



County of Henrico
General Government

TIME SENSITIVE

2022 VOLUNTARY BENEFITS ENROLLMENT

October 2 - 29, 2021



LEARN & ENROLL

www.pierceins.com/henrico

arranged by:





County of Henrico
General Government



Dear Henrico County Employees,

Your dedication and commitment to the citizens of County of Henrico inspire us to work hard for you. In partnership with Pierce Insurance, we strive to offer you best-in-class voluntary benefits that are designed to provide financial protection and peace of mind for you and your family.

We are pleased to announce Open Enrollment will be held October 2 - 29, 2021. We ask that you carefully review your voluntary benefits options and consider how these plans may provide the protection you and your family need. **Plans include:**

- Group Accident**
- Cancer**
- Group Critical Illness**
- Group Hospital Indemnity**
- Life Insurance with Long Term Care**
- Legal Plan** NEW
- Identity Theft Protection** NEW

If you have questions, would like to make changes, or wish to enroll, call Pierce Insurance at 800-421-3142, ext. 170 or visit www.pierceins.com/henrico.

Thank you for your dedicated commitment to Henrico County. We remain committed to providing you with the best and most affordable benefit options available.

Sincerely,
John Vithoukias
Henrico County Manager

Dr. Amy Cashwell
HCPS Superintendent



Pierce Insurance is committed to making smart decisions to manage our environmental impact responsibly. This is your custom-designed electronic benefit booklet. See a Benefit Counselor to obtain hard copy benefit brochures.

EMPLOYEE BENEFITS BOOKLET

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Henrico County Public Schools**

Plan Year: January 1 - December 31, 2022

Annual Enrollment Period: October 2 - 29, 2021

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IMPORTANT Note & Disclaimer

This is neither an insurance contract nor a summary plan description. Only your actual policy provisions will prevail. All information in this booklet, including premiums quoted is subject to change and is for information purposes only.

Learn about your health insurance, retirement and other benefit plans at:

- **County of Henrico General Government:** <https://employees.henrico.us/>
- **Henrico County Public Schools:** www.henicoschools.us

**County of Henrico General Government
Henrico County Public Schools**

Plan Year: January 1 - December 31, 2022

Annual Enrollment Period: October 2 - 29, 2021

New hires must enroll within the first 30 days of your hire date.

Benefit eligible new hires must enroll within the first 30 days of employment. To enroll please have dates of birth and social security numbers for each insured (self, spouse, child).

PRE-TAX BENEFITS

A pre-tax deduction is money that is taken out of employee's gross pay before any taxes are withheld from their paycheck. Pre-tax deductions reduce employee's taxable income, which means you may likely owe less income tax and/or FICA tax (which includes Social Security and Medicare).

-  **Group Accident Insurance**
-  **Group Hospital Indemnity Insurance**
-  **Group Critical Illness Insurance**
-  **Cancer Insurance**

POST-TAX BENEFITS

A post-tax deduction is money that is taken out of employee's paycheck after all applicable taxes have been withheld.

-  **Life Insurance (with Long-Term Care)**
-  **Legal Plan**
-  **Identity Theft Protection**

Elections made during the enrollment period cannot be changed outside of open enrollment unless there is a family status change as defined by the Internal Revenue Code. Examples: marriage, divorce, death of a spouse, birth or adoption of a child, termination or commencement of a spouse's employment or the transition of a spouse's employment from full time to part time. Once a family status change has occurred you have 30 days from the event to make changes. Call Pierce Insurance service center: [800-421-3142](tel:800-421-3142).

An employee taking a leave of absence, other than under the Family & Medical Leave Act, may not be eligible to re-enter the program until the next Plan Year.

Some policies may contain a pre-existing clause. Read your policy for full details.

There are certain insurance benefits that may be subject to federal and state tax when premium is paid by pre-tax deduction.

Coverage in most instances is portable when you leave employment.




Disclaimer: This is neither an insurance contract nor a summary plan description. Only your actual policy provisions will prevail. All information in this booklet, including premiums quoted, is subject to change and is for information purposes only.

WHEN TO ENROLL

 **OPEN ENROLLMENT: OCTOBER 2 - 29, 2021**

 **NEW HIRES MUST ENROLL WITHIN 30 DAYS OF YOUR HIRE DATE.**

HOW TO ENROLL, MAKE CHANGES, & ASK QUESTIONS

-  • Call 800-421-3142, ext. 170 to speak with a licensed benefits counselor
-  • Schedule an appointment: www.pierceins.com/henrico
-  • Enroll online: www.pierceins.com/henrico

 **Why speak with a licensed benefits counselor?**

- Help raise money for Children's Hospital of Richmond at VCU
- Learn about **NEW** benefits
- Ensure your coverage is properly renewed for 2022

 **Benefits That Benefit CHILDREN**

- Meet with a benefits counselor to learn about valuable voluntary benefits including Chubb's LifeTime Benefit Term, LegalEASE, and NortonLifelock and help raise money for Children's Hospital of Richmond at VCU.

**ACCESS YOUR BENEFITS
ANYTIME & ANYWHERE**

www.pierceins.com/henrico

**E-BENEFIT BOOKLET (PREMIUMS AND DETAILS)
HOW TO ENROLL • VIDEO LIBRARY
POLICYHOLDER RESOURCES • FAQ • CONTACT**

AVAILABLE 24/7 ONLINE

 **DESKTOP** |  **MOBILE** |  **TABLET**



FILE YOUR WELLNESS, HEALTH SCREENING or BENEFIT CLAIM

- Filing a claim with Aflac (annual wellness/health screening for accident, critical illness, and hospital indemnity).
Access directly: www.aflacgroupinsurance.com/customer-service/file-a-claim.aspx
- Filing a claim with Transamerica cancer, log into your portal: www.tebcs.com or call 888-763-7474.



Filing your annual wellness and health screening claim is important to your health. Each claim pays independent of the other, is available for family members and payment is tax free.

Plan Name	Wellness Benefit	Am I Enrolled?	Date Claim Filed
Group Accident Insurance	\$60	Y <input type="checkbox"/> N <input type="checkbox"/>	/ /
Group Critical Illness Insurance*	\$150	Y <input type="checkbox"/> N <input type="checkbox"/>	/ /
Group Hospital Indemnity	\$50	Y <input type="checkbox"/> N <input type="checkbox"/>	/ /
Cancer Insurance	\$50 - \$150	Y <input type="checkbox"/> N <input type="checkbox"/>	/ /

*Critical Illness Insurance Health Screening benefit is not paid for dependent children.

WHY VOLUNTARY INSURANCE IS IMPORTANT TO YOUR FINANCIAL WELL-BEING

What if you get sick, hurt, or die unexpectedly?

- Lost income
- Care giving expenses
- Mortgage payment
- Education expenses
- Childcare expenses
- Retirement funding
- Burial expenses
- Long-term-care expenses

Voluntary Insurance Helps Provide Peace of Mind



AFLAC GROUP HOSPITAL INDEMNITY

Policy Form C80100VA



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.

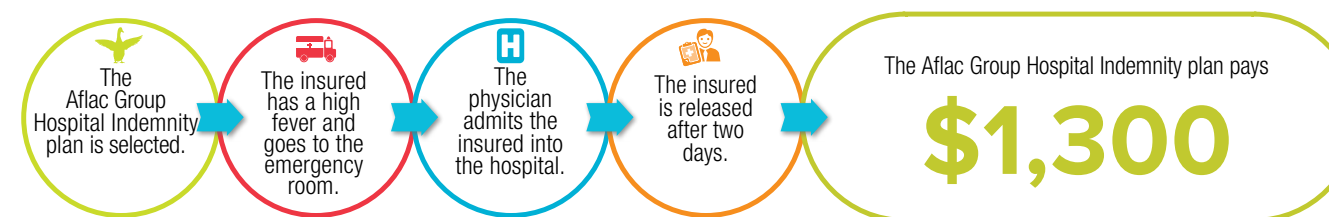
It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time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



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

We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).

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.

\$150

This benefit is payable in addition to the Hospital Confinement Benefit.

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.

\$75

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.

HEALTH SCREENING BENEFIT

The Health Screening Benefit is payable once per calendar year 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 each insured.

Residents of Massachusetts are not eligible for the Health Screening Benefit.

