Poquoson City Public Schools
A Tradition of Excellence

POQUOSON CITY PUBLIC SCHOOLS

EMPLOYEE BENEFITS GUIDE

September 1, 2021 – August 31, 2022 Plan Year

First Financial Group of America

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Poquoson City Public Schools offers eligible employees a competitive benefits package that includes both district-paid and voluntary products. We have worked closely with First Financial (FFGA) to provide you with a variety of benefits and resources to help you reach your healthcare and retirement needs. Details of all available benefits can be found on the Employee Benefits Center website, *www.benefits.ffga.com/poquosoncitypublicschools*.

Be sure to read the product descriptions carefully so you are well prepared before enrollment begins. If you have questions, feel free to reach out to your First Financial Account Manager, Michael Shelly or Debbie Bunting - Human Resources Coordinator.

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ELIGIBILITY & ENROLLMENT

Poquoson City Public Schools
500 City Hall Ave, Poquoson, VA 23662| 757-868-3055

ELIGIBILITY

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

BENEFITS ENROLLMENT

EMPLOYEE BENEFITS CENTER

The Employee Benefits Center (EBC) is a one-stop-shop for you to find all things benefits related. On the website, you'll find open enrollment and plan year dates, benefit descriptions, carrier contact information, product brochures, claim forms and enrollment details. Visit *benefits.ffga.com/poquosoncitypublicschools* today!

NEW EMPLOYEES

You have 31 days from your hire date to make benefit elections.

EXISTING EMPLOYEES

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

MID-YEAR BENEFIT CHANGES

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

QUALIFYING LIFE EVENTS INCLUDE:

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

DECLINING COVERAGE

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

BENEFITS ENROLLMENT

HOW TO ENROLL ONLINE

https://ffga.benselect.com/Enroll

LOGIN

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

VIEW CURRENT BENEFITS

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

VIEW/ADD DEPENDENTS

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

BEGIN ELECTIONS

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

Flexible Spending Accounts

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

HEALTHCARE FSA

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

Your maximum contribution amount for 2021 is $2,750.

HIGHLIGHTS

- Contributions are automatically deducted from your paycheck on a pre-tax basis, which helps reduce your taxable income and increase your spendable income.
- Your full election will be available to you at the beginning of the plan year.
- Be conservative – any money left in your account at the end of the plan year with be forfeited.
- Use your benefits card to pay for qualified expenses upfront so you don't have to spend money out of pocket.
- Keep all receipts in case you need to substantiate a claim for tax purposes.

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

DEPENDENT CARE FSA

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

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

HIGHLIGHTS

- Eligible dependents must be claimed as an exemption on your tax return.

FLEXIBLE SPENDING ACCOUNTS CONTINUED

- Eligible dependents must be children under age 13 or an adult dependent incapable of self-care.

- Contributions are not loaded upfront. Funds become available as contributions are made to your account.

- Keep all receipts in case you need to substantiate a claim for tax purposes.
- Balances will be forfeited at the end of the runoff or grace period.

FSA RESOURCES

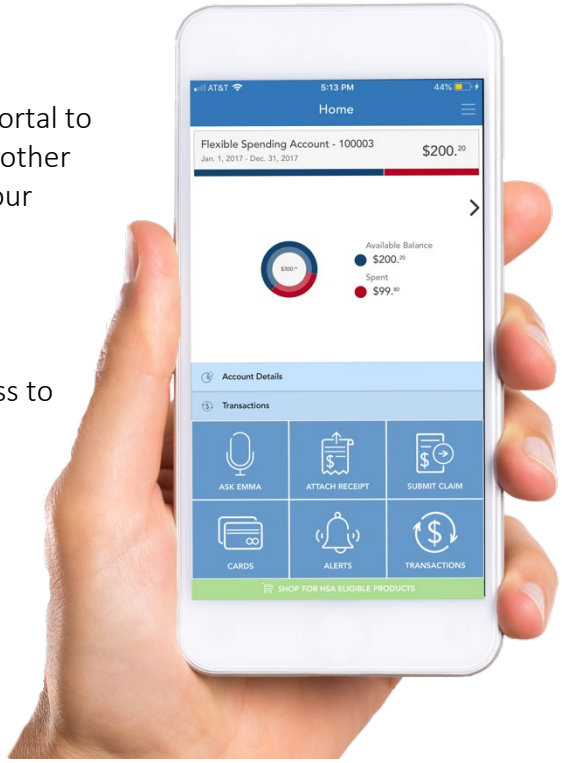
BENEFITS CARD

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

- **The IRS requires validation of most transactions for FSAs.** You must submit receipts for validation of expenses when requested. If you fail to substantiate by providing a receipt to First Financial within 90 days of the purchase or date of service your card will be suspended until the necessary, receipt or explanation of benefits from your insurance provider is received.
- **Dependent Care FSA Contributions are not loaded upfront.** Funds become available as contributions are made to your account.

ONLINE FSA PORTAL

Flexible Spending Account participants can log in to their online FSA portal to access account balances, check on claims, upload receipts and access other account details. Visit https://ffga.com/individuals to login or set up your account.



FF FLEX MOBILE APP

Managing your benefit accounts on the go is made easy with ***FF Flex Mobile App***. This powerful, intuitive mobile application gives you access to view your account balances, update your profile, submit a claim and much more – right from your Android or Apple device.

- Access account Information
- View card details and profile information
- Submit FSA claims using an electronic claim form
- View pending claims
- Upload receipts and documentation
- Receive alerts
- Update direct deposit information

FSA STORE

First Financial has partnered with the FSA Store to bring you an easy to use online store to better understand and manage your FSA. An online marketplace that connects consumers to FSA-eligible products, seasonal deals, and account support resources such as open enrollment guides and educational videos.

Visit http://www.ffga.com/fsaextras for more details & special deals!

- Shop for eligible items from bandages to wheelchairs and thousands of products in between
- Browse or search for eligible products and services using the Eligibility List
- Visit the Learning Center to help find answers to questions you may have about your account.

Clever RX

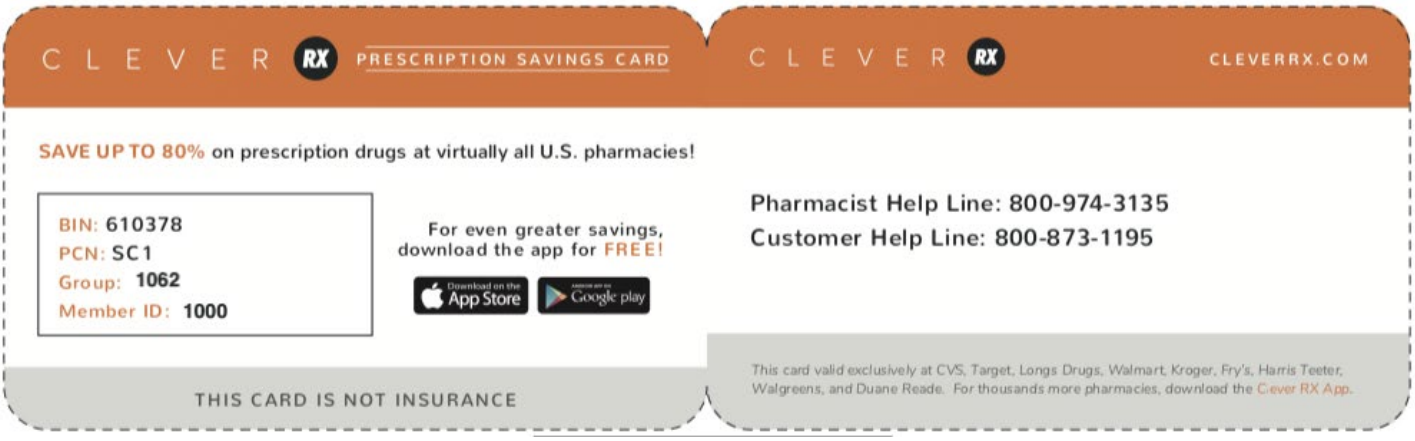
Clever RX | https://partner.cleverrx.com/ffga | 1.800.873.1195

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

HIGHLIGHTS

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

Use Clever RX every time you pay for a medication for instant savings! Download the app or visit the site to price a drug: https://partner.cleverrx.com/ffga.



POQUOSON CITY PUBLIC SCHOOLS

Eye Care Highlight Sheet

Ameritas

Focus® Plan Summary

	VSP Network	Out of Network
Deductibles		
	$15 Exam	$15 Exam
	$15 Eye Glass Lenses or Frames*	$15 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $35
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $70
Lenticular	Covered in full	Up to $90
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to $105	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$120	Up to $50
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

Lens Options (member cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $25 adults	No benefit
Solid Plastic Dye	$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	$15	No benefit
Photochromatic Lenses (Glass & Plastic)	$27-$76	No benefit
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Monthly Rates

Employee Only (EE)	$9.70
EE + Family	$23.76

Additional Focus® Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

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

POQUOSON CITY PUBLIC SCHOOLS

Eye Care Highlight Sheet

Ameritas

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

Life insurance can be an ideal way to provide money for your family when they need it most. PURELIFE-PLUS offers permanent insurance with a high death benefit and long guarantees[1] that can provide financial peace of mind for you and your loved ones. PURELIFE-PLUS is an ideal complement to any group term and optional term life insurance your employer might provide and has the following features:

- It's Affordable You own it
- You can take it with you when you change jobs or retire
- You pay for it through convenient payroll deductions
- You can cover your spouse, children and grandchildren, too[2]
- You can get a living benefit if you become terminally ill[3]
- You can get cash to cover living expenses if you become chronically ill[4]

3 QUICK QUESTIONS

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

DURING THE LAST SIX MONTHS, HAS THE PROPOSED INSURED:

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

1. After the guarantee period, premiums may go down, stay the same or go up.
2. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.
3. Conditions apply.
4. Chronic Illness Rider available for an additional cost for employees only. Conditions apply. Rider not available in CA. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15

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

19M016-C FFGA 1092 (exp0321)

First Financial Group of America
First in Service and Expertise

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

WOW!

LIFE INSURANCE YOU CAN KEEP!

PURELIFE-PLUS

- It's Affordable You own it
- You can take it with you when you change jobs or retire
- You pay for it through convenient payroll deductions: no checks to write or links to click
- You can cover your spouse, children and grandchildren, too[1]
- You can get a living benefit if you become terminally ill[2]
- You can get cash to cover living expenses if you become chronically ill[3]
- You can qualify by answering just 3 questions - no exam or needles

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

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

19M004-C FFGA 1003 (exp0321)

TEXASLIFE INSURANCE COMPANY — EMPLOYEE MONTHLY PREMIUMS

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages) $10,000	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		11.40	20.55	29.70	38.85	57.15	75.45	93.75	112.05	73
21-22		11.68	21.10	30.53	39.95	58.80	77.65	96.50	115.35	73
23-25		11.95	21.65	31.35	41.05	60.45	79.85	99.25	118.65	71
26		12.23	22.20	32.18	42.15	62.10	82.05	102.00	121.95	72
27		12.50	22.75	33.00	43.25	63.75	84.25	104.75	125.25	72
28		12.50	22.75	33.00	43.25	63.75	84.25	104.75	125.25	71
29		12.78	23.30	33.83	44.35	65.40	86.45	107.50	128.55	71
30-31		13.05	23.85	34.65	45.45	67.05	88.65	110.25	131.85	70
32		13.60	24.95	36.30	47.65	70.35	93.05	115.75	138.45	70
33		14.15	26.05	37.95	49.85	73.65	97.45	121.25	145.05	71
34		14.70	27.15	39.60	52.05	76.95	101.85	126.75	151.65	72
35		15.53	28.80	42.08	55.35	81.90	108.45	135.00	161.55	73
36		16.08	29.90	43.73	57.55	85.20	112.85	140.50	168.15	73
37		16.63	31.00	45.38	59.75	88.50	117.25	146.00	174.75	73
38		17.45	32.65	47.85	63.05	93.45	123.85	154.25	184.65	74
39		18.55	34.85	51.15	67.45	100.05	132.65	165.25	197.85	75
40	9.21	19.65	37.05	54.45	71.85	106.65	141.45	176.25	211.05	76
41	9.76	21.03	39.80	58.58	77.35	114.90	152.45	190.00	227.55	77
42	10.53	22.95	43.65	64.35	85.05	126.45	167.85	209.25	250.65	78
43	11.30	24.88	47.50	70.13	92.75	138.00	183.25	228.50	273.75	80
44	12.07	26.80	51.35	75.90	100.45	149.55	198.65	247.75	296.85	81
45	12.95	29.00	55.75	82.50	109.25	162.75	216.25	269.75	323.25	82
46	13.83	31.20	60.15	89.10	118.05	175.95	233.85	291.75	349.65	83
47	14.60	33.13	64.00	94.88	125.75	187.50	249.25	311.00	372.75	83
48	15.48	35.33	68.40	101.48	134.55	200.70	266.85	333.00	399.15	84
49	16.47	37.80	73.35	108.90	144.45	215.55	286.65	357.75	428.85	85
50	17.68	40.83	79.40	117.98	156.55					86
51	19.11	44.40	86.55	128.70	170.85					87
52	20.87	48.80	95.35	141.90	188.45					88
53	22.63	53.20	104.15	155.10	206.05					90
54	23.84	56.23	110.20	164.18	218.15					90
55	24.94	58.98	115.70	172.43	229.15					91
56	26.04	61.73	121.20	180.68	240.15					91
57	27.25	64.75	127.25	189.75	252.25					91
58	28.57	68.05	133.85	199.65	265.45					91
59	29.78	71.08	139.90	208.73	277.55					91
60	30.63	73.20	144.15	215.10	286.05					91
61	32.28	77.33	152.40	227.48	302.55					91
62	34.04	81.73	161.20	240.68	320.15					92
63	35.91	86.40	170.55	254.70	338.85					92
64	37.89	91.35	180.45	269.55	358.65					92
65	39.98	96.58	190.90	285.23	379.55					92
66	42.29									92
67	44.82									92
68	47.57									92
69	50.43									93
70	53.29									93

