
66	330.81	433.90	494.58	649.22	658.35	864.53	985.88	1,295.15	86
67	351.43	460.41	525.51	688.98	699.58	917.55	1,047.74	1,374.68	87
68	375.58	489.28	561.74	732.28	747.89	975.28	1,120.19	1,461.28	88
69	401.50	524.03	600.62	784.41	799.73	1,044.79	1,197.95	1,565.55	89
70	429.78	561.15	643.03	840.08	856.28	1,119.02	1,282.78	1,676.88	90

Underwriting requirements will vary depending on plan year, participation rates and other factors.
For more information see Group Enrollment Guide.

Form: 19M019EGS-ICC-B-L-3WP-D-NCV

TEXASLIFE INSURANCE COMPANY

RATES FOR INDIVIDUAL POLICIES FOR CHILDREN AND GRANDCHILDREN*

Eleventhly Premiums for Life Insurance Coverages Shown
Includes Added Cost for Accelerated Death Benefit for Chronic Illness

Issue Age	$10,000 Prem	$10,000 Cash Value At Age 65	$25,000 Prem	$25,000 Cash Value At Age 65	Policy is Pd Up at Attained Age	Issue Age	$10,000 Prem	$10,000 Cash Value At Age 65	$25,000 Prem	$25,000 Cash Value At Age 65	Policy is Pd Up at Attained Age
15d-1	$ 6.93	$ 4,630	$ 12.41	$ 11,575	65	9	$ 7.87	$ 4,630	$ 14.76	$ 11,575	65
2	6.93	4,630	12.41	11,575	65	10	7.99	4,630	15.06	11,575	65
3	7.05	4,630	12.70	11,575	65	11	8.23	4,630	15.65	11,575	65
4	7.16	4,630	13.00	11,575	65	12	8.46	4,630	16.24	11,575	65
5	7.28	4,630	13.29	11,575	65	13	8.70	4,630	16.83	11,575	65
6	7.40	4,630	13.59	11,575	65	14	8.93	4,630	17.42	11,575	65
7	7.52	4,630	13.88	11,575	65	15	9.17	4,630	18.00	11,575	65
8	7.64	4,630	14.18	11,575	65	16	9.41	4,630	18.59	11,575	65

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

Universal Life Plan

TEXASLIFE INSURANCE COMPANY

Common Issue Date: September 1, 2020

Why do I need more life insurance?

Life insurance is a core component of a comprehensive benefits package because it provides employees with essential protection for their families. However, many people depend on their group term life coverage as their only life insurance[1], which can put them at risk of not being adequately prepared during retirement. Permanent life insurance, such as a voluntary universal life individual policy, is a simple way to address employees' needs because it complements their existing group term life coverage. It has been designed to serve as a small—yet valuable—component of one's overall coverage. It can provide continued protection to help alleviate any financial burden, such as funeral costs, that loved ones may need to address.

Why PureLife-plus?

PureLife-plus, underwritten by Texas Life Insurance Company, combines several outstanding product features that can help you meet your financial needs and objectives:

You own it. - This voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually cost more and decline in death benefit.

Refund of Premium. Unique in the marketplace, PureLife-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. (Conditions apply).

High Death Benefit. With one of the highest death benefits available at the worksite,[2] PureLife-plus gives your loved one's peace of mind for a reasonable cost.

Payroll Deducted Premiums. No checks to write or links to click.

Long Guarantees. Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time.[3]

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

Applying is Easy – You can qualify by answering just 3 questions – no exams or needles.