WAIVER OF PREMIUM RIDER

After 90 days of total disability due to covered sickness or accidental injury for up to 12 months.

SUCCESSOR INSURED WAIVER OF PREMIUM RIDER BENEFIT

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

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

SUCCESSOR INSURED BENEFIT

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

COVERAGE

MONTHLY RATES (12pp/year)

Employee	\$21.33
Employee and Spouse	\$42.95
Employee and Dependent Children	\$34.20
Family	\$55.82

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 intellectual disability 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. See certificate for details.

NOTICES

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

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

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies. This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center. Benefits, terms, and conditions may vary by state.

This brochure is subject to the terms, conditions, and limitations of Policy Form C80100VA.

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

Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

What you need, when you need it.

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



GROUP ACCIDENT INSURANCE

	HIGH	LOW
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following:		
Hospital emergency room with X-Ray / without X-Ray	\$250/\$200	\$200/\$150
Urgent care facility with X-Ray / without X-Ray	\$250/\$200	\$200/\$150
Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	\$150/\$100	\$100/\$75
AMBULANCE (within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury.	\$400 Ground \$1,200 Air	\$300 Ground \$900 Air
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center.	\$200	\$150
EMERGENCY ROOM OBSERVATION (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury.	\$100 Each 24 hour period \$50 Less than 24 hours, but at least 4 hours	\$70 Each 24 hour period \$35 Less than 24 hours, but at least 4 hours
PRESCRIPTIONS (2 times per accident, within 6 months after the accident) Payable for a prescription filled that - due to a covered accidental injury - is ordered by a doctor, dispensed by a licensed pharmacist and medically necessary for the care and treatment of the insured (in Alaska, Massachusetts and Montana prescriptions do not have to be medically necessary). This benefit is not payable for therapeutic devices or appliances; experimental drugs; 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; or immunization agents, biological sera, blood or blood plasma. This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).	\$5	\$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury.	\$200	\$200
PAIN MANAGEMENT (once per accident, within 6 months after the accident) Payable when an insured, due to a covered accidental injury, is prescribed and receives a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is only payable for pain management techniques (as shown above) that are administered in a hospital or doctor's office. This benefit is not payable for an epidural administered during a surgical procedure.	\$100	\$75
CONCUSSION (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident.	\$500	\$350
TRAUMATIC BRAIN INJURY (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a covered accident. To qualify as TBI, the neurological deficit must require treatment by a neurologist and a prescribed course of physical, speech and/or occupational therapy under the direction of a neurologist.	\$5,000	\$3,500

COMA (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident.	\$10,000	\$7,500
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident.	\$50 Extraction \$200 Repair with a crown	\$30 Extraction \$120 Repair with a crown
BURNS (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered.		
Second Degree		
Less than 10%	\$100	\$75
At least 10% but less than 25%	\$200	\$150
At least 25% but less than 35%	\$500	\$375
35% or more	\$1,000	\$750
Third Degree		
Less than 10%	\$1,000	\$750
At least 10% but less than 25%	\$5,000	\$3,750
At least 25% but less than 35%	\$10,000	\$7,500
35% or more	\$20,000	\$15,000
EYE INJURIES Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia.	\$250	\$175
FRACTURES (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one fracture in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.	Up to \$4,000 based on a schedule	Up to \$3,000 based on a schedule
DISLOCATIONS (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.	Up to \$3,000 based on a schedule	Up to \$2,250 based on a schedule
LACERATIONS (once per accident, within 7 days after the accident) Payable when an insured receives a laceration in a covered accident and the laceration is repaired by a doctor. For multiple lacerations, we will pay a maximum of 200% of the benefit for the largest single laceration requiring stitches. Lacerations requiring stitches (including liquid skin adhesive):		
Over 15 centimeters	\$800	\$600
5-15 centimeters	\$400	\$300
Under 5 centimeters	\$100	\$75
Lacerations not requiring stitches	\$50	\$37.50

OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	\$400	\$300
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	\$100	\$75
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount.	\$50	\$35
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	\$1,000	\$750
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident) Payable for transportation if, because of a covered accident, an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city.	\$500 Plane \$200 Any ground transportation	\$350 Plane \$150 Any ground transportation
SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.		
Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.		
AFTER CARE BENEFITS	HIGH	LOW
APPLIANCES (within 6 months after the accident) Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion. Cane, Ankle Brace Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar Wheelchair, Knee Scooter, Body Jacket, Back Brace	\$40 \$100 \$400	\$30 \$75 \$300
ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident) Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident. Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment.	\$50	\$35
POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident) Payable if the insured is diagnosed with PTSD, a mental health condition triggered by a covered accident. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.	\$200	\$150

<p>REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured) Payable for each day that, due to a covered accidental injury, 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. We will pay the highest eligible benefit.</p>	\$100 per day	\$75 per day
<p>THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.</p>	\$50	\$35
<p>CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured receives acupuncture or chiropractic treatment.</p>	\$30	\$25

HOSPITALIZATION BENEFITS

HIGH LOW

<p>HOSPITAL ADMISSION (once per accident, within 6 months after the accident) Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury. This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment.</p>	\$1,250 per confinement	\$900 per confinement
<p>HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident) Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury. If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, 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. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.</p>	\$300 per day	\$225 per day
<p>HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.</p>	\$400 per day	\$300 per day
<p>INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury. We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in an intermediate intensive care step-down unit and an insured becomes confined to an intermediate intensive care step-down unit again within 6 months because of the same condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.</p>	\$200 per day	\$150 per day

<p>FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident) Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family. For this benefit to be payable: • The insured must be confined to a hospital for treatment of a covered accidental injury; • The hospital and motel/hotel must be more than 100 miles from the insured's residence; and • The treatment must be prescribed by the insured's treating doctor.</p>	\$200 per day	\$150 per day
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LIFE CHANGING EVENTS BENEFITS

DISMEMBERMENT (once per accident, within 6 months after the accident)
 Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident.
 Dismemberment means:
 • Loss of a hand -The hand is removed at or above the wrist joint;
 • Loss of a foot -The foot is removed at or above the ankle;
 • Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or
 • Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable).
 If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

SINGLE LOSS (the loss of one hand, one foot, or the sight of one eye)	HIGH	LOW
Employee	\$6,250	\$8,750
Spouse	\$2,500	\$3,750
Child(ren)	\$1,250	\$1,750
DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)		
Employee	\$12,500	\$17,500
Spouse	\$5,000	\$7,500
Child(ren)	\$2,500	\$3,500
LOSS OF ONE OR MORE FINGERS OR TOES		
Employee	\$625	\$875
Spouse	\$250	\$375
Child(ren)	\$125	\$175
PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)		
Employee	\$62.50	\$87.50
Spouse	\$62.50	\$87.50
Child(ren)	\$62.50	\$87.50
PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident) Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.		
Paraplegia	\$2,500	\$3,500
Quadriplegia	\$5,000	\$7,500

<p>PROSTHESIS (once per accident, up to 2 prosthetic devices and one replacement per device per insured)* Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury.</p> <p>Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices* and /or joint replacements.</p> <p>* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.</p>	\$1,500	\$2,000
<p>RESIDENCE/VEHICLE MODIFICATION (once per accident, within one year after the accident) Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of one of the following, due to a covered accidental injury:</p> <ul style="list-style-type: none"> • The sight of one eye; • The use of one hand/arm; or • The use of one foot/leg. 	\$1,000	\$1,500

WELLNESS RIDER

<p>WELLNESS BENEFIT (once per calendar year) Payable for wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.</p>	\$60	First year of certificate and thereafter
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WAIVER OF PREMIUM RIDER

If the employee becomes totally disabled due to a covered sickness* or accidental injury, after 90 days of total disability, we will waive premiums for the employee and any covered dependents. As long as the employee remains totally disabled, premium will be waived up to 24 months, subject to the terms of the plan.

*In New Hampshire, Tennessee, and Texas, not applicable.

COVERAGE	MONTHLY RATES (12pp/year)	
	High Plan	Low Plan
Employee	\$17.50	\$13.87
Employee and Spouse	\$28.30	\$22.52
Employee and Dependent Children	\$31.37	\$24.90
Family	\$42.17	\$33.55

INITIAL ACCIDENT EXCLUSIONS EXCLUSIONS

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

Plan exclusions apply to all riders unless otherwise noted.