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

Form: 18M049-ICC EXP-K-M-3AD

TEXASLIFE INSURANCE COMPANY — EMPLOYEE MONTHLY PREMIUMS

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		16.08	29.90	43.73	57.55	85.20	112.85	140.50	168.15	70
21-22		16.63	31.00	45.38	59.75	88.50	117.25	146.00	174.75	70
23-25		17.45	32.65	47.85	63.05	93.45	123.85	154.25	184.65	69
26		17.73	33.20	48.68	64.15	95.10	126.05	157.00	187.95	69
27		18.00	33.75	49.50	65.25	96.75	128.25	159.75	191.25	68
28		18.28	34.30	50.33	66.35	98.40	130.45	162.50	194.55	68
29		18.55	34.85	51.15	67.45	100.05	132.65	165.25	197.85	68
30-31		20.75	39.25	57.75	76.25	113.25	150.25	187.25	224.25	69
32		21.30	40.35	59.40	78.45	116.55	154.65	192.75	230.85	69
33		21.58	40.90	60.23	79.55	118.20	156.85	195.50	234.15	69
34		21.85	41.45	61.05	80.65	119.85	159.05	198.25	237.45	68
35		23.23	44.20	65.18	86.15	128.10	170.05	212.00	253.95	69
36		24.05	45.85	67.65	89.45	133.05	176.65	220.25	263.85	69
37		25.43	48.60	71.78	94.95	141.30	187.65	234.00	280.35	70
38		26.25	50.25	74.25	98.25	146.25	194.25	242.25	290.25	70
39		27.90	53.55	79.20	104.85	156.15	207.45	258.75	310.05	70
40	13.50	30.38	58.50	86.63	114.75	171.00	227.25	283.50	339.75	72
41	14.27	32.30	62.35	92.40	122.45	182.55	242.65	302.75	362.85	73
42	15.26	34.78	67.30	99.83	132.35	197.40	262.45	327.50	392.55	74
43	16.80	38.63	75.00	111.38	147.75	220.50	293.25	366.00	438.75	76
44	17.68	40.83	79.40	117.98	156.55	233.70	310.85	388.00	465.15	77
45	18.89	43.85	85.45	127.05	168.65	251.85	335.05	418.25	501.45	78
46	19.99	46.60	90.95	135.30	179.65	268.35	357.05	445.75	534.45	79
47	21.09	49.35	96.45	143.55	190.65	284.85	379.05	473.25	567.45	79
48	22.19	52.10	101.95	151.80	201.65	301.35	401.05	500.75	600.45	80
49	23.95	56.50	110.75	165.00	219.25	327.75	436.25	544.75	653.25	82
50	25.16	59.53	116.80	174.08	231.35					82
51	27.03	64.20	126.15	188.10	250.05					83
52	29.34	69.98	137.70	205.43	273.15					85
53	31.21	74.65	147.05	219.45	291.85					87
54	32.75	78.50	154.75	231.00	307.25					87
55	34.29	82.35	162.45	242.55	322.65					87
56	36.05	86.75	171.25	255.75	340.25					87
57	37.70	90.88	179.50	268.13	356.75					87
58	39.68	95.83	189.40	282.98	376.55					87
59	41.33	99.95	197.65	295.35	393.05					87
60	42.51	102.90	203.55	304.20	404.85					87
61	45.37	110.05	217.85	325.65	433.45					88
62	48.01	116.65	231.05	345.45	459.85					88
63	50.54	122.98	243.70	364.43	485.15					88
64	53.07	129.30	256.35	383.40	510.45					89
65	55.71	135.90	269.55	403.20	536.85					89
66	58.57									89
67	61.65									89
68	64.84									89
69	68.25									89
70	71.88									90

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

TEXASLIFE INSURANCE COMPANY — SPOUSE/CHILD MONTHLY PREMIUMS

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

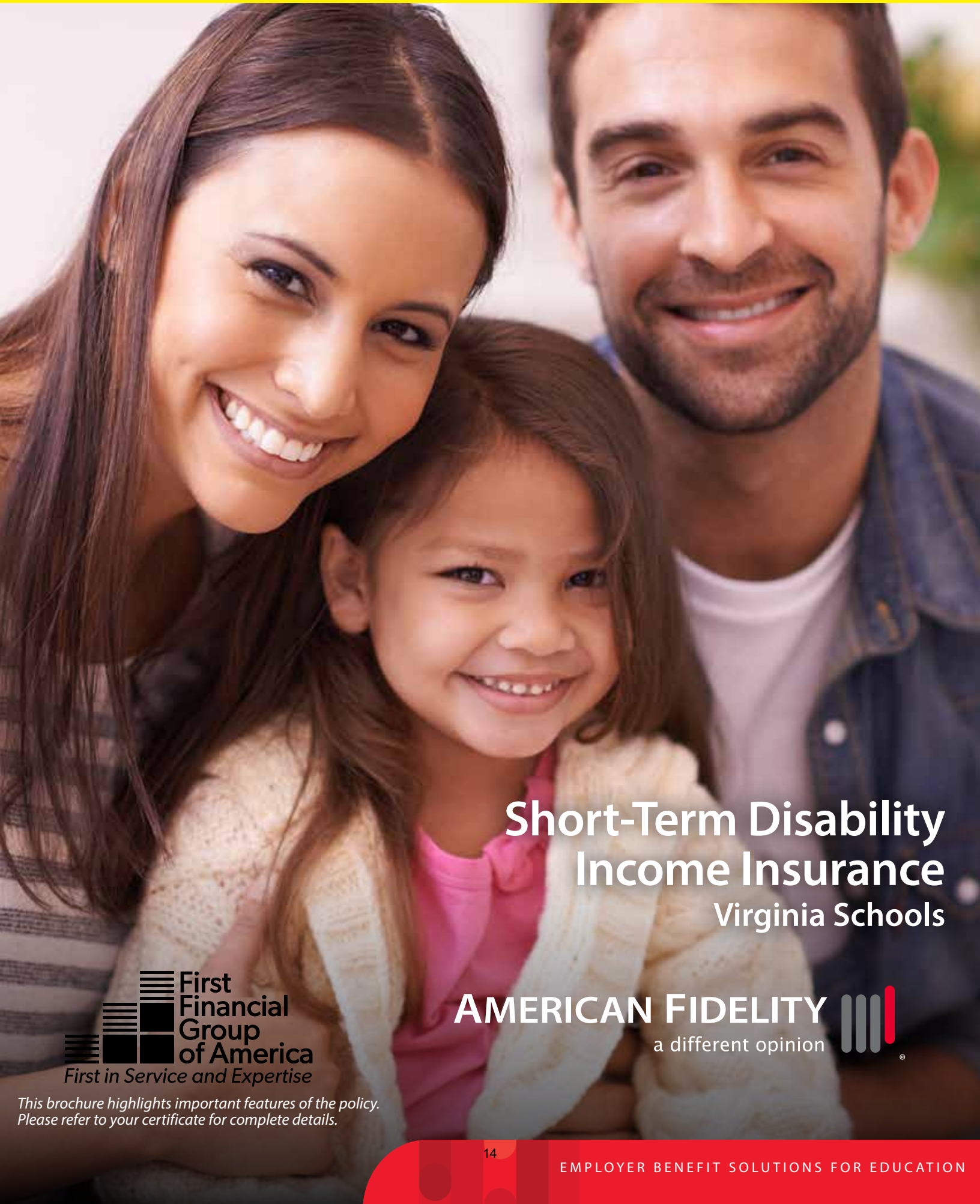
Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	
15D-1				8.00					13.75	83
2-3				8.25					14.25	83
4-10				8.50					14.75	79
11-16				8.75					15.25	75
17-20				10.75	12.45	14.15	15.85	17.55	19.25	73
21-22				11.00	12.75	14.50	16.25	18.00	19.75	73
23-25				11.25	13.05	14.85	16.65	18.45	20.25	71
26				11.50	13.35	15.20	17.05	18.90	20.75	72
27				11.75	13.65	15.55	17.45	19.35	21.25	72
28				11.75	13.65	15.55	17.45	19.35	21.25	71
29				12.00	13.95	15.90	17.85	19.80	21.75	71
30-31				12.25	14.25	16.25	18.25	20.25	22.25	70
32				12.75	14.85	16.95	19.05	21.15	23.25	70
33				13.25	15.45	17.65	19.85	22.05	24.25	71
34				13.75	16.05	18.35	20.65	22.95	25.25	72
35		9.60	12.05	14.50	16.95	19.40	21.85	24.30	26.75	73
36		9.90	12.45	15.00	17.55	20.10	22.65	25.20	27.75	73
37		10.20	12.85	15.50	18.15	20.80	23.45	26.10	28.75	73
38		10.65	13.45	16.25	19.05	21.85	24.65	27.45	30.25	74
39		11.25	14.25	17.25	20.25	23.25	26.25	29.25	32.25	75
40	8.65	11.85	15.05	18.25	21.45	24.65	27.85	31.05	34.25	76
41	9.15	12.60	16.05	19.50	22.95	26.40	29.85	33.30	36.75	77
42	9.85	13.65	17.45	21.25	25.05	28.85	32.65	36.45	40.25	78
43	10.55	14.70	18.85	23.00	27.15	31.30	35.45	39.60	43.75	80
44	11.25	15.75	20.25	24.75	29.25	33.75	38.25	42.75	47.25	81
45	12.05	16.95	21.85	26.75	31.65	36.55	41.45	46.35	51.25	82
46	12.85	18.15	23.45	28.75	34.05	39.35	44.65	49.95	55.25	83
47	13.55	19.20	24.85	30.50	36.15	41.80	47.45	53.10	58.75	83
48	14.35	20.40	26.45	32.50	38.55	44.60	50.65	56.70	62.75	84
49	15.25	21.75	28.25	34.75	41.25	47.75	54.25	60.75	67.25	85
50	16.35	23.40	30.45	37.50						86
51	17.65	25.35	33.05	40.75						87
52	19.25	27.75	36.25	44.75						88
53	20.85	30.15	39.45	48.75						90
54	21.95	31.80	41.65	51.50						90
55	22.95	33.30	43.65	54.00						91
56	23.95	34.80	45.65	56.50						91
57	25.05	36.45	47.85	59.25						91
58	26.25	38.25	50.25	62.25						91
59	27.35	39.90	52.45	65.00						91
60	28.05	40.95	53.85	66.75						91
61										91
62										92
63										92
64										92
65										92
66										92
67										92
68										92
69										93
70										93

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

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

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) $10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20				15.00	17.55	20.10	22.65	25.20	27.75	70
21-22				15.50	18.15	20.80	23.45	26.10	28.75	70
23-25				16.25	19.05	21.85	24.65	27.45	30.25	69
26				16.50	19.35	22.20	25.05	27.90	30.75	69
27				16.75	19.65	22.55	25.45	28.35	31.25	68
28				17.00	19.95	22.90	25.85	28.80	31.75	68
29				17.25	20.25	23.25	26.25	29.25	32.25	68
30-31				19.25	22.65	26.05	29.45	32.85	36.25	69
32				19.75	23.25	26.75	30.25	33.75	37.25	69
33				20.00	23.55	27.10	30.65	34.20	37.75	69
34				20.25	23.85	27.45	31.05	34.65	38.25	68
35		13.80	17.65	21.50	25.35	29.20	33.05	36.90	40.75	69
36		14.25	18.25	22.25	26.25	30.25	34.25	38.25	42.25	69
37		15.00	19.25	23.50	27.75	32.00	36.25	40.50	44.75	70
38		15.45	19.85	24.25	28.65	33.05	37.45	41.85	46.25	70
39		16.35	21.05	25.75	30.45	35.15	39.85	44.55	49.25	70
40	12.55	17.70	22.85	28.00	33.15	38.30	43.45	48.60	53.75	72
41	13.25	18.75	24.25	29.75	35.25	40.75	46.25	51.75	57.25	73
42	14.15	20.10	26.05	32.00	37.95	43.90	49.85	55.80	61.75	74
43	15.55	22.20	28.85	35.50	42.15	48.80	55.45	62.10	68.75	76
44	16.35	23.40	30.45	37.50	44.55	51.60	58.65	65.70	72.75	77
45	17.45	25.05	32.65	40.25	47.85	55.45	63.05	70.65	78.25	78
46	18.45	26.55	34.65	42.75	50.85	58.95	67.05	75.15	83.25	79
47	19.45	28.05	36.65	45.25	53.85	62.45	71.05	79.65	88.25	79
48	20.45	29.55	38.65	47.75	56.85	65.95	75.05	84.15	93.25	80
49	22.05	31.95	41.85	51.75	61.65	71.55	81.45	91.35	101.25	82
50	23.15	33.60	44.05	54.50						82
51	24.85	36.15	47.45	58.75						83
52	26.95	39.30	51.65	64.00						85
53	28.65	41.85	55.05	68.25						87
54	30.05	43.95	57.85	71.75						87
55	31.45	46.05	60.65	75.25						87
56	33.05	48.45	63.85	79.25						87
57	34.55	50.70	66.85	83.00						87
58	36.35	53.40	70.45	87.50						87
59	37.85	55.65	73.45	91.25						87
60	38.85	57.15	75.45	93.75						87
61										88
62										88
63										88
64										89
65										89
66										89
67										89
68										89
69										89
70										90

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".