3 Questions to Qualify: During the last six months, has the proposed insured:

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

Additional Benefits and Riders

Accelerated Death Benefit Due to Terminal Illness Rider. Included on all policies at no additional cost, the Accelerated Death Benefit Due to Terminal Illness Rider pays 92% of the death benefit, minus a $150 processing fee ($100 in Florida), upon a physician-certified diagnosis of a terminal illness expected to result in death within 12 months. The policy terminates upon exercise of this rider. Conditions apply. Form ICC07-ULABR-07 or Form Series ULABR-07

Accidental Death Benefit: Included for all employees and spouses at issue ages 17-59 at a cost of 8 cents per thousand of face amount per month. The Accidental Death Benefit will pay the insured's beneficiary double the death benefit if the insured dies within 180 days of an accident from injuries incurred in that accident.[5] The benefit is payable to the insured's age 65. Maximum in-force limits and exclusions apply. Form ICC 07-ULCL-ADB-07 or Form Series ULCL-ADB-07

Waiver of Premium: Included for all employees at issue ages 17-59 at cost of 10% of the base plan monthly premium. This benefit will waive the entire premium after the insured is disabled for 180 days for as long as the insured remains totally disabled. It also refunds the prior 180 days' premium. The benefit is payable to the insured's age 65. Conditions apply. Not available in CA. Form ICC07-ULCL-WP-07 or Form Series ULCL-WP-07

[1] LIMRA's Life Insurance Ownership Focus, U.S. Household Trends, 2016.
[2] Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, December 2018.
[3] After the guaranteed period, premiums may go down, stay the same, or go up.
[4] Coverage not available on children in WA or on grandchildren in WA or MD. In MD, child must reside with the applicant in order to be eligible for coverage.
[5] 90 days in CA, DC, DE, FL, ND, SD.
[6] Six Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that: (1) places the insured in jeopardy of harming him/herself or others and, therefore, the insured requires Substantial Supervision by another individual; and (2) is measured by clinical evidence and standardized tests which reliably measure impairment in: (a) short or long-term memory; (b) deductive or abstract reasoning.

PureLife-plus is a Flexible Premium Adjustable Life Insurance to Age 121. Some limitations apply. See the PureLife-plus brochure for details. Policy form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18. Texas Life is licensed to do business in the District of Columbia and every state but New York.

19M028-C 1101 M (exp0321)

If you have any questions regarding your Texas Life policy,
please call 800-283-9233, prompt #2