We will not pay benefits for accidental injury, disability or death contributed to, caused by, or resulting from*:

- **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.
 - In California: 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 or riot.
 - In Idaho: participating in any war or act of war, declared or undeclared, or participating or serving in the armed forces or units auxiliary thereto. War also includes participation in a riot or an insurrection.
 - In Illinois: the statement “war does not include acts of terrorism” is deleted.
 - In Michigan: voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
 - In North Carolina: 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 civil participation in an active riot. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
 - In Montana: committing or attempting to commit suicide, while sane
 - In Illinois, Michigan and Minnesota: this exclusion does not apply
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
 - Allergic reactions
 - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid or other arthropod bites or stings. In Illinois: any bacterial infection, except an infection which results from an accidental injury or an infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; any viral or microorganism infection or infestation; or any condition resulting from insect, arachnid or other arthropod bites or stings. In North Carolina: any viral or microorganism infestation or any condition resulting from insect, arachnid or other arthropod bites or stings
 - An error, mishap or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - Any related medical/surgical treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
 - In Idaho: intentionally self-inflicting injury.
 - In Montana: injuring or attempting to injure oneself intentionally, while sane
 - In Michigan: this exclusion does not apply
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
 - In Idaho: this exclusion does not apply
- **Illegal Occupation** – voluntarily participating in, committing or attempting

to commit a felony or illegal act or activity, or voluntarily working at or being engaged in, an illegal occupation or job.

- In California, Nebraska and Tennessee: voluntarily participating in, committing, or attempting to commit a felony; or voluntarily working at, or being engaged in, an illegal occupation or job.
- In Illinois and Pennsylvania: committing or attempting to commit a felony or being engaged in an illegal occupation
- In Michigan: voluntarily participating in, committing or attempting to commit a felony, or being engaged in an illegal occupation
- In Idaho and South Dakota: this exclusion does not apply
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
 - In California and Idaho: participating in any organized sport in a professional capacity for pay or profit
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
 - In Alaska, Massachusetts and Montana: having cosmetic surgery, other elective procedures or dental treatment except as a result of a covered accident.
 - In California: having cosmetic surgery or other elective procedures that are not medically necessary (“cosmetic surgery” does not include reconstructive surgery when the service is related to or follows surgery resulting from a covered accident); or having dental treatment except as a result of a covered accident.
 - In Idaho: having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident. Cosmetic surgery shall not include reconstructive surgery because of a Congenital Anomaly of a covered dependent child.

• **Felony** (In Idaho only) – participation in a felony
For 24-Hour Coverage, the following exclusions will not apply:

An injury arising from any employment.
An injury or sickness covered by worker’s compensation.
In North Carolina: services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina workers’ compensation act only to the extent such services or supplies are the liability of the employee, employer, or workers’ compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.

**“Contributed to” language doesn’t apply in Illinois

DEFINITIONS

Accidental Injury means accidental bodily damage to an insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. **A Covered Accidental Injury** is an accidental injury that occurs while coverage is in force. 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.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Dependent Child or Dependent Children means your or your spouse’s natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (and in Louisiana, unmarried). Newborn children may be automatically covered from the moment of birth for 60 days. Newly adopted children (and foster children in North Carolina and Florida) may also be automatically covered for 60 days. See certificate for details.

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

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

A Doctor does not include the insured or an insured's family member. In South Dakota however, a doctor who is an employee's family member may treat the insured if that doctor is the only doctor in the area and acts within the scope of his practice. For the purposes of this definition, family member includes the employee's spouse as well as the following members of the employee's immediate family son, daughter, mother, father, sister, and brother. This includes step-family members and family-members-in-law.

The term **Hospital** specifically excludes any facility not meeting the definition of hospital as defined in this plan, including but not limited to:

- 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, or
- An assisted living facility.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

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

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.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

HOSPITALIZATION BENEFITS

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the hospital called a hospital intensive care unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the hospital intensive care unit 24 hours a day; and
- Has a doctor assigned to the hospital intensive care unit on a full-time basis.

The term **Hospital Intensive Care Unit** specifically excludes any type of facility not meeting the definition of hospital intensive care unit as defined in this plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units and the following step-down units:

- A progressive care unit;
- A sub-acute intensive care unit; or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit;
- A sub-acute intensive care unit;
- An intermediate care unit; or
- A pre- or post-intensive care unit.

An intermediate intensive care step-down unit is not a hospital intensive care unit as defined in this plan.

AFTER CARE BENEFITS

Psychiatrist is a doctor of medicine who specializes in the diagnosis and treatment of mental disorders.

Psychologist is a clinical, mental health professional who works with patients. A psychologist is not a doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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.

WAIVER OF PREMIUM RIDER

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 accidental injury (or a covered sickness if applicable), and
- Unable to work.

Unable to Work means either:

- You are unable to work at the occupation you were performing when your total disability began, which was during the first 365 days of total disability; or
- You are unable to work at any gainful occupation for which you are suited by education, training, or experience after the first 365 days of total disability.

Definitions in Maine:

Total Disability or Totally Disabled means you are:

- Unable to engage in any employment or occupation for which you are or become qualified by reason of education, training, or experience, and are not, in fact, engaged in any employment or occupation for wage or profit.
- Under the care of a doctor for the treatment of a covered accidental injury (or a covered sickness if applicable).

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION OF COVERAGE

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

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.

AFLAC GROUP CRITICAL ILLNESS



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.

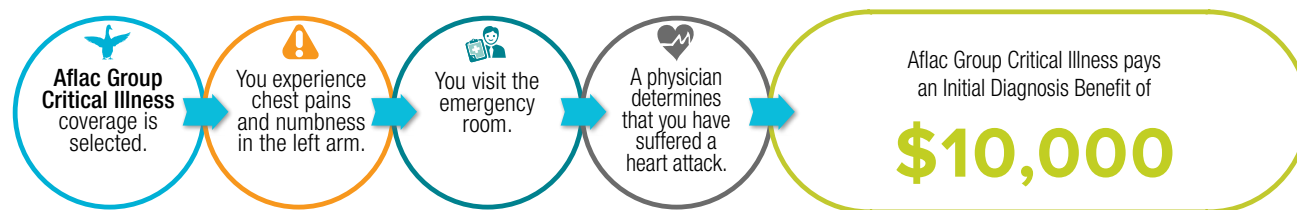
The Aflac Group Critical Illness plan benefits include:

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

Features:

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

How it works



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

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

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN*	100%
PARALYSIS**	100%
COMA**	100%
LOSS OF SPEECH / SIGHT / HEARING**	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS

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

ADDITIONAL DIAGNOSIS

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

REOCCURRENCE

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

CHILD COVERAGE AT NO ADDITIONAL COST

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

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 \$150 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse.

This benefit is not paid for dependent children.

OPTIONAL BENEFITS RIDER

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

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.

CHILDHOOD CONDITIONS RIDER

CYSTIC FIBROSIS	50%
CEREBRAL PALSY	50%
CLEFT LIP OR CLEFT PALATE	50%
DOWN SYNDROME	50%
PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU)	50%
SPINA BIFIDA	50%
TYPE 1 DIABETES	50%

One Time Benefit Amount

AUTISM SPECTRUM DISORDER (ASD)	\$3,000
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Benefits are payable if a dependent child is diagnosed with one of the conditions listed and the date of diagnosis is while the rider is in force. (In Indiana, diagnosis must not be specifically excluded by the plan.)