Short-Term Disability Income Insurance

Virginia Schools

First Financial Group of America
First in Service and Expertise

AMERICAN FIDELITY
a different opinion

This brochure highlights important features of the policy. Please refer to your certificate for complete details.

Disability income insurance is here for you.

- **Salary Protection for You and Your Loved Ones**
  Provides a steady benefit to cover expenses while you are unable to work. The plan makes it easy to help protect your future income in case of a sudden injury or sickness.
- **Several Elimination Periods Available**
  Based on your individual need, there are various elimination periods for you to choose from. The plan pays a percentage of your gross monthly income once you have satisfied the elimination period.
- **Benefit Payments Made Directly to You**
  Your monthly benefit payments may be deposited directly into your bank account. This gives you the freedom to pay your living expenses and make other purchases as you see fit.

Choose the Right Plan for You

Benefits Begin

Plan I - On the 15th day of Disability due to a covered Injury or Sickness.

Plan II - On the 31st day of Disability due to a covered Injury or Sickness.

In 2015, 77% of injuries requiring medical attention suffered by workers occured off the job.

National Safety Council, Injury Facts, 2017 Edition, p. 63.

Injury means physical harm or damage to the body you sustained which results directly from an accidental bodily injury, is independent of disease or bodily infirmity; and takes place while your coverage is in force.

Sickness means a disease or illness (including pregnancy). Disability must begin while your coverage is in force.

Hospital- the term "Hospital" shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Benefits Are Payable

Benefits are payable up to 1 year for a covered Injury or Sickness.

If you reside in a state other than your employer's state of domicile, where required by law, policy provisions and benefits may vary.

Eligibility
All permanent employees in subscribing group working 15 hours or more per week. Regarding your eligibility, we may require proof of good health and will rely on answers given on your application to determine if coverage can be issued. Regardless of your health at the time of application, if coverage is approved and issued, claims incurred while coverage is in force will be subject to all terms of the Policy including any Pre-Existing Condition limitation.

When Coverage Begins
Certificates will become effective on the requested effective date following the date we approve the application, provided you are on active employment and premium has been paid.

Physician Expense Benefit
Injury - $150.00 per Injury

If you need personal treatment by a Physician due to an Injury, we will pay the amount shown above provided no other claim has been paid under the Policy. You are not required to miss one full day of work in order to receive the Injury benefit. This benefit will be limited to 8 payments per calendar year.

Accidental Death Benefit
A lump sum of $10,000 will be paid to your designated beneficiary if you die as the direct result of an injury within 90 days after the injury.

Waiver of Premium
No premium payments are required while you are receiving payments under the plan after disability payments have been received for 90 consecutive days. We will require proof annually that you remain disabled during that time.

Donor Benefit
If you are disabled as a result of being an organ or tissue donor, we will pay your benefit as any other sickness under the terms of the plan.

Offsets With Other Sources of Income
Deductible Sources of Income include:

- Other group disability income. This provision shall not apply to individually underwritten and individually issued policies for which the entire premium has been paid by you, a member of your family or your guardian or conservator.
- Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.
- United States Social Security Act or similar plan or act, including any amounts due your dependent(s) on account of your disability.
- State Disability.
- Unemployment compensation.
- Workers' Compensation law, occupational disease law or any similar act or law.
- Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond 60 calendar days from the date of disability.

We reserve the right to estimate these Deductible Sources of Income that you may receive as defined in your Certificate.

Minimum Disability Benefit
The Minimum Disability Benefit is 10% of the Monthly Disability Benefit or $100.00, whichever is greater.

If You Are Disabled Due to a Covered Disability and Not Working
Your disability payment will be the disability benefit described in the benefit schedule less any deductible sources of income you receive or are entitled to receive. No disability payment will be provided for any period in which you are not under the regular and appropriate care of a physician.

Disability or disabled means that you are unable to perform the material and substantial duties of your regular occupation.

Return To Work Incentives: Disabled and Working
If you are disabled and working, you may be eligible to continue to receive a percentage of your disability payment in addition to your disability earnings. If your disability earnings exceed 80% of your monthly compensation, payments will stop and your claim will end.

- **Worksite Accommodation**
  As a part of our claims evaluation process, if worksite modifications may assist your return to work, we will evaluate your claim for appropriate action.

Policy Benefit Limitations and Exclusions

Pre-Existing Condition Limitation
No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before you have been continuously covered under the Policy for 12 months. This provision will not apply if you have: gone treatment-free; incurred no expense; taken no medication; and received no diagnosis or advice from a Physician, for 12 consecutive months for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after you have been continuously covered under the Policy for 12 months.

Any increase in benefits will be subject to this pre-existing condition limitation. A new pre-existing condition period must be satisfied with respect to any increase applied for and approved by us.

Pre-existing condition means a disease, Injury, Sickness, physical condition or mental illness for which you: had treatment; incurred expense; took medication; received care or services including diagnostic testing or related measures; or received a diagnosis or advice from a physician, during the 12 month period immediately before your effective date of coverage.

Exclusions
The Policy does not cover any loss, fatal or non-fatal, resulting from:

- Intentionally self-inflicted injury while sane or insane.
- An act of war, declared or undeclared.
- Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- Committing a felony.
- Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

Your coverage may be continued for up to 1 year during a leave of absence approved in writing by your employer. Coverage will continue as long as the group policy remains in force, the premiums are paid and you remain eligible for the coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, or your employment terminates. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

Benefit Policy Schedule

Several benefit options are available to you. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 60% of your Monthly Compensation.

			Monthly Premiums	
Monthly Salary	**Monthly Disability Benefit**	**Accidental Death Benefit**	**Plan I (15th)**	**Plan II (31st)**
$334.00 - $499.99	$200.00	$10,000.00	$4.40	$4.00
$500.00 - $666.99	$300.00	$10,000.00	$6.60	$6.00
$667.00 - $833.99	$400.00	$10,000.00	$8.80	$8.00
$834.00 - $999.99	$500.00	$10,000.00	$11.00	$10.00
$1,000.00 - $1,166.99	$600.00	$10,000.00	$13.20	$12.00
$1,167.00 - $1,333.99	$700.00	$10,000.00	$15.40	$14.00
$1,334.00 - $1,499.99	$800.00	$10,000.00	$17.60	$16.00
$1,500.00 - $1,666.99	$900.00	$10,000.00	$19.80	$18.00
$1,667.00 - $1,833.99	$1,000.00	$10,000.00	$22.00	$20.00
$1,834.00 - $1,999.99	$1,100.00	$10,000.00	$24.20	$22.00
$2,000.00 - $2,166.99	$1,200.00	$10,000.00	$26.40	$24.00
$2,167.00 - $2,333.99	$1,300.00	$10,000.00	$28.60	$26.00
$2,334.00 - $2,499.99	$1,400.00	$10,000.00	$30.80	$28.00
$2,500.00 - $2,666.99	$1,500.00	$10,000.00	$33.00	$30.00
$2,667.00 - $2,833.99	$1,600.00	$10,000.00	$35.20	$32.00
$2,834.00 - $2,999.99	$1,700.00	$10,000.00	$37.40	$34.00
$3,000.00 - $3,166.99	$1,800.00	$10,000.00	$39.60	$36.00
$3,167.00 - $3,333.99	$1,900.00	$10,000.00	$41.80	$38.00
$3,334.00 - $3,499.99	$2,000.00	$10,000.00	$44.00	$40.00
$3,500.00 - $3,666.99	$2,100.00	$10,000.00	$46.20	$42.00
$3,667.00 - $3,833.99	$2,200.00	$10,000.00	$48.40	$44.00
$3,834.00 - $3,999.99	$2,300.00	$10,000.00	$50.60	$46.00
$4,000.00 - $4,166.99	$2,400.00	$10,000.00	$52.80	$48.00
$4,167.00 - $4,333.99	$2,500.00	$10,000.00	$55.00	$50.00
$4,334.00 - $4,499.99	$2,600.00	$10,000.00	$57.20	$52.00
$4,500.00 - $4,666.99	$2,700.00	$10,000.00	$59.40	$54.00
$4,667.00 - $4,833.99	$2,800.00	$10,000.00	$61.60	$56.00
$4,834.00 - $4,999.99	$2,900.00	$10,000.00	$63.80	$58.00
$5,000.00 - $5,166.99	$3,000.00	$10,000.00	$66.00	$60.00
$5,167.00 - $5,333.99	$3,100.00	$10,000.00	$68.20	$62.00
$5,334.00 - $5,499.99	$3,200.00	$10,000.00	$70.40	$64.00
$5,500.00 - $5,666.99	$3,300.00	$10,000.00	$72.60	$66.00
$5,667.00 - $5,833.99	$3,400.00	$10,000.00	$74.80	$68.00
$5,834.00 - $5,999.99	$3,500.00	$10,000.00	$77.00	$70.00
$6,000.00 - $6,166.99	$3,600.00	$10,000.00	$79.20	$72.00
$6,167.00 - $6,333.99	$3,700.00	$10,000.00	$81.40	$74.00
$6,334.00 - $6,499.99	$3,800.00	$10,000.00	$83.60	$76.00

Benefit Policy Schedule (continued)

Several benefit options are available to you. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 60% of your Monthly Compensation.