TEXASLIFE INSURANCE COMPANY

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

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

Issue Age Issue	Eleventhly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Waiver of Premium Benefit (Ages 17-59)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-10			8.46							75
11-16			8.73							70
17-20			11.85	17.88	21.90	31.95	42.00	52.05	62.10	66
21			12.16	18.36	22.50	32.86	43.20	53.56	63.90	66
22			12.16	18.36	22.50	32.86	43.20	53.56	63.90	65
23-25			12.45	18.84	23.10	33.75	44.40	55.05	65.70	63
26			12.76	19.32	23.70	34.66	45.60	56.56	67.50	63
27			13.05	19.80	24.30	35.55	46.80	58.05	69.30	63
28			13.05	19.80	24.30	35.55	46.80	58.05	69.30	62
29			13.36	20.28	24.90	36.46	48.00	59.56	71.10	62
30-31			13.65	20.76	25.50	37.35	49.20	61.05	72.90	60
32			14.25	21.72	26.70	39.15	51.60	64.05	76.50	61
33			14.85	22.68	27.90	40.95	54.00	67.05	80.10	62
34			15.45	23.64	29.10	42.75	56.40	70.05	83.70	62
35		10.54	16.36	25.08	30.90	45.46	60.00	74.56	89.10	64
36		10.90	16.96	26.04	32.10	47.26	62.40	77.56	92.70	64
37		11.26	17.56	27.00	33.30	49.06	64.80	80.56	96.30	64
38		11.79	18.45	28.44	35.10	51.75	68.40	85.05	101.70	65
39		12.51	19.65	30.36	37.50	55.35	73.20	91.05	108.90	66
40	9.42	13.23	20.85	32.28	39.90	58.95	78.00	97.05	116.10	67
41	10.02	14.14	22.36	34.68	42.90	63.46	84.00	104.56	125.10	68
42	10.86	15.39	24.45	38.04	47.10	69.75	92.40	115.05	137.70	70
43	11.70	16.66	26.56	41.40	51.30	76.06	100.80	125.56	150.30	72
44	12.54	17.91	28.65	44.76	55.50	82.35	109.20	136.05	162.90	73
45	13.50	19.35	31.05	48.60	60.30	89.55	118.80	148.05	177.30	74
46	14.46	20.79	33.45	52.44	65.10	96.75	128.40	160.05	191.70	75
47	15.30	22.06	35.56	55.80	69.30	103.06	136.80	170.56	204.30	76
48	16.26	23.50	37.96	59.64	74.10	110.26	146.40	182.56	218.70	77
49	17.34	25.11	40.65	63.96	79.50	118.35	157.20	196.05	234.90	78
50	18.66	27.10	43.96	69.24	86.10	128.26				79
51	20.22	29.43	47.85	75.48	93.90	139.95				80
52	22.14	32.31	52.65	83.16	103.50	154.35				82
53	24.06	35.19	57.45	90.84	113.10	168.75				83
54	25.98	38.07	62.25	98.52	122.70	183.15				85
55	27.66	40.59	66.45	105.24	131.10	195.75				86
56	28.86	42.39	69.45	110.04	137.10	204.75				85
57	29.70	43.66	71.56	113.40	141.30	211.06				84
58	30.66	45.10	73.96	117.24	146.10	218.26				84
59	31.86	46.90	76.96	122.04	152.10	227.26				84
60	29.79	43.86	72.00	114.22	142.37	212.73				84
61	32.30	47.62	78.28	124.26	154.91	231.55				85
62	35.35	52.20	85.91	136.48	170.19	254.46				87
63	38.73	57.28	94.37	150.00	187.10	279.82				89
64	43.20	63.99	105.55	167.90	209.46	313.37				93
65	46.37	68.73	113.46	180.55	225.28	337.10				94
66	49.42									95
67	52.15									96
68	54.99									96
69	58.04									96
70	61.31									95