MONTHLY RATES (12pp/year)

CRITICAL ILLNESS NON-TOBACCO / Employee

Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$7.11	\$9.70	\$12.29	\$14.88	\$17.47	\$20.06	\$22.65	\$25.24	\$27.83	\$30.43
30-39	\$8.55	\$12.58	\$16.62	\$20.65	\$24.68	\$28.71	\$32.74	\$36.77	\$40.81	\$44.84
40-49	\$12.09	\$19.67	\$27.24	\$34.81	\$42.39	\$49.96	\$57.53	\$65.11	\$72.68	\$80.26
50-59	\$19.00	\$33.48	\$47.96	\$62.43	\$76.91	\$91.39	\$105.87	\$120.35	\$134.83	\$149.30
60+	\$31.98	\$59.44	\$86.91	\$114.37	\$141.83	\$169.29	\$196.75	\$224.21	\$251.68	\$279.14

CRITICAL ILLNESS TOBACCO / Employee

Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$8.04	\$11.56	\$15.08	\$18.59	\$22.11	\$25.63	\$29.15	\$32.67	\$36.19	\$39.71
30-39	\$10.64	\$16.76	\$22.88	\$29.00	\$35.12	\$41.24	\$47.36	\$53.48	\$59.60	\$65.72
40-49	\$16.26	\$27.99	\$39.73	\$51.46	\$63.20	\$74.93	\$86.67	\$98.40	\$110.14	\$121.87
50-59	\$27.71	\$50.89	\$74.08	\$97.27	\$120.45	\$143.64	\$166.83	\$190.01	\$213.20	\$236.38
60+	\$47.20	\$89.88	\$132.57	\$175.25	\$217.93	\$260.61	\$303.29	\$345.98	\$388.66	\$431.34

CRITICAL ILLNESS NON-TOBACCO / Spouse

Ages	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$6.80	\$7.93	\$9.07	\$10.21	\$11.35	\$12.49	\$13.63	\$14.76	\$15.90
30-39	\$8.24	\$10.10	\$11.96	\$13.81	\$15.67	\$17.53	\$19.39	\$21.25	\$23.11
40-49	\$11.78	\$15.41	\$19.04	\$22.67	\$26.30	\$29.93	\$33.56	\$37.19	\$40.82
50-59	\$18.68	\$25.77	\$32.85	\$39.93	\$47.01	\$54.09	\$61.18	\$68.26	\$75.34
60+	\$31.67	\$45.24	\$58.82	\$72.39	\$85.96	\$99.54	\$113.11	\$126.68	\$140.26

CRITICAL ILLNESS TOBACCO / Spouse

Ages	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$7.72	\$9.33	\$10.93	\$12.53	\$14.13	\$15.74	\$17.34	\$18.94	\$20.54
30-39	\$10.33	\$13.23	\$16.13	\$19.03	\$21.94	\$24.84	\$27.74	\$30.65	\$33.55
40-49	\$15.94	\$21.65	\$27.36	\$33.07	\$38.78	\$44.49	\$50.20	\$55.91	\$61.63
50-59	\$27.39	\$38.83	\$50.26	\$61.70	\$73.14	\$84.57	\$96.01	\$107.45	\$118.88
60+	\$46.89	\$68.07	\$89.26	\$110.44	\$131.62	\$152.81	\$173.99	\$195.18	\$216.36

LIMITATIONS AND EXCLUSIONS

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, excess blasts),
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia), or
- Myelodysplastic syndrome – RAEB (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 – RARS (refractory anemia with ring sideroblasts)
- Myelodysplastic Syndrome – RA (refractory anemia)

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.

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

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

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

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 phosphokinase (CPK) a CPK-MB measurement must be used.)

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

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

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

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

- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

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

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

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

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.

OPTIONAL BENEFITS RIDER

Date of Diagnosis is defined as follows:

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

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

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

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

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

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

- Exhibit at least two of the following clinical manifestations:
 - Muscle rigidity
 - Tremor
 - Bradykinesia (abnormal slowness of movement, sluggishness of

physical and mental responses), and

- Require substantial physical assistance from another adult to perform at least three ADLs.
- Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

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

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

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

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

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.

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

CHILDHOOD CONDITIONS RIDER

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

Date of Diagnosis is defined as follows:

- Cystic Fibrosis: The date a doctor diagnoses a dependent child as having Cystic Fibrosis and where such diagnosis is supported by medical records.
- Cerebral Palsy: The date a doctor diagnoses a dependent child as having Cerebral Palsy and where such diagnosis is supported by medical records.
- Cleft Lip or Cleft Palate: The date a doctor diagnoses a dependent child as having Cleft Lip or Cleft Palate and where such diagnosis is supported by medical records.
- Down Syndrome: The date a doctor diagnoses a dependent child as having Down Syndrome and where such diagnosis is supported by medical records.
- Phenylalanine Hydroxylase Deficiency Disease (PKU): The date a doctor diagnoses a dependent child as having PKU and where such diagnosis

is supported by medical records.

- Spina Bifida: The date a doctor diagnoses a dependent child as having Spina Bifida and where such diagnosis is supported by medical records.
- Type I Diabetes: The date a doctor diagnoses a dependent child as having Type I Diabetes and where such diagnosis is supported by medical records.
- Autism Spectrum Disorder: The date a doctor diagnoses a dependent child as having Autism Spectrum Disorder and where such diagnosis is supported by medical records.

If a dependent child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

A doctor must diagnose Phenylalanine Hydroxylase Deficiency Disease (PKU) based on a PKU test.

A doctor must diagnose Type I Diabetes based on one of the following diagnostic tests:

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

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

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION OF COVERAGE

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

NOTICES

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

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

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Introducing Health Advocacy, Medical Bill Saver[™] and Telemedicine services, now part of your Aflac plan.

We've enhanced your plan without adding cost. Now, if you have an eligible Aflac plan, you also have access to three services that make it easier to access care, reduce out-of-pocket medical expenses and navigate the health care system with greater ease:

- **Get answers and expert help** with Health Advocacy from Health Advocate
- **Let advocates negotiate your medical bills** with Medical Bill Saver, also from Health Advocate
- **Connect with health providers via phone,** app or online with MeMD

Best of all, you can start using them as soon as your Aflac coverage starts.



Start using Health Advocacy and Medical Bill Saver from Health Advocate and Telemedicine from MeMD when your coverage begins. Questions?

Health Advocate and Medical Bill Saver: 855.423.8585

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Get more without spending more

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BENEFIT**



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You have **24/7** access to personal health advocates who start helping from the first call:

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- Resolve benefits issues and coordinate benefits
- Assist with eldercare issues, Medicare and more
- Help transfer medical records, lab results and x-rays
- Work with insurance companies to obtain approvals and clarify coverage



More than just cash benefits. Medical Bill SaverTM from Health Advocate

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- They contact the provider to negotiate a discount
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- Get ePrescriptions,* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- Prescription for common medicine

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, North Carolina, South Dakota and Utah.

When medically necessary, MeMD providers can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

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Continental American Insurance Company | Columbia, South Carolina

AGC1500186 R7

EXP 3/21



CancerSelect Plus, underwritten by Transamerica Life Insurance Company, can help provide extra protection in the event of a cancer diagnosis.

Nancy knows that her family history may put her at higher risk for a cancer diagnosis. When a coworker battled cancer and faced a financial strain due to his deductible, copays, and missed work, his situation hit close to home. She worries that her medical insurance might not be enough.

GOOD MEDICAL INSURANCE HELPS, BUT IS IT ENOUGH?

Health insurance may cover some of the cost of cancer treatment but individuals could still face substantial out-of-pocket costs.

IF CANCER IS THE DISEASE YOU WORRY ABOUT MOST, YOU'RE NOT ALONE

If you or one of your family members were to be diagnosed with cancer, would you want to face those chances? Now there's a way you can add more benefits for you and your family.

With this supplemental benefit, you'll have more resources to cope with a diagnosis of cancer and wellness benefits to help you detect it early, when it's most treatable.

YOU CAN INSURE YOURSELF OR ADD YOUR ELIGIBLE SPOUSE AND CHILDREN

If you are 18 years of age or older, you can purchase this valuable supplemental benefit. You can also choose to insure your eligible family members, including your spouse age 18 or older and your children from birth through age 25.

VALUABLE BENEFITS FOR YOUR LIFE

Review the attached benefits and costs for the insurance policy. It's a long list of benefits, but they're all important. As you read through the list of all the ways this supplemental insurance pays, think about how you could possibly pay for all these costs on your own. Fighting cancer can be challenging both financially and emotionally, and the more resources you have, the better prepared you and your family will be.


This is a brief summary of *CancerSelect Plus*, cancer-only insurance, underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy form series CPCAN200 and CCCAN200. Forms and numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate, and riders for complete details.


Up-to-date information regarding our compensation practices can be found in the Disclosures section of our website at tebcs.com.