			Monthly Premiums	
Monthly Salary	Monthly Disability Benefit	Accidental Death Benefit	Plan I (15th)	Plan II (31st)
$6,500.00 - $6,666.99	$3,900.00	$10,000.00	$85.80	$78.00
$6,667.00 - $6,833.99	$4,000.00	$10,000.00	$88.00	$80.00
$6,834.00 - $6,999.99	$4,100.00	$10,000.00	$90.20	$82.00
$7,000.00 - $7,166.99	$4,200.00	$10,000.00	$92.40	$84.00
$7,167.00 - $7,333.99	$4,300.00	$10,000.00	$94.60	$86.00
$7,334.00 - $7,499.99	$4,400.00	$10,000.00	$96.80	$88.00
$7,500.00 - $7,666.99	$4,500.00	$10,000.00	$99.00	$90.00
$7,667.00 - $7,833.99	$4,600.00	$10,000.00	$101.20	$92.00
$7,834.00 - $7,999.99	$4,700.00	$10,000.00	$103.40	$94.00
$8,000.00 - $8,166.99	$4,800.00	$10,000.00	$105.60	$96.00
$8,167.00 - $8,333.99	$4,900.00	$10,000.00	$107.80	$98.00
$8,334.00 - $8,499.99	$5,000.00	$10,000.00	$110.00	$100.00
$8,500.00 - $8,666.99	$5,100.00	$10,000.00	$112.20	$102.00
$8,667.00 - $8,833.99	$5,200.00	$10,000.00	$114.40	$104.00
$8,834.00 - $8,999.99	$5,300.00	$10,000.00	$116.60	$106.00
$9,000.00 - $9,166.99	$5,400.00	$10,000.00	$118.80	$108.00
$9,167.00 - $9,333.99	$5,500.00	$10,000.00	$121.00	$110.00
$9,334.00 - $9,499.99	$5,600.00	$10,000.00	$123.20	$112.00
$9,500.00 - $9,666.99	$5,700.00	$10,000.00	$125.40	$114.00
$9,667.00 - $9,833.99	$5,800.00	$10,000.00	$127.60	$116.00
$9,834.00 - $9,999.99	$5,900.00	$10,000.00	$129.80	$118.00
$10,000.00 - $10,166.99	$6,000.00	$10,000.00	$132.00	$120.00
$10,167.00 - $10,332.99	$6,100.00	$10,000.00	$134.20	$122.00
$10,333.00 - $10,499.99	$6,200.00	$10,000.00	$136.40	$124.00
$10,500.00 - $10,666.99	$6,300.00	$10,000.00	$138.60	$126.00
$10,667.00 - $10,832.99	$6,400.00	$10,000.00	$140.80	$128.00
$10,833.00 - $10,999.99	$6,500.00	$10,000.00	$143.00	$130.00
$11,000.00 - $11,166.99	$6,600.00	$10,000.00	$145.20	$132.00
$11,167.00 - $11,332.99	$6,700.00	$10,000.00	$147.40	$134.00
$11,333.00 - $11,499.99	$6,800.00	$10,000.00	$149.60	$136.00
$11,500.00 - $11,666.99	$6,900.00	$10,000.00	$151.80	$138.00
$11,667.00 - $11,832.99	$7,000.00	$10,000.00	$154.00	$140.00
$11,833.00 - $11,999.99	$7,100.00	$10,000.00	$156.20	$142.00
$12,000.00 - $12,166.99	$7,200.00	$10,000.00	$158.40	$144.00
$12,167.00 - $12,332.99	$7,300.00	$10,000.00	$160.60	$146.00
$12,333.00 - $12,499.99	$7,400.00	$10,000.00	$162.80	$148.00
$12,500.00 and up	$7,500.00	$10,000.00	$165.00	$150.00

Hospital Indemnity Limited Benefit Rider

This rider is designed to pay a daily benefit amount for a Hospital Confinement, up to a maximum of 90 days, if you are confined to a Hospital.

Summary of Hospital Indemnity Limited Benefit Rider Benefits:

Benefits are not payable for Injury or Sickness incurred in the first 12 months of coverage due to a pre-existing condition as defined in the base policy. Patient must be confined to a Hospital for a minimum of 18 hours and charged room and board.

Hospital Indemnity Limited Benefit Rider

Daily Benefit Amount	Monthly Premium
$100.00	$6.00
$150.00	$9.00

Spousal Accident Only Disability Benefit Rider

This rider is designed to provide a monthly benefit if your spouse suffers a Disability due to a non-occupational accident.

Summary of Accident Only Spousal Benefit Rider Benefits:

Pays a monthly benefit amount to you for your spouse who is disabled as a result of a non-occupational accident. Benefits begin on the 31st consecutive day after the Injury and will continue for up to two years.

Spousal Accident Only Disability Benefit Rider

Monthly Benefit Amount	Annual Salary	Monthly Premium
$500.00	up to $10,000.00	$4.00
$1,000.00	$10,001.00 - $20,000.00	$8.00
$1,500.00	$20,001.00 - $30,000.00	$12.00
$2,000.00	$30,001.00 and over.	$16.00

COBRA Funding Rider

This rider is designed to help cover the cost of COBRA premiums if you elect COBRA coverage while you are receiving Disability Benefits.

Summary of COBRA Funding Rider Benefits:

In order to receive benefits under this Rider, you must: be receiving benefits under your Disability base plan; elect medical COBRA coverage; and be paying medical COBRA premiums. This benefit will pay up to the end of the disability benefit period or to the end of your medical COBRA benefit period, whichever occurs first.

COBRA Funding Rider

Monthly Benefit Amount	Monthly Premium
$300.00	$4.50
$600.00	$9.00

Survivor Benefit Rider

This rider is designed to provide a benefit to your beneficiary or estate, if you die while receiving Disability Benefits.

Summary of Survivor Benefit Rider Benefits:

Benefits are payable if you have been disabled and not working for at least 90 days, and die while receiving Disability Benefits. Pays a monthly benefit up to one year or until the maximum disability period is exhausted, whichever occurs first.

Survivor Benefit Rider

Monthly Benefit Amount	Monthly Premium
$2,000.00	$6.80

Critical Illness Benefit Rider

This rider is designed to provide a lump sum benefit based on diagnosis of a certain critical illness.

Summary of Critical Illness Benefit Rider Benefits:

Benefits are payable at a one-time lump sum benefit amount based on diagnosis of the following conditions Heart Attack, Stroke, Kidney Failure, Paralysis, or Major Organ Failure. In the case of Heart Attack, a physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms.

Critical Illness Benefit Rider

Benefit Amount	Monthly Premium
$10,000.00	$9.80
$15,000.00	$13.18
$20,000.00	$16.56
$25,000.00	$19.94

Benefit Rider Limitations and Exclusions

Hospital Indemnity Limited Benefit Rider

The Hospital Confinement Benefit will not be payable for an Injury or Sickness incurred in the first 12 months of coverage if the Injury or Sickness is caused by or resulting from a Pre-Existing Condition as defined in the Policy. In addition to the Exclusions listed in the Policy, no benefits will be payable under this Rider for any Hospital Confinement that is caused by or resulting from Mental Illness or Drug or Alcohol Abuse. Benefits are reduced by 50% at age 70. Successive Hospital stays will be considered as one confinement if they are separated by less than 90 days of confinement to a Hospital.

The term "Hospital" shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or as an extended care facility for the care of convalescent, rehabilitative , or ambulatory patients.

Critical Illness Benefit Rider

The Critical Illness Rider will not be payable for any loss caused by or resulting from: (a) a Critical Illness when the Date of Diagnosis occurs during the Waiting Period; (b) a Critical Illness diagnosed outside of the United States; or (c) a Sickness or Injury not specifically defined in this Rider.

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs before you have been continuously covered under this Rider for 12 consecutive months. Following 12 consecutive months this exclusion does not apply.

Pre-Existing Condition means a disease, Injury, Sickness, physical condition or mental illness for which you have experienced any of the following: (a) treatment; (b) incurred expense; (c) took medication; (d) received care or services including diagnostic testing or related measures; or (e) received a diagnosis or advise from a Physician, during the 12-month period immediately before the Effective Date of this Rider. Benefits reduce by 50% at age 70. No benefits will be paid for a Critical Illness when the Date of Diagnosis occurs during the Critical Illness Waiting Period. The waiting period is 30 days from the Effective Date of this Rider.

COBRA Funding Benefit Rider

Proof of election of medical COBRA continuation must be provided to American Fidelity. Proof of continued medical COBRA participation will be required before benefits are paid under this Rider. Your employment must have terminated for the benefit to be payable.

Spousal Accident Only Disability Benefit Rider

This Rider does not provide benefits for your Spouse for any Disability, fatal or non-fatal, which results from any of the following: (a) Intentionally self-inflicted Injury while sane or insane; (b) An act of war, declared or undeclared; (c) Injury sustained or contracted while in the service of the armed forces of any country; (d) Committing a felony; (e) Penal incarceration. American Fidelity will not pay benefits during any period for which your Spouse is incarcerated in a penal or correctional institution or for any Injury that occurs while your Spouse is incarcerated in a penal or correctional institution; (f) Injury arising out of and in the course of any occupation for wage or profit or for which your Spouse is entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which your Spouse is entitled to Workers' Compensation benefits; (g) Participation in any sport for wage or profit; (h) Participation in any contest of speed in a power driven vehicle for wage or profit.

Spouse means the person you are lawfully married to who is less than age 70. No benefits are payable for your Spouse under this Rider for a Disability from an Injury that occurred outside of the United States or its territories. No benefit will be provided for any period in which your Spouse is not under the regular and appropriate care of a Physician. No benefits will be paid for any Injury to your Spouse which is caused by or resulting from spousal abuse.

Survivor Benefit Rider

The Policy does not cover any loss, fatal or non-fatal, which results from: intentionally self-inflicted injury while sane or insane; an act of war, declared or undeclared; Injury sustained or Sickness contracted while in the service of the armed forces of any country; committing a felony; penal incarceration. American Fidelity will not pay benefits for Disability or any other loss for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer; or Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation. No Disability Payment will be provided for any period in which you are not under the regular and appropriate care of a physician.

Your coverage with respect to the riders listed above will end on the earliest of these dates: the end of the last period for which premium has been paid; the date you notify us in writing to terminate coverage; the date the rider is discontinued; the date the policy is discontinued; or the date your employment terminates.

Availability of riders may vary by state, employer and short-term coverage with a benefit period of less than 12 months. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed. Riders have limitations, exclusions, and waiting periods. Refer to your policy for complete details. These Riders will terminate on the same date as the Policy or Certificate to which it is attached.

Virginia Disclosure Notice

IMPORTANT NOTICE TO HYBRID PLAN PARTICIPANTS APPLYING FOR GROUP DISABILITY INCOME.

THIS INSURANCE MAY DUPLICATE THE BENEFITS OF THE VIRGINIA RETIREMENT SYSTEM'S HYBRID PLAN

This insurance pays group disability income benefits if you are disabled as defined in the policy. Benefits under this disability income policy may be reduced by other income sources such as benefits received from any other group disability income policy, including benefits that may be received from the Virginia Retirement System (VRS). A reduction in benefits from other income sources may result in the receipt of only the minimum disability income benefit of 10% of your monthly disability benefit or $100, whichever is greater.

If you are eligible for disability income coverage under a plan provided through the Virginia Retirement System this insurance may duplicate VRS benefits when:

- You were hired after January 1, 2014.
- You have more than 12 months of continuous coverage with your employer.
- You have changed employers within the last 12 months.
- You exercised your option to convert to the VRS Hybrid Plan.

Before you purchase this Group Disability Income Insurance

Before you purchase this insurance and to avoid purchasing duplicate coverage:

- Know your eligibility status. You may already be eligible to receive disability income benefits through VRS.
- Be sure you understand the difference between disability income insurance and disability retirement.
- Carefully review all materials regarding the group disability income plans available to you.

IF YOU ARE UNSURE OF THE DISABILITY INCOME OPTIONS AVAILABLE TO YOU THROUGH YOUR EMPLOYER, CONTACT YOUR HUMAN RESOURCES REPRESENTATIVE WITH THE VIRGINIA RETIREMENT SYSTEM.

View and print your policies plus file a claim at americanfidelity.com

American Fidelity's Online Service Center provides you convenient, secure 24/7 access to manage your account or file a claim.

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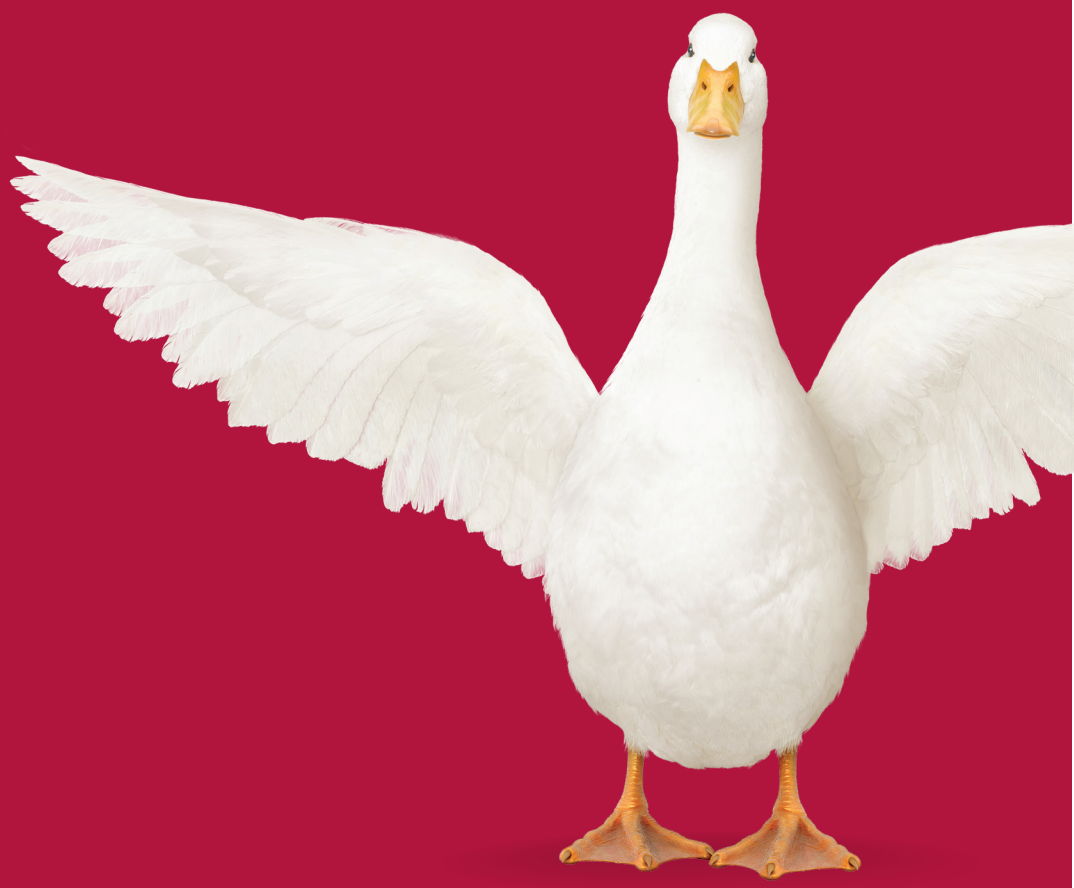
Aflac

Group Critical Illness Advantage

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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



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

Aflac®

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AFLAC GROUP CRITICAL ILLNESS ADVANTAGE

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

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

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

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

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

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

What you need, when you need it.