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

PureLife2010-C4AAD5ACD9AL

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

Issue Age Issue	Eleventhly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Waiver of Premium Benefit (Ages 17-59)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$25,000	$40,000	$50,000	$75,000	$100,000	$125,000	$150,000	
15D-10										75
11-16										70
17-20			16.96	26.04	32.10	47.26	62.40	77.56	92.70	66
21			17.56	27.00	33.30	49.06	64.80	80.56	96.30	66
22			17.56	27.00	33.30	49.06	64.80	80.56	96.30	65
23-25			18.45	28.44	35.10	51.75	68.40	85.05	101.70	63
26			18.76	28.92	35.70	52.66	69.60	86.56	103.50	63
27			19.05	29.40	36.30	53.55	70.80	88.05	105.30	63
28			19.36	29.88	36.90	54.46	72.00	89.56	107.10	62
29			19.65	30.36	37.50	55.35	73.20	91.05	108.90	62
30-31			22.05	34.20	42.30	62.55	82.80	103.05	123.30	60
32			22.65	35.16	43.50	64.35	85.20	106.05	126.90	61
33			22.96	35.64	44.10	65.26	86.40	107.56	128.70	62
34			23.25	36.12	44.70	66.15	87.60	109.05	130.50	62
35		15.58	24.76	38.52	47.70	70.66	93.60	116.56	139.50	64
36		16.11	25.65	39.96	49.50	73.35	97.20	121.05	144.90	64
37		17.02	27.16	42.36	52.50	77.86	103.20	128.56	153.90	64
38		17.55	28.05	43.80	54.30	80.55	106.80	133.05	159.30	65
39		18.63	29.85	46.68	57.90	85.95	114.00	142.05	170.10	66
40	14.10	20.26	32.56	51.00	63.30	94.06	124.80	155.56	186.30	67
41	14.94	21.51	34.65	54.36	67.50	100.35	133.20	166.05	198.90	68
42	16.02	23.14	37.36	58.68	72.90	108.46	144.00	179.56	215.10	70
43	17.70	25.66	41.56	65.40	81.30	121.06	160.80	200.56	240.30	72
44	18.66	27.10	43.96	69.24	86.10	128.26	170.40	212.56	254.70	73
45	19.98	29.07	47.25	74.52	92.70	138.15	183.60	229.05	274.50	74
46	21.18	30.87	50.25	79.32	98.70	147.15	195.60	244.05	292.50	75
47	22.38	32.67	53.25	84.12	104.70	156.15	207.60	259.05	310.50	76
48	23.58	34.47	56.25	88.92	110.70	165.15	219.60	274.05	328.50	77
49	25.50	37.35	61.05	96.60	120.30	179.55	238.80	298.05	357.30	78
50	26.82	39.34	64.36	101.88	126.90	189.46				79
51	28.86	42.39	69.45	110.04	137.10	204.75				80
52	31.38	46.18	75.76	120.12	149.70	223.66				82
53	33.42	49.23	80.85	128.28	159.90	238.95				83
54	35.94	53.02	87.16	138.36	172.50	257.86				85
55	37.74	55.71	91.65	145.56	181.50	271.35				86
56	39.30	58.06	95.56	151.80	189.30	283.06				85
57	40.50	59.86	98.56	156.60	195.30	292.06				84
58	42.66	63.10	103.96	165.24	206.10	308.26				84
59	44.46	65.79	108.45	172.44	215.10	321.75				84
60	41.57	61.53	101.46	161.35	201.28	301.10				84
61	44.40	65.79	108.55	172.70	215.46	322.37				85
62	48.00	71.19	117.55	187.10	233.46	349.37				87
63	51.71	76.75	126.82	201.93	252.00	377.19				89
64	55.75	82.80	136.91	218.08	272.19	407.46				93
65	58.48	86.90	143.73	228.99	285.82	427.91				94
66	61.53									95
67	64.59									96
68	67.97									96
69	71.46									96
70	75.28									95

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

PureLife2010-C4AAD5ACD9AL

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

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Eleventhly Premiums Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Waiver of Premium Benefit (Ages 17-59) $18.00	$20.00	$24.00	$28.00	$30.00	$32.00	$35.00	$40.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-10										75
11-16										70
17-20		40,288	45,274	55,211	65,173	70,150	75,125	82,588	95,019	66
21		39,129	43,948	53,612	63,278	68,116	72,945	80,185	92,271	66
22		39,129	43,948	53,612	63,278	68,116	72,945	80,185	92,271	65
23-25		38,029	42,722	52,113	61,499	66,196	70,892	77,935	89,660	63
26		36,982	41,551	50,685	59,818	64,384	68,948	75,800	87,215	63
27		36,000	40,445	49,334	58,216	62,667	67,112	73,778	84,883	63
28		36,000	40,445	49,334	58,216	62,667	67,112	73,778	84,883	62
29		35,055	39,388	48,052	56,710	61,039	65,368	71,854	82,684	62
30-31		34,171	38,390	46,833	55,275	59,494	63,714	70,043	80,591	60
32		32,517	36,544	44,573	52,611	56,617	60,632	66,661	76,707	61
33		31,035	34,861	42,515	50,180	54,023	57,847	63,602	73,180	62
34		29,671	33,328	40,657	47,986	51,644	55,302	60,802	69,960	62
35		27,833	31,272	38,145	45,012	48,451	51,890	57,045	65,622	64
36		26,732	30,034	36,627	43,235	46,523	49,833	54,779	63,035	64
37		25,715	28,889	35,233	41,588	44,762	47,937	52,699	60,633	64
38		24,322	27,322	33,334	39,340	42,343	45,343	49,843	57,358	65
39		22,690	25,490	31,086	36,695	39,496	42,297	46,499	53,499	66
40	9.42	21,258	23,883	29,133	34,383	37,008	39,633	43,570	50,132	67
41	10.02	19,709	22,140	27,008	31,874	34,303	36,730	40,388	46,473	68
42	10.86	17,874	20,080	24,499	28,919	31,124	33,330	36,639	42,164	70
43	11.70	16,364	18,384	22,419	26,465	28,485	30,500	33,533	38,586	72
44	12.54	15,079	16,945	20,670	24,395	26,257	28,115	30,913	35,567	73
45	13.50	13,838	15,556	18,972	22,388	24,103	25,812	28,377	32,649	74
46	14.46	12,797	14,376	17,535	20,696	22,275	23,852	26,225	30,168	75
47	15.30	12,000	13,480	16,442	19,404	20,889	22,371	24,593	28,291	76
48	16.26	11,199	12,587	15,353	18,119	19,499	20,886	22,960	26,415	77
49	17.34	10,422	11,712	14,282	16,856	18,147	19,430	21,364	24,582	78
50	18.66		10,793	13,166	15,537	16,725	17,913	19,692	22,657	79
51	20.22			12,053	14,222	15,308	16,393	18,023	20,736	80
52	22.14			10,915	12,879	13,861	14,845	16,323	18,780	82
53	24.06				11,769	12,668	13,567	14,915	17,161	83
54	25.98				10,833	11,662	12,490	13,729	15,798	85
55	27.66				10,132	10,905	11,679	12,838	14,771	86
56	28.86					10,419	11,161	12,270	14,116	85
57	29.70					10,108	10,824	11,899	13,692	84
58	30.66						10,465	11,504	13,237	84
59	31.86						10,047	11,045	12,708	84
60	29.79					10,078	10,788	11,854	13,629	84
61	32.30							10,884	12,514	85
62	35.35								11,380	87
63	38.73								10,342	89
64	43.20									93
65	46.37									94
66	49.42									95
67	52.15									96
68	54.99									96
69	58.04									96
70	61.31									95