263428R1 09/21

HOW IT WORKS

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888-763-7474

Product Details

Hospital Benefits	Plan Option 1 - 1.00 Units	Plan Option 2 - 2.00 Units	Plan Option 3 - 3.00 Units	Policy Pays
Hospital Confinement	\$100	\$200	\$300	per day of covered confinement
Extended Benefits	\$200	\$400	\$600	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	\$20	\$40	\$60	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	\$15	\$30	\$45	per day while hospital confined
Private Duty Nurse	\$100	\$200	\$300	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	\$100	\$200	\$300	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	\$100	\$200	\$300	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	\$100	\$200	\$300	per day of covered confinement; in lieu of all other benefits
Hospice Care	\$100	\$200	\$300	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined

Product Details

Surgery Benefits	Plan Option 1 - 1.00 Units	Plan Option 2 - 2.00 Units	Plan Option 3 - 3.00 Units	Policy Pays	
Surgery	Inpatient	\$1,000	\$2,000	\$3,000	maximum benefit; actual benefit is determined by the surgery schedule in the contract; for multiple procedures in same incision only the highest benefit is paid; for multiple procedures in separate incisions will pay highest benefit and then 50% for each lesser procedure
	Outpatient	\$1,500	\$3,000	\$4,500	
Anesthesia	25%	25%	25%	of covered surgery benefit	
Prosthesis	\$500	\$1,000	\$1,500	maximum benefit; pays actual charges per device requiring implantation	
Hair Prosthesis	\$50	\$100	\$150	maximum benefit; pays actual charges for wig to cover hair loss from cancer treatment	
Reconstructive Surgery	Breast Cancer: simple or total mastectomy	\$120	\$240	\$360	for reconstructive surgery within 2 years of the initial cancer removal; excludes skin cancer and malignant melanoma; benefit not payable if paid under any other provision of the policy
	Breast Cancer: radical mastectomy	\$170	\$340	\$510	
	Cancers of the male or female genitalia	\$170	\$340	\$510	
	Cancer of the head, neck, or oral cancers	\$250	\$500	\$750	
Second Surgical Opinion	\$100	\$200	\$300	when surgery is prescribed; excludes skin cancer	
Ambulatory Surgical Center	\$150	\$300	\$450	maximum per day; pays actual charges for outpatient surgery at an ambulatory surgical center	

Product Details

Skin Cancer	One removal	\$75	\$150	\$225	for removal of skin cancer (skin cancer does not include malignant melanoma or mycosis fungoides)
	Per additional removal	\$35	\$70	\$105	
Radiation and Chemotherapy Benefits		Plan Option 1 - 1.00 Units	Plan Option 2 - 1.00 Units	Plan Option 3 - 2.00 Units	Policy Pays
Radiation and Chemotherapy		\$5,000	\$5,000	\$10,000	maximum benefit per 12-month period; pays actual charges
Associated Radiation & Chemo Expenses		\$250	\$250	\$500	maximum benefit per 12-month period; pays actual charges for treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant		\$5,000	\$5,000	\$10,000	maximum benefit per 12-month period; pays actual charges
Associated Blood & Plasma Expenses		\$250	\$250	\$500	maximum benefit per 12-month period; pays actual charges for administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses

Product Details

New or Experimental Treatment	\$5,000	\$5,000	\$10,000	maximum benefit per 12-month period; pays actual charges for drugs or chemical substances approved by the FDA for experimental use on humans or surgery or therapy endorsed by either the NCI or ACS for experimental studies received in the US or its territories
Wellness & Non-Medical Benefits	Plan Option 1 - 1.00 Units	Plan Option 2 - 2.00 Units	Plan Option 3 - 3.00 Units	Policy Pays
Annual Cancer Screening	\$50	\$100	\$150	per calendar year for cancer screening tests: <ul style="list-style-type: none"> • mammogram • pap smear • flexible sigmoidoscopy • prostate-specific antigen test • chest x-ray • hemocult stool specimen • ultrasound • CEA • CA125 • biopsy • thermography • colonoscopy • serum protein electrophoresis • bone marrow testing • blood screening
Magnetic Resonance Imaging (MRI) Scan	\$50	\$100	\$150	per calendar year for MRI scan used as diagnostic tool for breast cancer
Non-Local Transportation	Included	Included	Included	round-trip charges or private vehicle allowance, up to 750 miles at \$0.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for an insured person and an adult immediate family member during confinement; payable once per confinement

Product Details

Family Member Lodging	\$50	\$100	\$150	per day (maximum 50 days per 12 month period) for lodging expenses for an adult immediate family member when non-local hospital confinement is required
Outpatient Lodging	\$50	\$100	\$150	per day (maximum 50 days per 12 month period) for lodging expenses for an insured person to receive radiation or chemotherapy on an outpatient basis if not available locally
Physical Therapy & Speech Therapy	\$25	\$50	\$75	per treatment; limit one treatment per day
At-Home Nursing	\$50	\$100	\$150	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Waiver of Premium	Included	Included	Included	waives premium for total disability due to cancer after 60 consecutive days of total disability; total disability must begin prior to the insured person's 70th birthday
Cancer Maintenance Therapy Benefit	Plan Option 1 - 1.00 Units	Plan Option 2 - 1.00 Units	Plan Option 3 - 2.00 Units	Policy Pays
<ul style="list-style-type: none"> • Cancer Suppressive Therapy • Hematological Drugs • Anti-Nausea Drugs • Motility Agents 	\$1,000	\$1,000	\$2,000	maximum benefit per 12-month period; pays actual charges

Product Details

First Occurrence Rider (Rider Form Series CROCC100, 200 or 300)	Plan Option 1 - 0 Units	Plan Option 2 - 0 Units	Plan Option 3 - 1.00 Units	Policy Pays
Initial Diagnosis Benefit	None	None	\$1,000	pays a one-time, lump-sum benefit when an insured person is initially diagnosed with cancer (except skin cancer), based on a microscopic examination of fixed tissue or preparations from the hemic system. Clinical diagnosis is accepted under certain conditions.
Intensive Care Rider (Rider Form Series CRICU100, 200 or 300)	Plan Option 1 - 0 Units	Plan Option 2 - 2.00 Units	Plan Option 3 - 3.00 Units	Policy Pays
Intensive Care Unit Maximum of 45 days per covered confinement	None	\$200	\$300	per day of confinement in an ICU such as a cardiac care unit, burn unit, or neonatal unit
Step-Down Unit	None	\$100	\$150	per day of confinement in a step-down unit for progressive, sub-acute or intermediate care
Ambulance Benefit	None	\$400	\$600	maximum benefit; pays actual charges; per period of ICU confinement for transportation between medical facilities by a licensed professional ambulance service; benefit is not payable if paid under the base contract provision

Product Details

Specified Illness and Disease Rider (Rider Form Series CRSPD200)	Plan Option 1 - 0 Units	Plan Option 2 - 1.00 Units	Plan Option 3 - 2.00 Units	Policy Pays
Provides benefits for losses that are the direct result of a covered specified illness or disease.				
Hospital Confinement	None	\$100	\$200	per day of covered confinement
Extended Benefits	None	\$200	\$400	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	None	\$20	\$40	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	None	\$15	\$30	per day while hospital confined
Private Duty Nurse	None	\$100	\$200	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	None	\$100	\$200	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	None	\$100	\$200	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	None	\$100	\$200	per day of covered confinement; in lieu of all other benefits
Hospice Care	None	\$100	\$200	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined

Product Details

Surgery	None	\$1,000	\$2,000	per surgery; pays the lesser of the amount shown or an amount determined by multiplying the work relative value unit obtained from the Medicare Physician Fee Schedule by \$25
Outpatient Surgery	None	\$1,500	\$3,000	per surgery; pays 150% of the surgery benefit
Anesthesia	None	25%	25%	per surgery; pays the selected percentage of the surgery benefit
Second Surgical Opinion	None	\$100	\$200	for a second opinion when the first opinion prescribes surgery as treatment
Ambulatory Surgical Center	None	\$150	\$300	maximum per day; pays charges for surgery performed at an ambulatory surgical center or hospital as an outpatient; paid in addition to the outpatient surgery benefit
Covered Specified Illnesses and Diseases include:				
Adrenal Hypofunction (Addison's Disease)	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	Botulism	Brucellosis	Budd-Chiari Syndrome
Cerebral Palsy	Cholera	Cystic Fibrosis	Diphtheria	Encephalitis
Hansen's Disease	Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)	Histoplasmosis	Huntington's Chorea	Legionnaires' Disease
Lupus	Lyme Disease	Mad Cow Disease	Malaria	Meningitis
Muscular Dystrophy	Myasthenia Gravis	Necrotizing Fascitis	Osteomyelitis	Poliomyelitis
Primary Biliary Cirrhosis	Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)	Q Fever	Rabies	Reye's Syndrome
Rheumatic Fever	Rocky Mountain Spotted Fever	Scarlet Fever	Scleroderma	Sickle Cell Anemia
Tay-Sachs Disease	Tetanus	Thalassemia	Toxic Epidermal Necrolysis	Toxic Shock Syndrome
Trichinosis	Tuberculosis	Tularemia	Typhoid Fever	Whooping Cough (Pertussis)

Product Details

Actual charges means the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.