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

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

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

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

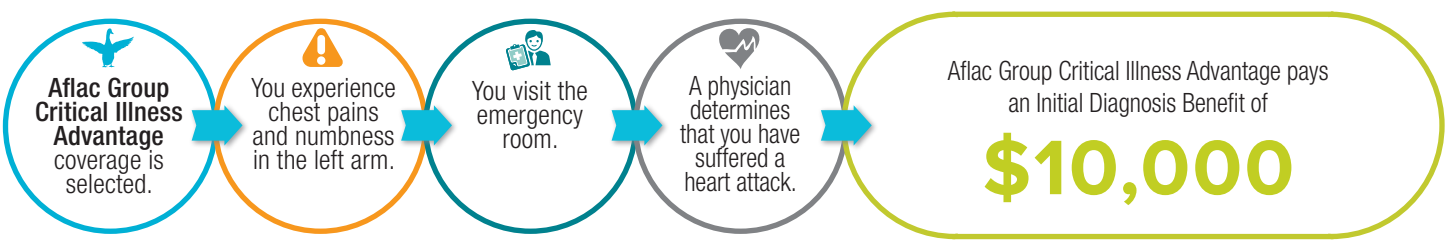
The Aflac Group Critical Illness plan benefits include:

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

Features:

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

How it works



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

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

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN*	100%
PARALYSIS**	100%
COMA**	100%
LOSS OF SPEECH / SIGHT / HEARING**	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

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

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

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

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

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

*This benefit is only payable for a burn due to, caused by, and attributed to, a covered accident.
**These benefits are payable for loss due to a covered underlying disease or a covered accident.

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

WAIVER OF PREMIUM

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

SUCCESSOR INSURED BENEFIT

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

HEALTH SCREENING BENEFIT (Employee and Spouse only)

We will pay $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

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

PROGRESSIVE DISEASES RIDER

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

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

OPTIONAL BENEFITS RIDER

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

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

CHILDHOOD CONDITIONS RIDER	% OF EMPLOYEE BENEFIT AMOUNT
CYSTIC FIBROSIS	50%
CEREBRAL PALSY	50%
CLEFT LIP OR CLEFT PALATE	50%
DOWN SYNDROME	50%
PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU)	50%
SPINA BIFIDA	50%
TYPE 1 DIABETES	50%
AUTISM SPECTRUM DISORDER	One-time Benefit Amount $3,000

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

SPECIFIED DISEASES RIDER (These benefits will be paid based at 25% of the face amount in effect on the critical illness date of diagnosis.)

Addison's Disease, Cerebrospinal Meningitis, Diphtheria, Huntington's Chorea, Legionnaire's Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis

LIMITATIONS AND EXCLUSIONS

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

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

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

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

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job:
- **Participation in Aggressive Conflict:**
  - War (declared or undeclared) or military conflicts;
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

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

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

TERMS YOU NEED TO KNOW

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

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

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

Cancer (internal or invasive) is a disease that meets either of the following definitions:
A malignant tumor characterized by:

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

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

Cancer (internal or invasive) also includes:

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

The following are not considered internal or invasive cancers:

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

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

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

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

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

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

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

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

Cancer, non-invasive cancer, or skin cancer must be diagnosed in one of two ways:

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

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

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

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

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- Major Organ Transplant: The date the surgery occurs.

- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place.
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

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

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

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

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

Doctor is a person who is:

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

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

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

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

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

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

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

Heart Attack (Myocardial Infarction) does not include:

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

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

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

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

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

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

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

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

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

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

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

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

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

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

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

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

Coma does not include a medically-induced coma. To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

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

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

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

The diagnosis of paralysis must be supported by neurological evidence.

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

- Retinal disease
- Optic nerve disease
- Hypoxia

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

- Alzheimer's disease
- Arteriovenous malformation

Loss of Hearing means the total and irreversible loss of hearing in both ears.

Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must

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

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

Pathologist is a doctor who is licensed:

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

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

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

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

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

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

Stroke does not include:

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

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

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

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

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

Total Disability or Totally Disabled means you are:

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

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

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

PROGRESSIVE DISEASES RIDER

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

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

Diagnosis is supported by medical records.

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

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

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

OPTIONAL BENEFITS RIDER

Date of Diagnosis is defined as follows:

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

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

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

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

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

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

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

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

- Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
- Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.
- Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.
- Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:
- Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This

includes the ability to get into and out of the tub or shower with or without the assistance of equipment;

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

CHILDHOOD CONDITIONS RIDER

Date of Diagnosis is defined as follows:

- Autism Spectrum Disorder: The date a Doctor Diagnoses a Dependent Child as having Autism Spectrum Disorder and where such Diagnosis is supported by medical records.
- Cystic Fibrosis: The date a Doctor Diagnoses a Dependent Child as having Cystic Fibrosis and where such Diagnosis is supported by medical records.
- Cerebral Palsy: The date a Doctor Diagnoses a Dependent Child as having Cerebral Palsy and where such Diagnosis is supported by medical records.
- Cleft Lip or Cleft Palate: The date a Doctor Diagnoses a Dependent Child as having Cleft Lip or Cleft Palate and where such Diagnosis is supported by medical records.
- Down Syndrome: The date a Doctor Diagnoses a Dependent Child as having Down Syndrome and where such Diagnosis is supported by medical records.
- Phenylalanine Hydroxylase Deficiency Disease (PKU): The date a Doctor Diagnoses a Dependent Child as having PKU and where such Diagnosis is supported by medical records.
- Spina Bifida: The date a Doctor Diagnoses a Dependent Child as having Spina Bifida and where such Diagnosis is supported by medical records.
- Type I Diabetes: The date a Doctor Diagnoses a Dependent Child as having Type I Diabetes and where such Diagnosis is supported by medical records.

Autism Spectrum Disorder is a biological based neurodevelopment disorder characterized by impairment in two major domains:

- Deficits in social communication and interaction; and
- Restricted repetitive patterns of behavior, interests, and activities.

A Doctor must Diagnose Autism Spectrum Disorder based on DSM-V diagnostic criteria. The Diagnosis must include the DSM-V severity level specifier for both major domains listed above.

Cystic Fibrosis is a hereditary chronic disease of the exocrine glands. This disease is characterized by the production of viscid mucus that obstructs the pancreatic ducts and bronchi, leading to infection and fibrosis.

Cerebral Palsy is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, involuntary and uncontrolled movements, or disturbed sensation.

- Spastic Cerebral Palsy is characterized by stiffness and movement difficulties.
- Athetoid Cerebral Palsy is characterized by involuntary and uncontrolled movements.
- Ataxic Cerebral Palsy is characterized by a disturbed sense of balance and depth perception.

Cleft Lip occurs when there is an opening (one or two vertical fissures) in the lip. A Cleft Palate occurs when the two sides of a palate do not join, resulting in an opening in the roof of the mouth or soft tissue in the back of the mouth. Sometimes, an opening in the bones of the upper jaw or upper gum accompanies a Cleft Palate.

A Cleft Lip or Palate can occur on one or both sides of the face. If a Dependent Child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

Down Syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole or part.

Phenylalanine Hydroxylase Deficiency Disease (PKU) is an autosomal recessive metabolic genetic disorder characterized by homozygous or compound heterozygous mutations in the gene for the hepatic enzyme phenylalanine hydroxylase (PAH), rendering it nonfunctional. A Doctor must Diagnose this disease based on a PKU test.

Spina Bifida refers to any birth defect involving incomplete closure of the spinal canal or spine. This includes:

- Spina Bifida Cystica, which is a condition where a cyst protrudes through the defect in the vertebral arch.
- Spina Bifida Occulta, which is a condition where the bones of the spine do not close, but the spinal cord and meninges remain in place. Skin usually covers the defect.
- Meningoceles, which is a condition where the tissue covering the spinal cord sticks out of the spinal defect, but the spinal cord remains in place.
- Myelomeningocele, which is a condition where the un-fused portion of the spinal column allows the spinal cord to protrude through an opening. The meningeal membranes that cover the spinal cord form a sac enclosing the spinal elements.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of a Dependent Child along with continuous dependence on exogenous insulin in order to maintain life. A Doctor must Diagnose Type I Diabetes based on one of the following diagnostic tests:

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

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

SPECIFIED DISEASE RIDER

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

- Adrenal Hypofunction (Addison's Disease): The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- Cerebrospinal Meningitis: The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- Diphtheria: The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- Huntington's Chorea: The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- Legionnaire's Disease: The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding Legionella bacteria in a clinical specimen taken from the Insured.
- Malaria: The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.
- Muscular Dystrophy: The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- Myasthenia Gravis: The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.
- Necrotizing Fasciitis: The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- Osteomyelitis: The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- Poliomyelitis: The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.
- Rabies: The date a Doctor Diagnoses an Insured as having Rabies and where

such Diagnosis is supported by medical records.

- Sickle Cell Anemia: The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.
- Systemic Lupus: The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.
- Systemic Sclerosis (Scleroderma): The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.
- Tetanus: The date a Doctor Diagnoses an Insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.
- Tuberculosis: The date a Doctor Diagnoses an Insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

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

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

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

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

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

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

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

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

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

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

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

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

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

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

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

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

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

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

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

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION OF COVERAGE

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

NOTICES

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

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

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Poquoson City Public Schools - Monthly Critical Illness Rates

Employee - Non-Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.19	$7.46	$9.72	$11.99	$14.25	$16.52	$18.78	$21.05	$23.31	$25.58
30-39	$6.45	$9.96	$13.48	$17.00	$20.51	$24.03	$27.55	$31.06	$34.58	$38.10
40-49	$9.53	$16.12	$22.72	$29.31	$35.91	$42.51	$49.10	$55.70	$62.30	$68.89
50-59	$14.84	$26.75	$38.66	$50.57	$62.47	$74.38	$86.29	$98.20	$110.11	$122.02
60+	$22.44	$41.94	$61.45	$80.96	$100.47	$119.97	$139.48	$158.99	$178.50	$198.00

Employee - Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$6.00	$9.07	$12.15	$15.22	$18.29	$21.36	$24.44	$27.51	$30.58	$33.65
30-39	$8.26	$13.59	$18.93	$24.26	$29.59	$34.92	$40.26	$45.59	$50.92	$56.25
40-49	$13.15	$23.36	$33.58	$43.79	$54.01	$64.22	$74.44	$84.65	$94.87	$105.08
50-59	$22.00	$41.06	$60.13	$79.19	$98.26	$117.32	$136.39	$155.45	$174.52	$193.58
60+	$33.24	$63.56	$93.87	$124.19	$154.50	$184.82	$215.13	$245.45	$275.76	$306.08

Spouse - Non-Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$4.92	$6.91	$8.91	$10.90	$12.89	$14.88	$16.88	$18.87	$20.86	$22.85
30-39	$6.17	$9.42	$12.66	$15.91	$19.15	$22.40	$25.64	$28.89	$32.13	$35.38
40-49	$9.25	$15.58	$21.90	$28.23	$34.55	$40.87	$47.20	$53.52	$59.84	$66.17
50-59	$14.58	$26.23	$37.88	$49.54	$61.19	$72.84	$84.49	$96.14	$107.79	$119.45
60+	$22.22	$41.50	$60.79	$80.07	$99.36	$118.64	$137.93	$157.21	$176.50	$195.78

Spouse - Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.73	$8.53	$11.33	$14.13	$16.93	$19.73	$22.53	$25.33	$28.13	$30.93
30-39	$7.99	$13.05	$18.11	$23.17	$28.23	$33.29	$38.35	$43.41	$48.47	$53.53
40-49	$12.87	$22.82	$32.76	$42.70	$52.65	$62.59	$72.53	$82.47	$92.42	$102.36
50-59	$21.74	$40.55	$59.35	$78.16	$96.97	$115.78	$134.59	$153.39	$172.20	$191.01
60+	$33.02	$63.11	$93.21	$123.30	$153.39	$183.48	$213.58	$243.67	$273.76	$303.85