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

PureLife2010-C4AAD5ACD9AL

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

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Eleventhly Premiums Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Waiver of Premium Benefit (Ages 17-59) $28.00	$30.00	$35.00	$40.00	$45.00	$50.00	$55.00	$60.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-10										75
11-16										70
17-20		43,235	46,523	54,779	63,035	71,279	79,538	87,789	96,040	66
21		41,588	44,762	52,699	60,633	68,566	76,500	84,445	92,381	66
22		41,588	44,762	52,699	60,633	68,566	76,500	84,445	92,381	65
23-25		39,340	42,343	49,843	57,358	64,864	72,373	79,880	87,388	63
26		38,642	41,593	48,968	56,337	63,717	71,091	78,467	85,833	63
27		37,969	40,869	48,109	55,363	62,609	69,849	77,099	84,348	63
28		37,322	40,167	47,284	54,411	61,539	68,656	75,784	82,906	62
29		36,695	39,496	46,499	53,499	60,499	67,508	74,509	81,509	62
30-31		32,342	34,815	40,988	47,161	53,334	59,507	65,674	71,842	60
32		31,411	33,813	39,809	45,804	51,798	57,794	63,789	69,782	61
33		30,960	33,334	39,244	45,154	51,056	56,974	62,880	68,795	62
34		30,537	32,867	38,695	44,523	50,350	56,171	62,005	67,833	62
35		28,541	30,719	36,166	41,611	47,055	52,500	57,949	63,398	64
36		27,464	29,560	34,798	40,042	45,284	50,520	55,763	61,006	64
37		25,837	27,811	32,734	37,669	42,604	47,535	52,466	57,396	64
38		24,944	26,856	31,618	36,381	41,143	45,905	50,667	55,429	65
39		23,352	25,133	29,591	34,047	38,499	42,959	47,412	51,866	66
40	14.10	21,299	22,927	26,992	31,057	35,121	39,184	43,253	47,315	67
41	14.94	19,940	21,462	25,267	29,068	32,877	36,681	40,488	44,289	68
42	16.02	18,423	19,832	23,346	26,860	30,380	33,896	37,409	40,929	70
43	17.70	16,478	17,731	20,881	24,026	27,166	30,315	33,459	36,603	72
44	18.66	15,537	16,725	19,692	22,657	25,620	28,589	31,552	34,516	73
45	19.98	14,409	15,510	18,262	21,010	23,760	26,510	29,263	32,014	74
46	21.18	13,516	14,548	17,132	19,711	22,288	24,872	27,451	30,031	75
47	22.38	12,728	13,703	16,131	18,562	20,990	23,417	25,850	28,278	76
48	23.58	12,030	12,945	15,244	17,537	19,833	22,129	24,427	26,722	77
49	25.50	11,055	11,897	14,007	16,118	18,228	20,338	22,447	24,555	78
50	26.82	10,472	11,271	13,270	15,268	17,267	19,265	21,263	23,261	79
51	28.86		10,419	12,270	14,116	15,965	17,813	19,658	21,506	80
52	31.38			11,223	12,914	14,605	16,294	17,985	19,675	82
53	33.42			10,499	12,080	13,662	15,244	16,825	18,404	83
54	35.94				11,189	12,653	14,117	15,583	17,048	85
55	37.74				10,628	12,021	13,409	14,803	16,193	86
56	39.30				10,185	11,519	12,854	14,185	15,519	85
57	40.50					11,163	12,455	13,747	15,039	84
58	42.66					10,573	11,797	13,019	14,244	84
59	44.46					10,127	11,297	12,471	13,642	84
60	41.57					10,861	12,113	13,364	14,618	84
61	44.40					10,141	11,309	12,478	13,648	85
62	48.00						10,431	11,509	12,589	87
63	51.71							10,656	11,656	89
64	55.75								10,787	93
65	58.48								10,269	94
66	61.53									95
67	64.59									96
68	67.97									96
69	71.46									96
70	75.28									95