Monthly Premium	Individual	Single Parent Family	Family
Plan Option 1	\$9.81	\$11.32	\$18.04
Monthly Premium			
Plan Option 2	\$17.32	\$20.09	\$31.49
Monthly Premium			
Plan Option 3	\$30.12	\$34.69	\$54.53

Issue State: Virginia
Rate generation date: March 12, 2018

Limitations and Exclusions

We provide benefits only for cancer as defined herein, which is positively diagnosed while insurance is in force. It does not provide benefits for any other illness or disease.

- We may reduce or deny a claim or void insurance for loss incurred by an insured person:
 - During the first 2 years from the effective date of such insurance for any misstatements in the application which would have materially affected our acceptance of the risk;
 - At any time for fraudulent misstatements in the application.
- We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of cancer, except as specifically covered under the contract.
- If a covered hospital confinement is due to more than one covered condition, benefits will be payable as though the confinement or expense were due to one condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
- Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for pre-existing conditions for which the insured person has been diagnosed, treated, or for which the insured person has incurred expense or has taken medication within 12 months prior to the effective date of such person's policy. Pre-existing condition also includes a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience.

12-Month Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the insured person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each insured person.

First Occurrence Rider

Benefits are not payable:

- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from insurance by name or specific description.

Intensive Care Rider

We will only pay one daily indemnity benefit per day. We will not pay any benefits for loss resulting from:

- Specifically excluded diseases or conditions in the Contract or in this Rider;
- An attempted suicide while sane or insane or an intentionally self-inflicted injury;
- Any act of war either declared or undeclared;
- Alcoholism or drug addiction;
- Mental or nervous disorders;
- An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician;
- Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician;
- Injury received while engaging in an illegal occupation or activity.

Limitations and Exclusions

Specified Illness and Disease Rider

This Rider provides benefits for the Initial Positively Diagnosed Specified Illness or Disease defined in this Rider on or after the Effective Date of this Rider. It does not provide benefits for any other illness or disease.

We will only pay for loss as a direct result of a Specified Illness or Disease. Proof of Positive Diagnosis must be submitted with each new claim. We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of a Specified Illness or Disease or its treatment.

Benefits under "Waiver of Premium" of the Contract do not apply to this Rider for Total Disability due to a Specified Illness or Disease.

Termination of Insurance

Employee insurance will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for insurance;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel insurance.

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent insurance; or
- The date the employee sends us a written notice to cancel dependent insurance.

We will have the right to terminate the insurance of any insured person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this insurance.

Disclosures

GROUP BENEFITS DISCLOSURE POLICY

Transamerica Employee Benefits (TEB) is a unit of Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. TEB markets and administers voluntary insurance benefits through licensed insurance agents. These agents are typically appointed to sell our products, and products of other providers, and receive various forms of compensation from us for the services provided. We believe our compensation arrangements with our agents are conducted with honesty, fairness and integrity. In addition, we realize that having trusted relationships between our agents and our customers is essential to all involved. To ensure this trust continues and to address any concerns within the industry, we have outlined our policy on agent compensation disclosure.

TEB's policy supports transparency and full disclosure of agent compensation to our customers and prospective customers. In addition, we have put controls in place to facilitate this disclosure and obligate our agents to disclose compensation information to customers: 1) when asked by a customer; 2) when receiving both a fee from the customer and compensation from TEB; and 3) when otherwise required by law. Agents must comply with all applicable laws in the sale of TEB products, including any pertaining to the disclosure of compensation information.

TEB's Group Benefits Compensation Disclosure Notice (below) describes the various means by which agents may be compensated for the sale of our products. It is the responsibility of your agent to share specific information with you about his or her compensation arrangements with TEB. Accordingly, please direct any compensation disclosure questions directly to your agent.

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees, or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed policy documents or policy certificate package for more information on any such arrangements.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.



Life Insurance— Valuable protection for your loved ones



You work hard to provide a good life for your family. However, what if something happened to you? Would your family be able to continue covering expenses you may have today like mortgage payments, childcare, credit card payments, college tuition and other household expenses? What about burial expenses or expenses for long term care like nursing home or assisted living care?

Many families would struggle, especially if the primary wage earner died. And few families are able to afford nursing home care without some type of financial assistance.

LifeTime Benefit Term can help.

<p>52% of people turning age 65 will need some type of Long Term Care.¹</p>	<p>\$85,775 median annual nursing home cost, semi-private room in 2017.¹</p>	<p>35% of households would feel the financial impact... if the primary wage earner died.²</p>
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For employees of

Henrico County: General Government and Public School Systems

CWB-LBT-LTC-1120

LifeTime Benefit Term Provides You with the Protection Your Family Needs

LifeTime Benefit Term helps protect you and your family if you were no longer able to provide for them. Your family can receive cash benefits paid directly to them upon your death that they can use to help cover expenses like mortgage payments, credit card debt, childcare, college tuition and other household expenses.

Cash benefits can also be paid directly to you while you are living for long term care expenses.

You Decide How You Want to Use LifeTime Benefit Term Benefits

When you make the promise to protect your family with LifeTime Benefit Term, there are several ways it can work.

As Life Insurance

LifeTime Benefit Term protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long Term Care* (LTC)

If you become chronically ill, LifeTime Benefit Term will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

- Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.
- With Extension of Benefits*, if you continue to need LTC after you have exhausted your Death Benefits, you can receive up to 50 more months of benefits, for a total of 75 months of LTC benefits.



How LifeTime Benefit Term Can Be Used					
Three Options	Life Situation	Death Benefit	Long Term Care	Long Term Care Extension	Total Benefits
1. Life Insurance	You lead a full life and do not need Long Term Care (LTC)	\$100,000	---	---	\$100,000
2. Long Term Care (LTC) insurance	You lead a full life and need assisted living or nursing home care	---	\$100,000	---	
3. Split your Death Benefit for LTC & life insurance	You lead a full life but also need some LTC funds (Example: 4% of \$100,000 for 12 months)	\$52,000	\$48,000	---	
Additional Coverage for Long Term Care and Death Benefits					
Extra Long Term Care for up to 50 additional months	You lead a full life and need extended benefits for assisted living or nursing home care	---	---	\$200,000	\$200,000
Option 1, 2 or 3 + Extra LTC Coverage = TOTAL COVERAGE					\$300,000

This product is underwritten by Combined Insurance Company of America, a Chubb company.

Term Life Insurance Built for Today

Guaranteed Premiums*

Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue to age 121.

Guaranteed Benefits During Working Years

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

Guaranteed Benefits After Age 70

After age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50% of the original death benefit.

Paid-up Benefits

After 10 years, paid up benefits begin to accrue. At any point thereafter, if you stop paying the premium, a reduced paid up benefit is issued and can never lapse. That means when you retire, you can stop paying the premium and have a death benefit for the rest of your life—guaranteed.

Additional Benefit Options (additional premiums required)

Child Term

Death Benefits available up to \$25,000. Guaranteed conversion to individual coverage at age 26—up to 5 times the benefit amount.

Long Term Care (LTC)*

If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Extension of Benefits*

Extends the monthly Long Term Care benefit for up to an additional 50 months, after 100% of the base death benefit has been used for LTC.

Terminal Illness

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



Good things happen every day, and unfortunately hardship happens too. Let us help you protect everything you value.

* LTC and Extension of Benefits premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums will not be increased solely because of an independent claim. New premiums will be based on the insured's age and premium class on the rider's coverage date.

LifeTime Benefit Term Features

Affordable Financial Security

Lifelong protection with premiums beginning as low as \$3 per week.