Poquoson City Public Schools - Monthly Critical Illness Buy-Up Rates

Employee - Non-Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$2.26	$4.53	$6.79	$9.06	$11.32	$13.59	$15.85	$18.12	$20.38
30-39	$3.52	$7.03	$10.55	$14.07	$17.58	$21.10	$24.62	$28.13	$31.65
40-49	$6.60	$13.19	$19.79	$26.38	$32.98	$39.58	$46.17	$52.77	$59.37
50-59	$11.91	$23.82	$35.73	$47.64	$59.54	$71.45	$83.36	$95.27	$107.18
60+	$19.51	$39.01	$58.52	$78.03	$97.54	$117.04	$136.55	$156.06	$175.57

Employee - Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$3.07	$6.14	$9.22	$12.29	$15.36	$18.43	$21.51	$24.58	$27.65
30-39	$5.33	$10.66	$16.00	$21.33	$26.66	$31.99	$37.33	$42.66	$47.99
40-49	$10.22	$20.43	$30.65	$40.86	$51.08	$61.29	$71.51	$81.72	$91.94
50-59	$19.07	$38.13	$57.20	$76.26	$95.33	$114.39	$133.46	$152.52	$171.59
60+	$30.31	$60.63	$90.94	$121.26	$151.57	$181.89	$212.20	$242.52	$272.83

Spouse - Non-Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$1.99	$3.98	$5.98	$7.97	$9.96	$11.95	$13.95	$15.94	$17.93
30-39	$3.24	$6.49	$9.73	$12.98	$16.22	$19.47	$22.71	$25.96	$29.20
40-49	$6.32	$12.65	$18.97	$25.30	$31.62	$37.94	$44.27	$50.59	$56.91
50-59	$11.65	$23.30	$34.95	$46.61	$58.26	$69.91	$81.56	$93.21	$104.86
60+	$19.29	$38.57	$57.86	$77.14	$96.43	$115.71	$135.00	$154.28	$173.57

Spouse - Tobacco

Age Band	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20
30-39	$5.06	$10.12	$15.18	$20.24	$25.30	$30.36	$35.42	$40.48	$45.54
40-49	$9.94	$19.89	$29.83	$39.77	$49.72	$59.66	$69.60	$79.54	$89.49
50-59	$18.81	$37.62	$56.42	$75.23	$94.04	$112.85	$131.66	$150.46	$169.27
60+	$30.09	$60.18	$90.28	$120.37	$150.46	$180.55	$210.65	$240.74	$270.83

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Cancer can be a costly disease.

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

The financial impact of a cancer diagnosis can affect anyone's financial situation. American Fidelity Assurance Company's Limited Benefit Cancer Insurance may offer a solution to help you and your family focus on fighting the disease. This plan may assist with the expenses that may not be covered by other medical insurance.

Over 1.6 million new cases of cancer will be diagnosed this year.*

Did You Know?

According to the American Institute for Cancer Research about one-third of cases of the most common cancers in the U.S. could be prevented by eating healthy, being active, and staying lean.** It is essential to have a plan in place that could help if you were diagnosed.

How It Works

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

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

American Fidelity's Limited Benefit Cancer Insurance features:

- Benefits paid directly to you, to be used however you see fit.
- Policy is guaranteed renewable for as long as premiums are paid as required.
- The company has the right to change premium rates by class.
- Employee, Single Parent, and Family plans are available.

SCREENING BENEFIT+

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

DIAGNOSTIC AND PREVENTION BENEFIT *(per calendar year)*	
Basic	Enhanced
$60	$75

Plan Options

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

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

**American Cancer Society: Cancer Facts and Figures 2017, pg. 1.*
***American Institute for Cancer Research: For Cancer Prevention Month; accessed at www.aicr.org January 31, 2017.*
+The premium and amount of benefits vary based upon the plan selected.

Schedule of Benefits by Plan+

Marketed by: First Financial Group of America

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

Schedule of Benefits by Plan+ (continued)

	Basic	Enhanced
SURGICAL TREATMENT BENEFITS		
Surgical Benefit *Unit Dollar Amount (per surgical unit)* *Maximum Per Operation*	 $30 $3,000	 $40 $4,000
Anesthesia Benefit	25% of the amount paid for covered surgery	
Outpatient Hospital or Ambulatory Surgical Center Benefit *(per day)*	$400	$600
Second & Third Surgical Opinion Benefit *(per diagnosis)* *(additional $300 for 3rd if required)*	$300	$300
CONTINUING CARE BENEFITS		
Prosthesis Benefit **Non-Surgical** *(per device - 1 per site, lifetime max of 3)* **Surgical Implantation** *(per device, includes surgical fee - 1 per site, lifetime max of 2)* **Hair Prosthesis** *(once per life)*	 $150 $1,500 $150	 $200 $2,000 $200
Extended Care Facility Benefit *(per day for the first 30 days)* *(per day thereafter)*	 $75 $100	 $100 $150
Physical or Speech Therapy Benefit *(per visit up to 4 per calendar month - lifetime max of $1,000)*	$25	$25
Hospice Care Benefit *(per day - $13,500 lifetime max for Basic; $18,000 lifetime max for Enhanced)*	$75	$100
Home Health Care Benefit *(per day for the first 30 days)* *(per day thereafter)*	 $75 $100	 $100 $150

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

Enhance your plan++

First Occurrence of Internal Cancer Benefit Rider

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

Schedule of Benefits	
Cancer Benefit *(per unit - maximum $10,000)*	$2,500

Summary of First Occurrence of Internal Cancer Benefit Rider Benefits:

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

+The premium and amount of benefits provided vary based upon the plan selected.
++Availability of riders may vary by state and employer. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed.

Diagnostic, Prevention and Cancer Screening Follow-up Benefits

Pays the indemnity amount for one generally medically recognized internal Cancer screening test per Covered Person per Calendar Year. Tests include but are not limited to Mammogram, ThinPrep Pap test, Prostate Specific Antigen Blood Test (PSA), Colonoscopy, and Chest X–ray. Refer to the policy for a complete listing. Screening tests payable under this benefit will ONLY be paid under this benefit and does not include any test payable under the Medical Imaging Benefit. Benefits will only be paid for tests performed after the 30–day period following the Covered Person's effective date of coverage.

Cancer Screening Follow–Up Benefit pays the indemnity amount for a Covered Person to receive one invasive follow–up test needed due to an abnormal covered cancer screening result. Diagnostic surgeries which result in a positive diagnosis of Cancer will be paid under the Surgical Benefit.

Radiation/Chemotherapy/Immunotherapy Benefit

Pays the indemnity amount when a Covered Person receives Radiation, Chemotherapy, or Immunotherapy as defined in the policy. We will pay only one Radiation/Chemotherapy/Immunotherapy benefit per calendar month - regardless of the number of Radioactive, chemotherapy or immunotherapy treatments received during the month. This benefit does not cover other procedures related to Radiation/Chemotherapy/Immunotherapy. Design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, scans, medical supplies and equipment used in administration (IV solutions, needles, dressings, pumps, catheters, etc.) are not covered under this benefit. For chemotherapy and immunotherapy, coverage will be limited to the drugs only. Anti-nausea drugs are not covered under this benefit. This benefit does not include any drugs/medicines covered under the Drugs and Medicine Benefit or the Hormone Therapy Benefit.

Medical Imaging Benefit

Pays the indemnity amount for a Covered Person who has been diagnosed with Cancer who receives either an MRI; CT scan; CAT scan; or PET scan when performed at the request of a Physician due to Cancer or the treatment of Cancer.

Hormone Therapy Benefit

Pays the indemnity amount for hormone therapy treatments as defined in the policy, prescribed by a Physician. This benefit covers drugs and medicines only and does not include associated administrative processes. This benefit does not include drugs/medicines covered under the Radiation/Chemotherapy/Immunotherapy Benefit or the Drugs and Medicine Benefit.

Administrative/Lab Work Benefit

Pays the indemnity amount once per calendar month, when the Covered Person is receiving Radiation/Chemotherapy/Immunotherapy Benefit that month, for related procedures such as treatment planning, treatment management, etc.

Blood, Plasma and Platelets Benefit

Pays the indemnity amount for blood, plasma and platelets. This does not include any laboratory processes. Colony stimulating factors are not covered under this benefit. Benefits for Blood, Plasma and Platelets are ONLY provided under this benefit.

Bone Marrow Benefit/Stem Cell Transplant Benefit

Pays the indemnity amount for blood, plasma and platelets. This does not include any laboratory processes. Colony stimulating factors are not covered under this benefit. Benefits for Blood, Plasma and Platelets are ONLY provided under this benefit.

Hospital Confinement Benefit

Pays the indemnity amount for a Covered Person while confined to a Hospital for at least 18 continuous hours for the treatment of Cancer. ***A Hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction, no lifetime max.

Drugs and Medicines Benefit

Pays the indemnity amount for anti–nausea and pain medication prescribed by a Physician for a Covered Person for treatment of Cancer, who is also receiving Radiation Therapy/Chemotherapy/Immunotherapy, a covered surgery, or a Bone Marrow/Stem Cell Transplant. This benefit does not cover associated administrative processes. This benefit does not include drugs/medicines covered under the Radiation/Chemotherapy/Immunotherapy Benefit or the Hormone Therapy Benefit.

Attending Physician Benefit

Pays the indemnity amount for one Physician's visit per day when a Covered Person requires the services of a Physician, other than a surgeon while Hospital Confined for the treatment of Cancer.

U.S. Government/Charity Hospital /HMO Benefit

If an itemized list of services is not available because a Covered Person is: confined in a charity Hospital or U.S. Government owned Hospital; or covered under a Health Maintenance Organization (H.M.O.) or Diagnostic Related Group (D.R.G.) where no charges are made to the Covered Person, the Primary Insured may convert benefits under the policy to pay the indemnity amount shown in schedule of benefits. This benefit will be paid in lieu of most benefits under the policy.

Ambulance Benefit

Pays the indemnity amount per day for either licensed air or ground ambulance transportation of a Covered Person to a Hospital or from one medical facility to another where the Covered Person is admitted as an Inpatient and hospital confined for at least 18 consecutive hours for treatment of Cancer.

Transportation and Lodging Benefits

These benefits pay for the transportation of a Covered Person and/or one adult family member when the Covered Person has been diagnosed with Cancer and receives covered Radiation Therapy, Chemotherapy, Immunotherapy, Bone Marrow/Stem Cell Transplant, or surgery due to Cancer in the nearest Physician prescribed Hospital providing such treatment that is at least 50 miles away from the Covered Person's residence, using the most direct route. Travel must be by scheduled bus, plane or train, or by car and be within the United States or its Territories.

Transportation and Lodging Benefits (continued)
Benefits will be provided for only one mode of transportation per round trip and will be paid for up to 12 round trips per Calendar Year. Benefits for travel of the Covered Person and/or family member will be paid: once per Hospital Confinement; or only on days of the Covered Person's outpatient specialized treatment. Benefits for lodging of the Covered Person's and/or family member will be paid: once per Covered Person's Hospital Confinement; or only on days of the Covered Person's outpatient specialized treatment. If the family member and the Covered Person travel in the same car or lodge in the same room, benefits for travel and lodging will only be paid under the Transportation and Lodging Benefit for the patient.

Surgical Benefit
Pays an indemnity benefit up to the Maximum Per Operation amount shown in the Schedule of Benefits in the policy when a surgical operation is performed on a Covered Person for covered diagnosed Cancer, Skin Cancer, or reconstructive surgery due to Cancer. Benefits will be calculated by multiplying the surgical unit value assigned to the procedure, as shown in the most current Physician's Relative Value Table, by the Unit Dollar Amount shown in the Schedule of Benefits. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Any diagnostic surgery covered under the Diagnostic and Prevention Benefit will not be covered under this benefit. Bone marrow surgeries are paid under the Bone Marrow Transplant Benefit. Surgeries required to implant a permanent prosthetic device are covered under the Prosthesis Benefit.

Anesthesia Benefit
Pays 25% of the amount paid for a covered surgery for the services of an anesthesiologist. Services of an anesthesiologist for bone marrow transplants, Skin Cancer, or surgical prosthesis implantation are not covered under this benefit.

Outpatient Hospital or Ambulatory Surgical Center Benefit
We will pay the indemnity amount shown towards the facility fee charges of an Ambulatory Surgical Center or Hospital for an outpatient surgical procedure of a diagnosed Cancer. Surgical procedures for Skin Cancer are not covered under this benefit, no lifetime max.