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

PureLife2010-C4AAD5ACD9AL

Continuation of Benefits

If you Leave Employment

Aflac Group Accident, Hospital Indemnity & Critical Illness

You may continue your Aflac Accident, Hospital Indemnity and/or Critical Illness plans by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, contact Aflac at 1-800-433-3036.

Allstate Cancer

You may continue your Allstate Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information, contact Allstate at 1-800-433-3036.

AUL Short-Term Disability

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to port your coverage by calling 1-800-553-5318.

FBA Flexible Spending Account

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. You will receive notification and continuation options shortly following your termination of employment. For more information, please call Flexible Benefit Administrators (FBA) at 1-800-437-3539.

Texas Life Whole & Universal Life

When you leave employment, you may continue your Whole and Universal Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting Texas Life at 1-800-283-9233 prompt #2.

Contact Information

Allstate Benefits
1776 American Heritage Life Dr.
Jacksonville, FL 32224
Policy questions please call: 1-800-521-3535
Claim questions please call: 1-800-348-4489
Email claims to: claimsresearch@allstate.com
www.allstate.com or allstatebenefits.com

Aflac
Continental American Insurance Company
P.O. Box 84075
Columbus, GA 31993
Phone: 1-800-433-3036
Email: cscmail@Aflac.com
Aflacgroupinsurance.com

American United Life (AUL)
One America Square
P.O. Box 368
Indianapolis, IN 46206-0368
Claims Toll-Free Number
1-855-517-6365
Customer Service
1-800-553-5318
www.oneamerica.com

Flexible Benefit Administrators, Inc.
2875 Sabre Street, Suite 300
Virginia Beach, VA 23450
Phone: 1-800-437-3539
Fax: 1-757-431-1155
www.flex-admin.com

Texas Life Insurance Company
PO Box 830
Waco, TX 76703-0830
1-800-283-9233
www.texaslife.com

NOTES

View additional benefits information
or download forms at:
mymarkiii.com

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Mark III
Employee Benefits

300 W. Watauga Ave.
Johnson City, TN 37604

(800) 532-1044
(704) 365-4280

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