Dependable Guarantees

Guaranteed life insurance premium and death benefits last a lifetime.

Highly Competitive Rates

For the same premium, LifeTime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Fully Portable and Guaranteed Renewable for Life

Your coverage cannot be cancelled as long as premiums are paid as due.

Family Coverage

Coverage is available for your spouse, children and dependent grandchildren.

LifeTime Benefit Term Exclusions

If the insured commits suicide, while sane or insane, within two years (one year in some states) from the Date of Issue, and while this Coverage is in force, We will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Long Term Care Exclusions

We will not pay Long Term Care benefits for care that is received or loss incurred as a result of: 1) an intentionally self-inflicted injury, or attempted suicide; or 2) war or any act of war, declared or undeclared, or service in the armed forces of any country; or 3) treatment of the Insured's alcohol, drug or other chemical dependence, except if the drug dependency was sustained or acquired at the hands of a Physician, or except while under treatment for an injury or sickness; or 4) the Insured's participation in a riot or insurrection, or the commission of, or attempt to commit, a felony.

We will not pay Long Term Care benefits if the Confinement, Home Health Care services, or Adult Day Care service: 1) is received outside the United States and its territories; or 2) is provided by ineligible providers; or 3) is rendered by members of the Certificateholder's or the Insured's Immediate Family.

If you have questions about this product contact (855) 241-9891.

This document is a brief description of Form Nos. C34544 and P34544 (or applicable state version) and riders: Dependent Child=34546, Accelerated Death Benefit for Terminal Illness=34550, Long Term Care=34553 and Extension of Benefits=34554). Refer to your policy for specific details about benefits, exclusions and limitations.

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

1. Long-Term Support and Services Fact Sheet. AARP Public Policy Institute, March 2017, www.aarp.org
2. The 2018 Insurance Barometer Study. Life Happens, LIMRA

Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. This insurance product is underwritten by Combined Insurance Company of America, Chicago, IL, a Chubb company.

Chubb. Insured.SM

CWB-LBT-LTC75-HenricoCounty-0621



Meet with a Benefits Counselor to learn about valuable voluntary benefits including Chubb's LifeTime Benefit Term* and **\$10** per person** seen will be donated to Children's Hospital of Richmond at VCU.

No Purchase is Necessary for a Donation.



Helping Children's Hospitals Help More Children

* The LifeTime Benefit Term Product is underwritten and issued by Combined Insurance Company of America, a Chubb company.

** \$10.00 donation will apply to employees that have not reviewed Chubb's LifeTime Benefit Term product in the past. You must speak with a Benefit Counselor to review the LifeTime Benefit Term to qualify.



Help Your Children's Hospital

Benefits That Benefit Children is a cause marketing program that supports children's hospitals throughout the country. It was created by National Benefit Partners (NBP), an independent employee benefits distribution organization.

Benefits That Benefit Children provides donations to Children's Hospital Foundations when you meet with a benefit counselor to review Chubb's LifeTime Benefit Term product.

Become A
"Children's Champion."



How do I become a Children's Champion?

It's easy. Simply review the benefits provided with a Benefits Counselor and either purchase or decline to purchase on the enrollment system and that will trigger a **Benefits That Benefit Children** donation which is made to your local children's hospital foundation.

Chubb's LifeTime Benefit Term with Long Term Care is a part of the Benefits That Benefit Children program. For every employee that meets with a benefits counselor during open enrollment, \$10 will be raised and donated to Children's Hospital of Richmond at VCU. No purchase is necessary for the donation to be made. A donation will only be made for those employees who have not previously reviewed Chubb's LifeTime Benefit Term product and meets with a benefits counselor.

Why Children's Hospitals?



Children's Hospitals are community organizations that provide special attention and services for children's unique medical needs.

Children's Hospitals provide:

- Specialized health care for children – regardless of their ability to pay
- Ground-breaking research and treatment specifically designed for pediatrics
- An environment that allows children to be children despite their illnesses
- Special uncompensated services like: School, Library, Music Therapy, Play Areas and Special Events

Why "Benefits That Benefit Children?"

Benefits That Benefit Children is a unique cause marketing program that creates a winning combination for employees, and the health of children in the community.

- Employees receive an opportunity to learn about best-in-class voluntary benefits
- Children's Champions participation creates donations to children's hospitals that are funded by your broker, NBP and benefit providers
- Children's Champions participation creates awareness for the needs of the children's hospital and community





New for 2021!

LegalEASE and NortonLifelock are participating in Benefits That Benefit Children to help raise money for:



When an employee enrolls in either LegalEASE (\$1.00 per month) or NortonLifelock (\$0.90 per month) will be donated on behalf of Henrico County to the Children's Hospital of Richmond at VCU.

The donation will continue for as long as the employee maintains coverage and works for Henrico County.

Be fully prepared and confident with Legal Insurance



Legal Insurance Plan proudly offered to the employees of Henrico County



Protect your family's future with LegalEASE.

LegalEASE offers valuable benefits to shield your family and savings from unexpected personal legal issues.

What you get with a LegalEASE plan:

- An attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In- and out-of-network coverage
- Concierge help navigating common individual or family legal issues

Enroll in the LegalEASE Insurance Plan.

To learn more:

Call: 1(800) 248-9000

Visit: www.legaleaseplan.com/henrico



A legal insurance plan can ease the biggest stresses - finding and paying for legal expertise when you need it most.

LegalEASE offers an insurance plan that provides support and protection from unexpected personal legal issues.

Plan Details:

**\$17.44 monthly,
via payroll deduction**

Who's covered:

Employee

Spouse

Dependent Children
Up to age 26

The value of a LegalEASE insurance plan.

Being a member saves costly legal fees and provides coverage for:



HOME & RESIDENTIAL

Purchase of Primary Residence, Sale of Primary Residence, Refinancing of Primary Residence, Vacation or Investment Home Sale/Purchase/Refinancing, Tenant Dispute, Tenant Security Deposit Dispute, Landlord Dispute with Tenant, Security Deposit Dispute with Tenant, Construction Defect Dispute, Neighbor Dispute, Noise Reduction Dispute, Foreclosure



FINANCIAL & CONSUMER

Debt Collection: Pre-litigation Defense & Trial Defense, Bankruptcy (Chapter 7 or 13), Tax Audits, Student Loan Refinancing/Collection Defense, Document Preparation, Consumer Dispute, Small Claims Court, Financial Advisor, Mail Order or Internet Purchase Dispute, Bank Fee Dispute, Cell Phone Contract Dispute, Warranty Dispute, Healthcare Coverage Disputes and Records, Identity Theft Defense



AUTO & TRAFFIC

Traffic Ticket, Serious Traffic Matters (Resulting in Suspension or Revocation of License), Administrative Proceeding (Regarding Suspension or Revocation of License), First-time Vehicle Buyer, Vehicle Repair and Lemon Law Litigation, DUI/DWI Defense



FAMILY

Separation, Divorce, Post-Divorce Proceedings, Prenuptial Agreement, Name Change, Guardianship/Conservatorship, Adoptions, Juvenile Court Proceedings



ESTATE PLANNING & WILLS

Will or Codicil, Living Will, Health Care Power of Attorney, Living Trust Document, Probate of Small Estate



GENERAL

Civil Litigation Defense, Incompetency Defense, Initial Law Office Consultation, Review of Simple Documents, Discounted Contingency Fees, Mediation, Misdemeanor Defense, Identity Theft Assistance

Limitations apply. Please visit <https://www.legaleaseplan.com/henrico> for specific plan benefits.



For more information, visit:

<https://www.legaleaseplan.com/henrico>



To learn more, call:

1(800) 248-9000 and reference "Henrico County"



Limitations and exclusions apply. This benefit summary is intended only to highlight benefits and should not be relied upon to fully determine coverage. More complete descriptions of benefits and the terms under which they are provided are received upon enrolling in the plan. Group legal plans are administered by Legal Access Plans, L.L.C. or LegalEASE Home Office: 5151 San Felipe, Suite 2300, Houston, TX. This legal plan may not be regulated as insurance in some states, but is available in all states. Underwritten by Virginia Surety Company in all states except where underwriting is not required but the product is available. Please contact LegalEASE for complete details.
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Opt-in to Cyber Safety

No one intends to be unsafe online. Help protect your identity and devices with Norton LifeLock Benefit Plans. Let us help you empower you and your family to live your digital lives safely.