Second and Third Surgical Opinion Benefit
Pays the indemnity amount once per diagnosis for a Covered Person's second surgical opinion and if the second disagrees with the first, a third opinion, when the attending Physician recommends surgery for the treatment of Cancer. Surgical opinions for reconstructive, Skin Cancer, or prosthesis surgeries are not covered under this benefit.

Prosthesis Benefits
Pays the indemnity amount for a prosthetic device received due to Cancer that manifested after the Effective Date, and its surgical implantation if required as a direct result of surgery for Cancer. This benefit does not cover prosthetic related supplies. Temporary prosthetic devices used as tissue expanders are covered under the Surgical Benefit. **Hair Prosthesis** benefit pays the indemnity amount for a Covered Person's hair prosthesis needed as a direct result of Cancer or the treatment of Cancer. This benefit is payable once per Covered Person per lifetime.

Extended Care Facility Benefit
Pays the indemnity amount for each day room and board charges are incurred while a Covered Person is confined in an Extended Care Facility due to Cancer at the direction of a Physician that begins within 14 days after a covered Hospital Confinement. Paid up to 100 days per lifetime of the Covered Person.

Physical or Speech Therapy Benefit
Pays the indemnity amount if a Physician advises a Covered Person to seek physical therapy or speech therapy. Physical or speech therapy must be performed by a caregiver licensed in physical or speech therapy and be needed as a result of Cancer or the treatment of Cancer. We will pay for one treatment per day up to four treatments per calendar month per Covered Person for any combination of physical or speech therapy treatments up to a lifetime maximum of $1,000.

Hospice Care Benefit
Pays the indemnity amount for Hospice Care directed by a licensed Hospice organization, as defined in the policy, of a Covered Person expected to live six months or less due to Cancer.

Home Health Care Benefit
Pays the indemnity amount for a Covered Person's Home Health Care, as described in the policy, required due to Cancer when prescribed by a Physician in lieu of Hospital Confinement beginning within 14 days after a Hospital Confinement. This benefit does not include: nutrition counseling; medical social services; medical supplies; prosthesis or orthopedic appliances; rental or purchase of durable medical equipment; drugs or medicines; child care; meals or housekeeping services. This benefit does not include physical or speech therapy. This benefit will be paid up to 100 days per lifetime of the Covered Person. If the Covered Person qualifies for coverage under the Hospice Care Benefit, the Hospice Care Benefit will be paid in lieu of this benefit.

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

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

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

Experimental Treatment Benefit
We will provide coverage for Experimental Treatment prescribed by a Physician, as defined in the policy, the same as any other benefit covered under this policy. This benefit does not provide coverage for treatments received outside of the United States or its territories.

Donor Benefit
Pays the indemnity amount shown for a donor's expenses incurred on behalf of a Covered Person for a covered surgery due to organ transplant or a Bone Marrow/Stem Cell Transplant. Blood donor expenses are not covered under this benefit. Benefits shall be provided to reimburse any medical expenses of a live donor to the extent that benefits remain and are available under this policy, after benefits for the Covered Person's expenses have been paid.

Dread Disease Benefit

Pays an indemnity amount for each period of Hospital Confinement for treatment of a Dread Disease as defined in the policy, including: Addison's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Grand Mal Epilepsy, Legionnaire's Disease, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever, and Whipple's Disease. Benefits for Dread Disease are ONLY provided under this benefit.

Inpatient Special Nursing Services Benefit

Pays the indemnity amount shown for Full-time special nursing care (other than that regularly furnished by a Hospital) while a Covered Person is Hospital Confined for treatment of Cancer. "Full-time" means at least eight consecutive hours during a 24 hour period. Care must be provided by a Nurse, as defined by the Policy, be prescribed by a Physician and be Medically Necessary for the treatment of Cancer.

See your policy for more information regarding the benefits listed above.

Eligibility

This policy will be issued only to those persons who meet American Fidelity's insurability requirements, which includes satisfactory responses to medical questions.

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

This product is inappropriate for those people who are eligible for Medicaid Coverage.

Base Policy

All diagnosis of Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. This policy pays only for loss resulting from definitive cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. This policy also covers other conditions or diseases directly caused or aggravated by Cancer or the treatment of Cancer. This policy does not cover any other disease, sickness or incapacity except for conditions specifically provided in the Dread Disease Benefit.

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

(1) for which within 12 months prior to the Effective Date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession; or

(2) that manifested itself within six months prior to the Covered Person's effective date of coverage.

Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered.

All benefits payable only up to the maximum amount listed in the Schedule of Benefits in the policy.

First Occurrence of Internal Cancer Benefit Rider

Benefits will only be paid for a First Occurrence of Internal Cancer as shown on the Policy Schedule page in the policy. No benefits will be provided for any loss caused by or resulting from: a Pre-Existing Condition, defined as any sickness or condition for which, within 12 months prior to the Effective Date of coverage under this rider, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or that manifested itself within six months prior to the Covered Person's effective date of coverage; or an internal Cancer when the Date of Diagnosis occurs during the Waiting Period, if applicable. If any Covered Person is diagnosed as having an Internal Cancer during the 30-day period immediately following the Effective Date, you may elect to void this rider from the beginning and receive a full refund of premium. Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: acquired immune deficiency syndrome (AIDS); or actinic keratosis; or myelodysplastic and non-malignant myeloproliferative disorders; or aplastic anemia; or atypia; or nonmalignant monoclonal gamopathy; or pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or cancer in situ or any skin cancer, as defined in the policy, other than invasive malignant melanoma into the dermis or deeper.

Termination of Insurance

This policy/rider will terminate and coverage will end for all Covered Persons on the earliest of: the end of the grace period if the premium remains unpaid; or the end of the Policy/Rider Month in which we receive a written request from you to terminate this policy/rider(s); or the date of your death, if this is an Individual Plan; or the date insurance has ceased on all persons covered under this policy/rider.

Guaranteed Renewable

You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

Cancer Insurance Premiums

Base Plan Monthly Premiums*

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

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

Optional Benefit Rider Monthly Premiums*

First Occurrence of Internal Cancer Benefit Rider

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

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

*The premium and amount of benefits provided vary based upon the plan selected.
This is a brief description of the coverage. For complete benefits and other provisions, please refer to the policy and riders. This coverage does not replace Workers' Compensation Insurance. **These products are inappropriate for people who are eligible for Medicaid Coverage.**

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EMPLOYER BENEFIT SOLUTIONS
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*An **Accident** is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause.*

EMERGENCY ACCIDENT

Hypothetical Example [1]

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

	BASIC	ENHANCED
Accident Emergency Treatment	$150	$200
Accident Follow-Up Treatment (4 visits)	$200	$200
Physical Therapy (8 treatments)	$200	$200
Medical Imaging	$200	$200
X-Ray	$50	$100
Appliances	$100	$100
Surgical Facility	$150	$250
Torn Knee Cartilage Repair	$500	$500
Anesthesia	$150	$200
TOTAL	**$1,700**	**1,950**

Annual Wellness Benefit

BASIC
$50

ENHANCED
$75

Paid directly to you!

Benefits for Policy and Enhancement Rider

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT			
BASIC	**PRIMARY**	**SPOUSE**	**CHILD**
Common Carrier	$50,000	$50,000	$25,000
Other Accident	$15,000	$15,000	$7,500
Dismemberment	$1,000 to $15,000	$1,000 to $15,000	$500 to $7,500
ENHANCED	**PRIMARY**	**SPOUSE**	**CHILD**
Common Carrier	$100,000	$100,000	$50,000
Other Accident	$30,000	$30,000	$15,000
Dismemberment	$1,500 to $30,000	$1,500 to $30,000	$750 to $15,000

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

Schedule of Benefits for Policy and Enhancement Rider

ACCIDENT BENEFITS	BASIC	ENHANCED
EMERGENCY ACCIDENT TREATMENT		
Accident Emergency Treatment	$150	$200
Emergency Accident Follow-up Treatment (up to four treatments)	$50	$50
NON-EMERGENCY ACCIDENT TREATMENT		
Non-Emergency Accident Initial Treatment	$75	$100
Non-Emergency Accident Follow-up Treatment (up to two treatments)	$50	$50
MEDICAL IMAGING		
MRI, CT, CAT, PET, US	$200	$200
X-Rays	$50	$100
HOSPITAL CONFINEMENT		
Hospital Admission	$500	$1,000
Intensive Care Unit (up to 15 days)	$300	$600
Hospital Confinement (up to 365 days)	$100	$200
AMBULANCE		
Ground	$300	$300
Air	$1,500	$1,500
TREATMENT		
Outpatient Hospital or Ambulatory Surgical Center	$150	$250
Anesthesia	$150	$200
TRANSPORTATION BENEFITS		
Transportation Patient only, per round trip for up to 3 round trips per calendar year	$300	$300
Family Member Lodging and Meals Per day per accident; up to 30 days per confinement	$100	$100

MONTHLY PREMIUMS For Policy And Benefit Enhancement Rider**	BASIC	ENHANCED
Individual	$19.90	$26.10
Individual & Spouse	$28.30	$34.90
Individual & Child(ren)	$31.50	$41.00
Family	$39.90	$49.80

ACCIDENT INJURY BENEFITS	ALL COVERAGE LEVELS
INJURY TREATMENT	
Fractures Benefit Depending on open or closed reduction, bone involved, or chip fracture	$25 to $3,000
Lacerations Benefit Not requiring sutures	$25
Sutured lacerations up to two inches	$100
Sutured lacerations totaling two to six inches	$200
Sutured lacerations totaling over six inches	$400
Appliances Benefit Crutches, leg braces, etc.	$100
Torn Knee Cartilage or Ruptured Disc Benefit	$500
Eye Injury Benefit Injury with surgical repair, for one or both eyes	$250
Removal of foreign body by a physician, for one or both eyes	$50
Dislocations Benefit Depending on open or closed reduction, with or without anesthesia and joint involved.	$25 to $3,000
Concussion Benefit	$200
2nd & 3rd Degree Burns Skin grafts are 25% of benefit	$100 to $10,000
Internal Injuries Benefit Resulting in open abdominal or thoracic surgery	$1,000
Paralysis Benefit: Paraplegia / Quadriplegia	$5,000 / $10,000
Tendons, Ligaments, and Rotator Cuff Benefit One tendon, ligament, or rotator cuff	$500
More than one tendon, ligament, or rotator cuff	$750
Blood, Plasma, and Platelets Benefit	$250
Exploratory Surgery without Surgical Repair Benefit	$250
Physical Therapy Benefit Per treatment up to eight treatments	$25
Prosthesis Benefit	$500
Emergency Dental Work Benefit Broken teeth repaired with crown	$150
Extraction of broken teeth (regardless of number)	$50

WELLNESS BENEFIT	BASIC	ENHANCED
WELLNESS		
Annual Routine Physical Exam Requires a 12-month waiting period before use. One exam per policy per calendar year	$50	$75

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

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

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

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

Accidental Death and Dismemberment Benefit The applicable benefits apply when an Accidental Death or Dismemberment occurs within 90 days of an Accident. In the event that Accidental Death and Dismemberment result from the same Accident, only the Accidental Death Benefit will be paid. If Accidental Death or Dismemberment occurs within one year from the date of the Accident and during a period of continuous total disability resulting from the Accident and commencing within 30 days of the date of the Accident, we will pay the amount shown in the schedule of benefits. The term "totally disabled" as used in this benefit means that Covered Person is: unable to work at any job for which you are qualified by education, training, or experience; and not working at any job for pay or benefits; and under the care of a Physician.

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

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

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

Blood, Plasma and Platelets Benefit Payable for blood, plasma and platelets. This benefit does not provide benefits for immunoglobulins.

Burns Benefit Payable for 2nd and 3rd degree burns when treated by a Physician within 72 hours.

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

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

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

Exploratory Surgery without Surgical Repair Benefit Payable when an exploratory surgical operation without surgical repair is performed.

Eye Injury Benefit Payable for one or both eyes requiring treatment by a Physician due to an Accident.

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

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

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

Hospital Confinement Benefit Pays a daily benefit for a Hospital Confinement that is longer than 18 hours for up to 365 days.

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

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

Lacerations Benefit This benefit varies based on the severity of the laceration due to an Accident.

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

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

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

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

Plan Highlights (cont.)

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

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

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

Tendons, Ligaments and Rotator Cuff Benefit Payable for the repair of one or more tendons, ligaments, or rotator cuffs. The tendons, ligaments, or rotator cuff must be repaired through surgery performed by a Physician, as a result of an Accident.

Torn Knee Cartilage or Ruptured Disc Benefit Payable for surgical repair as a result of an Accident.

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

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

Limitations and Exclusions For Policy and Benefit Enhancement Rider

No benefits will be provided for an Accident that is caused by or occurs as a result of:
(1) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
(2) participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft;
(3) any act that was caused by war, declared or undeclared, or service in any of the armed forces;
(4) participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions;
(5) participation in, or attempting to participate in, a felony, riot or insurrection. (A felony is as defined by the law of the jurisdiction in which the activity takes place.)