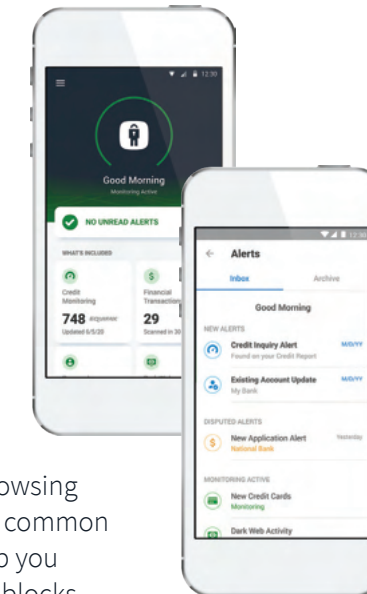
Device Security

Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware.



Online Privacy

Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.¹



Screen modified for demonstration purposes. Features may differ depending on plan.



Identity

We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.[†]



Home & Family

Take action to monitor your child's online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

¹ No one can prevent all identity theft or cybercrime.

[†] We do not monitor all transactions at all businesses.

¹ Norton Cloud Backup, Norton SafeCam, Norton Family, and Norton Parental Control features are not supported on Mac, Windows 10 in S mode, and Windows running on ARM processor.

	Benefit Essential	Benefit Premier
Identity		
LifeLock Identity Alert™ System ¹	●	●
• Identity Verification Monitoring ^{1,2}	●	●
• Telecom & Cable Applications for New Service	●	●
• Payday - Online Lending Alerts ³	●	●
• Credit Alerts & Social Security Alerts ⁴	●	●
Dark Web Monitoring ⁵	●	●
Home Title Monitoring	●	●
USPS Address Change Verification	●	●
Stolen Wallet Protection	●	●
Social Media Monitoring ⁶	●	●
Data Breach Notifications	●	●
Bank & Credit Card Activity Alerts ^{1,7}	●	●
Checking & Savings Account Application Alerts ^{1,8}	●	●
Bank Account Takeover Alerts ^{1,9}	●	●
401k & Investment Account Activity Alerts ^{1,10}	●	●
Prior Identity Theft Remediation ⁹	●	●
<small>This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.</small>		
U.S.-based Identity Restoration Specialists	●	●
24/7 Live Member Support	●	●
Million Dollar Protection™ Package ¹¹		
• Stolen Funds Reimbursement	Up to \$1 Million each	Up to \$1 Million each
• Personal Expense Compensation		
• Coverage for Lawyers and Experts		
Credit Application Alerts ^{2,12}	One-Bureau ¹	One-Bureau ¹
Credit Monitoring ^{1,13}	One-Bureau ¹	Three-Bureau ¹
Annual Credit Reports & Credit Scores ^{1,14}		On Demand – Three-Bureau ¹
<small>The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.</small>		
• Identity Lock ^{1,15}	●	●
Monthly Credit Score Tracking ^{1,16}		One-Bureau ¹
<small>The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.</small>		
Credit, Bank & Utility Account Freezes ¹⁷	●	●

	Benefit Essential	Benefit Premier
Device Security		
Secures PCs, Mac & mobile devices ¹⁸	Up to 3 devices (Family gets 6 devices)	Up to 5 devices (Family gets 10 devices)
Online Threat Protection ¹⁹	●	●
Password Manager ²⁰	●	●
Smart Firewall ²¹	●	●
Cloud Backup ²²	10 GB	50 GB
Home & Family		
Parental Control ²³	●	●
Online Privacy		
Norton Secure VPN ²⁴	●	●
Privacy Monitor	●	●
SafeCam ²⁵	●	●

Benefit Plan - Monthly Rates	Benefit Essential	Benefit Premier
👤 Employee Only (18+ Years Old)	\$4.99	\$9.49
👤👤 Employee + Family ⁴	\$9.98	\$18.98

¹ If your plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU. If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful plan enrollment. Please note that in order to enjoy all features in your chosen plan, such as bank account alerts, credit monitoring, and credit reports, it may require additional action from you and may not be available until completion.

² If your plan includes One Bureau Credit Application Alerts, two requirements must be met to receive said features: (i) your identity must be successfully verified with TransUnion; and (ii) TransUnion must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE ONE BUREAU CREDIT APPLICATION ALERTS. One Bureau Credit Application Alerts will take several days to begin after your successful LifeLock plan enrollment.

³ Norton Cloud Backup, Norton SafeCam, Norton Family, and Norton Parental Control features are not supported on Mac, Windows 10 in S mode, and Windows running on ARM processor.

⁴ Norton Family and Norton Parental Control can only be installed and used on a child's Windows PC, iOS and Android devices but not all features are available on all platforms. Parents can monitor and manage their child's activities from any device – Windows PC, Mac, iOS and Android – via our mobile apps, or by signing into their account at my.Norton.com and selecting Parental Control via any browser.

⁵ Locking or unlocking your credit file does not affect your credit score and does not stop all companies and agencies from pulling your credit file. The credit lock on your TransUnion file will be unlocked if your subscription is downgraded or cancelled.

⁶ The LifeLock alert network includes a variety of product features and data sources. Although it is very extensive, our network does not cover all transactions at all businesses, so you might not receive a LifeLock alert in every single case.

⁷ The LifeLock Benefit Junior plan is for minors under the age of 18. LifeLock enrollment is limited to employees and their eligible dependents. Eligible dependents must live within the employee's household, or be financially dependent on employee. LifeLock services will only be provided after receipt and applicable verification of certain information about you and each family member. Please refer to employer group for the required information under your plan. In the event you do not complete the enrollment process for any family member, those individuals will not receive LifeLock services, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete enrollment. If you do not complete the enrollment process for each family member, you may continue to pay more for LifeLock services than you otherwise would if you had selected a lower tier plan.

⁸ Reimbursement and Expense Compensation, each with limits of up to \$1 million for LifeLock with Norton Benefit Essential and LifeLock with Norton Benefit Premier and up to \$1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: NortonLifeLock.com/legal.

⁹ Does not include monitoring of chats or direct messages.

¹⁰ These features are not enabled upon enrollment. Member must take action to activate this protection.

¹¹ Subject to eligibility requirements defined in [Terms & Conditions](#). NortonLifeLock reserves the right to change and/or cease services at any time.

No one can prevent all identity theft or cybercrime.

Not all products, services and features are available on all devices or operating systems. System requirement information on Norton.com.

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→ YES! I WOULD LIKE TO KEEP MY COVERAGE. ←

To avoid losing coverage due to termination of employment or other losses of eligibility, employees and covered dependents may continue certain benefits. The following chart lists the continuation options.

Coverage	Option	Remarks
Transamerica: Cancer Insurance	Direct Bill	You will receive a continuation package from Transamerica on how to continue your policy on direct bill. If you have questions you may call 888-763-7474
Chubb: LifeTime Benefit Term Insurance	Direct Bill	Call Pierce Insurance Agency 800-421-3142
Aflac Group: Accident Insurance	Direct Bill	Call customer service at 800-433-3036 and request a port packet to arrange for direct bill.
Aflac Group: Critical Illness Insurance	Direct Bill	Call customer service at 800-433-3036 and request a port packet to arrange for direct bill.
Aflac Group: Hospital Indemnity	Direct Bill	Call customer service at 800-433-3036 and request a port packet to arrange for direct bill.
LegalEASE: Group Legal Plan	Direct Bill	You will receive a continuation package from LegalEASE on how to continue your policy on direct bill. If you have questions call 800-421-3142.
Norton LifeLock: Identity Theft Protection	Direct Bill	You will receive a continuation package from LifeLock on how to continue your policy on direct bill. If you have questions call 800-421-3142.



County of Henrico
General Government



BENEFITS AVAILABLE:

-  Group Accident
-  Cancer
-  Group Critical Illness
-  Group Hospital Indemnity
-  Life Insurance with Long Term Care
-  Legal Plan **NEW**
-  Identity Theft Protection **NEW**

**ACCESS YOUR BENEFITS
ANYTIME & ANYWHERE**

pierceins.com/henrico
800-421-3142

263428R1 09/21

arranged by:
**PIERCE
INSURANCE**
Employee Benefits Specialists