Benefits will not be provided for medical treatment for an Accident received outside the United States or its territories. Benefits will not be paid for services rendered by a member of the immediate family of a Person.

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

A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Eligibility includes you, your lawful spouse and each unmarried natural, adopted or step child who is under 26 years of age.

Guaranteed Renewable

You cannot be singled out for a rate increase for any reason. The Insurer has the right to increase premium rates only if rates for all policies in this class change.

Termination Notice

Policy/rider(s) will terminate and coverage will end for all Covered Persons on the earliest of: the end of the grace period if the premium remains unpaid; or the end of the Policy/Rider(s) Month in which we receive a written request from you to terminate this policy/rider(s); or the date of your death, if this is an Individual Plan. If the plan is other than Individual the remaining Covered Persons may have the right to continue or convert their coverage. Coverage for any Covered Person will terminate when they no longer meet the eligibility requirements.

Marketed by:

First Financial Group of America
First in Service and Expertise

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

Underwritten and administered by:

American Fidelity Assurance Company
9000 Cameron Parkway, Oklahoma City, Oklahoma 73114
800-662-1113 • **americanfidelity.com**

Refer to Plan Benefit Highlights section for more Benefit Descriptions on the Accident Only Insurance Policy and Benefit Enhancement Rider.

This brochure contains a brief description of the coverage. For complete benefits, limitations, exclusions and other provisions, please refer to the policy, AO-03, and Accident Only Benefit Enhancement Rider, AMDI-258 series. This coverage does NOT replace Workers' compensation Insurance. Availability of riders may vary by employer. ***This product is inappropriate for people who are eligible for Medicaid coverage.***

SB-25787(VA)(FFGA)-0619

Policy AO-03 Series and AMDI-258 Series
013-383, 013-384

Aflac

Group Hospital Indemnity

INSURANCE

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

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

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

Aflac®

We've got you under our wing.®

AFLAC GROUP HOSPITAL INDEMNITY

Policy Form C80100VA

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

Does your major medical insurance cover all of your bills?

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

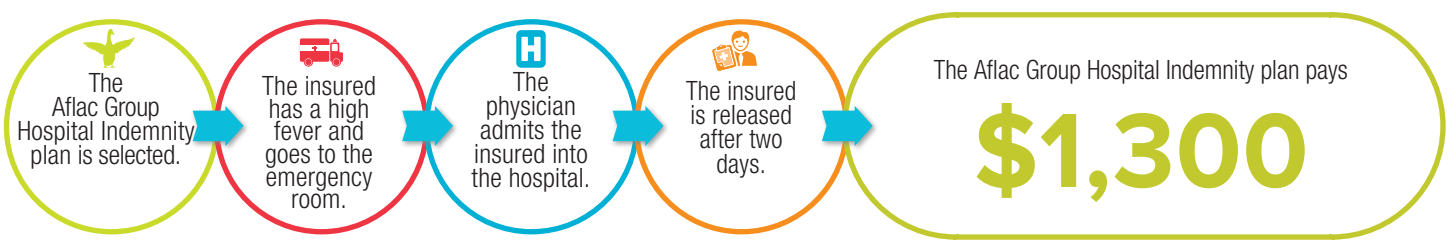
That's how the Aflac Group Hospital Indemnity plan can help.

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

The Aflac Group Hospital Indemnity plan benefits include the following:

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

How it works



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

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

Benefits Overview

	BENEFIT AMOUNT
HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured) Payable when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.	$1,000
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$150
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$150
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$75

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident.

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a family member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
  - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
  - Congenital defects in newborns.

TERMS YOU NEED TO KNOW

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

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

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

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

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

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

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

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

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

You May Continue Your Coverage
Your coverage may be continued with certain stipulations. See certificate for details.

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

NOTICES

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

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

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Policy Series C80000

HI G

TREATMENT BENEFITS

	BENEFIT AMOUNT
OUTPATIENT DOCTOR'S OFFICE VISIT (maximum of 6 visits per calendar year for each insured) We will pay the amount shown for each day that an insured visits a doctor's office. This benefit is not payable for visits to a chiropractor's office.	$25
TELEMEDICINE SERVICES (maximum of 6 per calendar year for each insured) We will pay the benefit amount shown for each day that, because of a covered accidental injury or covered sickness, an insured seeks medical advice from a doctor via telemedicine services. The telemedicine services must be provided in lieu of an outpatient doctor's office visit.	$15
CHIROPRACTOR VISIT (maximum of 4 visits per calendar year for each insured) We will pay the amount shown for each day that an insured receives services from a chiropractor for treatment of a covered accidental injury or because of a covered sickness. Visits to a chiropractor's office are not payable under the outpatient doctor's office visit benefit.	$20
MAJOR DIAGNOSTIC EXAMS (once per covered sickness or accident per calendar year) We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams: · Computerized Tomography (CT/CAT scan) · Magnetic Resonance Imaging (MRI) · Electroencephalography (EEG)	$150
OUT OF HOSPITAL PRESCRIPTION DRUG (maximum of $100 per calendar year for each insured) We will pay the amount shown for each day an insured has a prescription filled. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the insured. This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; (d) immunization agents, biological sera, blood or blood plasma; or (e) contraceptive materials, devices or medications or infertility medication, except where required by law.	$20
HOSPITAL EMERGENCY ROOM VISIT (maximum of 5 visits per calendar year for each insured) We will pay the amount shown for each day that an insured visits a hospital emergency room due to a covered accidental injury or for treatment due to a covered sickness.	$100
EMERGENCY ROOM OBSERVATION (1 visit for each covered sickness or accident per calendar year, maximum of 5 total visits per calendar year for each insured) We will pay the amount shown for each period of observation that, because of a covered accidental injury or covered sickness, an insured: · Receives treatment in a hospital emergency room, and · Is held in a hospital for observation without being admitted as an inpatient.	$50 Minimum 4 hours $100 More than 24 hours
REHABILITATION FACILITY per day (maximum of 15 days per confinement, no more than 30 days total per calendar year for each insured) We will pay the amount shown for each day that, due to a covered accidental injury or a covered sickness, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid.	$75

Aflac®

We've got you under our wing.®

Residents of Massachusetts are not eligible for these benefits.

TERMS YOU NEED TO KNOW

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

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

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

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

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

Premium Rates

Monthly Premiums

Coverage	Premium
Employee	$41.67
Employee and Spouse	$80.10
Employee and Child(ren)	$69.06
Family	$107.49

The rates and product availability indicated in this proposal are subject to change as a result of final underwriting.

iLOCK360

Powered By experian.

HAVE YOU EVER?

- ☐ Worried about being a victim of identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information online
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

WHAT is iLOCK360?

In 2012, TCG Services developed iLOCK360 in order to protect its clients and their employees from the growing threat of identity theft.

Today, iLOCK360 helps educators, businesses, employees, and individuals Live Safely™, knowing their identities are monitored around the clock.

iLOCK360 MEMBERSHIP INCLUDES

CyberAlert Internet Surveillance
Our exclusive technology scours the web 24/7/365 to identify trading or selling of your personal information online.

Full Service Restoration
An iLOCK360 Certified Identity Theft Restoration Specialist will work diligently on your behalf to restore all aspects of your identity.

Social Security Number Tracing
Know if your SSN becomes associated with another individual's name or address.

$1 Million in Identity Theft Insurance
You are insured with a one million dollar insurance policy to cover identity theft restoration expenses.

Credit Monitoring
Find out your credit score, analyze your credit report, and monitor your identity for credit-related activity.

Monthly Payroll Deduction	Individual	Family
iLOCK360	$8.95	$18.95

Plan	Cyber Alert℠	Credit Bureau Monitoring	SSN Trace	Court Records	Address Change	24/7 Support	$1M Insurance
Plus	✓	✓	✓	✓	✓	✓	✓
Basic	✓						

All district employees can choose to receive free Basic coverage that includes only CyberAlert℠

Universal Availability Notice

First Financial Group of America

Act Now to Maximize Your 403(b) and 457(b) Contributions

In compliance with the requirements of IRC §403(b)(12(A)(ii) this Notice will advise you of the voluntary 403(b) Program established and maintained for the benefit of all employees.

Now is the time to act if you wish to maximize your pre-tax contributions to the 403(b) and 457(b) Plans or make changes for this calendar (taxable) year.

Go to www.ffga.com to view your employers' retirement plan options and availability. You can also verify if the plan offers both 403(b) and 457(b) Plans before you decide how to proceed.

Eligibility - All employees who are employed by the Employer, including full and part-time employees.

Contributions - When you enroll in the program, the amounts you designate as salary deferrals are withheld from your wages and forwarded to an investment provider of your choice. Several types of contributions may be available in your plan:

Pre-Tax Salary Deferrals: These are amounts contributed into a 403(b) Plan that are deferred from your paycheck before federal income taxes are applied.

Roth Salary Deferrals: (If your plan allows) These amounts are also deferred from your paycheck, but are subject to federal income taxes. When you withdraw monies from a Roth plan the funds may be excluded from taxation. Special rules apply to Roth contributions and you should contact your tax advisor before electing this option.

For 2020, you may defer from your wages, a maximum of $19,500 to all 403(b) and 457(b) plans unless you will reach 50 years of age during the year. In that case, you would be eligible to contribute an additional $6,000. Deferrals may not exceed 100% of your wages.

Rollovers: (If your plan allows) You may also rollover funds from another employer's plan if you receive an eligible rollover distribution.

Plan Investment Options - Your contributions to the 403(b) Plan must be made to an investment provider approved by your Employer. Before enrolling in the plan, you must first establish an account with one of the Providers listed. Once you have executed an investment contract and established an account, you can begin making contributions.

Assistance - You may enroll in the plan or receive assistance with these provisions by contacting the plan's Third Party Administrator, First Financial Administrator, Inc. or a representative for one of the plan's Investment Companies listed on www.ffga.com.

Additional information about the provisions and options in your plan are available by contacting First Financial Administrators at (800) 523-8422 or from the plan's web site, www.ffga.com.

Universal Availability Notice

First Financial Group of America

The following are some guidelines to assist you with your decisions. Note that any changes you make now will continue in 2020 forward, so don't forget to readjust your contributions once 2021 begins, if that is what you wish to do.

403(b) Retirement Plan

The tax structure of a 403(b) is similar to 401k. As you make contributions through your salary, on a pre-tax basis, they attract interest. It is when you start receiving monthly payments from the plan on maturity that you are required to pay taxes, just like any other ordinary income. This is why 403(b) is also known as Tax Sheltered Annuity (TSA). This plan is popular among non-profit organizations, and employers opt for it, as it is exempt from Employer Retirement Income Security Act which allows the employer to offer this plan to all employees.

457(b) Retirement Plan

A 457(b) is a retirement benefit plan that is open for mostly government sector employees. The employer may offer this plan which is also similar to a 401k. The contributions made by an employee are exempt from tax until the employee receives a benefit from the plan, this is also known as a tax deferred plan. But unlike 401k or 403b, there is no penalty for withdrawal before the age of 59 ½ (subject to a qualifying event under 457(b) provisions). However, the amount withdrawn is subject to ordinary taxation. This plan allows employees to save a part of their income without paying tax on contributions, or the earnings that accrue in the form of interest, until funds are distributed from the plan based on a qualifying event.

Difference between 403(b) and 457(b)

Both are tax deferred plans.

In 457(b), there is no minimum retirement age which means there is not a 10% penalty upon withdrawal of money based on a qualifying event. An early withdrawal penalty does apply to both 403(b) and 401k plans.

What is notable is that if an employer offers both 457(b) and 403(b), an employee can choose to contribute to both from his salary.

While under 403(b), an employee can withdraw money for hardship circumstances such as buying a home or for the education of himself or a qualified dependent. Such withdrawals are not allowed under the unforeseen emergency provisions of a 457(b) plan.

Questions? Contact First Financial at (800) 523-8422 or visit us at www.ffga.com.

First Financial Administrators, Inc.
First in Service and Expertise

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CONTACTS			
BENEFIT	CARRIER	WEBSITE	PHONE
Eastern Region of FFGA	First Financial Administrators	www.ffga.com	800.924.3539
Flexible Spending Accounts	First Financial Administrators	www.ffga.com	866.853.3539

EMPLOYEE BENEFITS CENTER

https://benefits.ffga.com/poquosoncitypublicschools

The Employee Benefits Center (EBC) is a one-stop-shop for you to find all things benefits related. On the website, you'll find open enrollment and plan year dates, benefit descriptions, carrier contact information, product brochures, claim forms and enrollment details.

Visit *https://benefits.ffga.com/poquosoncitypublicschools* today!