CITY OF FORT LAUDERDALE

STRONG. HEALTHY. PREPARED.

United On Our Wellness Journey

Voluntary Benefits Guide

2023

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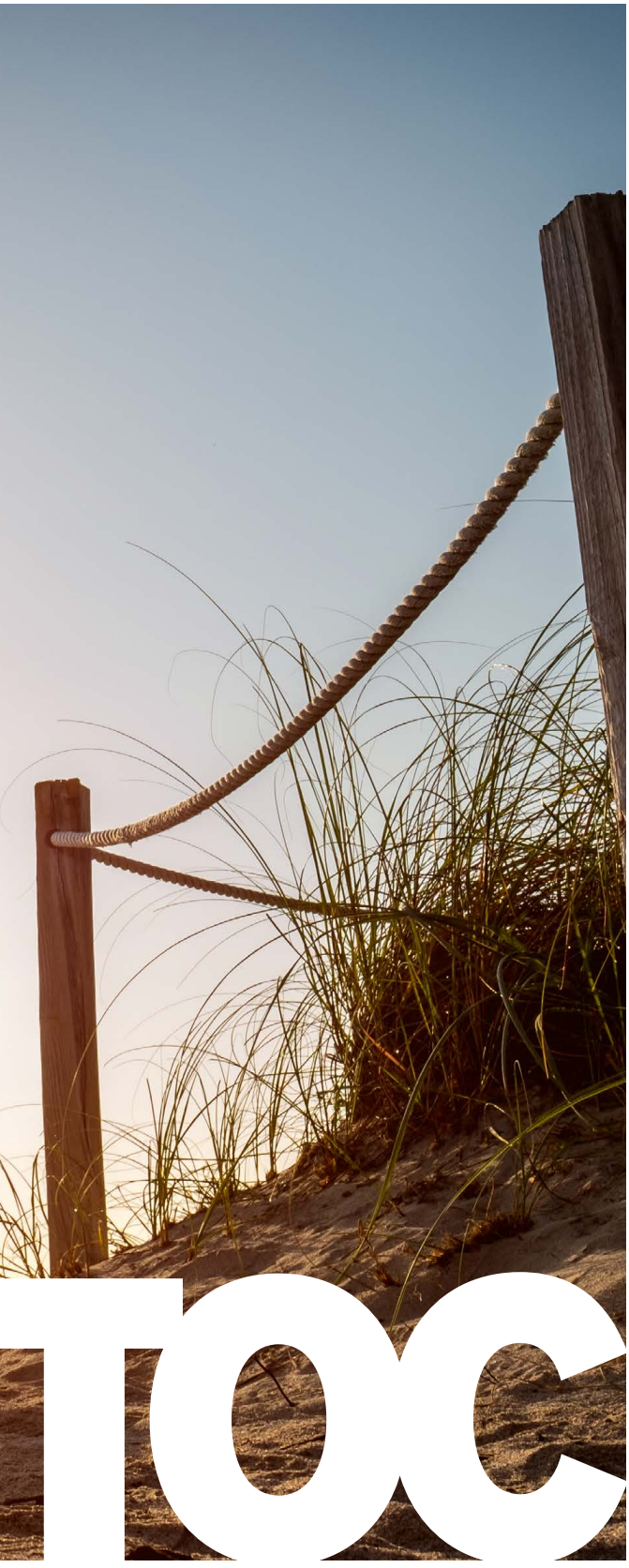

Schedule your enrollment appointment now
cofl.fbmcbenefits.com

SCAN ME

LET'S GET STARTED

Reminders

- **This year is a passive enrollment, meaning if you are currently enrolled in any of the Voluntary Benefits and do not wish to make any changes, your current Voluntary Benefits will automatically rollover to the 2023 Plan Year. You must enroll if you wish to make changes or begin new coverage.**
- Canceling or changing your pre-tax benefits can only be done during Open Enrollment or if you experience a mid-year qualifying life event. If you experience a Qualified Life Event (QLE) (as defined by the Internal Revenue Code (IRC)), you will need to complete an election change via the Selerix BenSelect portal within 30 days.
- **The following Voluntary Benefits will be offered on a guarantee issue* basis:**

1. Aflac Group Accident Insurance
2. Aflac Group Critical Illness Insurance
3. Aflac Group Hospital Indemnity Insurance
4. Aflac Group Short Term Disability Insurance

* Guarantee issue plans do not require any information about your health status, including information on pre-existing conditions, in order to qualify for these benefits.

What are Voluntary Benefits?

Voluntary Benefits help fit your specific insurance needs and desires. Whether it's a hospital visit due to a broken bone or offering salary compensation in case you cannot work, voluntary benefits add coverage to your overall insurance. In addition to saving money with a plan in place, voluntary benefits are typically offered through an employer at preferred rates not available to individuals on their own. This means going through an employer for Accident Insurance will generally be less expensive than seeking that type of insurance individually. Last but not least, these plans have the added benefit of paying premiums directly through payroll deduction.

Who Is Eligible for Coverage?

The City of Fort Lauderdale offers voluntary benefits to all benefits eligible active full-time employees. These are optional benefit plans that are paid 100% by the employee.

How to Enroll or Make Changes

Self-Enroll with Selerix BenSelect

Complete and submit your 2023 benefit selections through the online enrollment platform Selerix BenSelect. The City of Fort Lauderdale Employee Self-Service website is available at **www.benselect.com/enroll.** Self-enrollment requires your employee ID and a four digit PIN (All pins have been reset to a 4-digit default pin, which is your 2-digit birth month and the last two digits of your birth year.) For more details on how to enroll, please see your Employee Open Enrollment newsletter.

- Post-tax voluntary benefits can be canceled without a QLE. via the Selerix BenSelect portal. Please note you cannot re-enroll unless you experience a QLE or during the following open enrollment.

Make An Appointment

At any time during Open Enrollment, you can speak with a Professional Benefits Counselor/Enroller to enroll in voluntary and core benefit offerings. If you wish to speak with a Professional Benefits Counselor/Enroller, they will be available to meet with you face-to-face or telephonically. To ensure a convenient and timely enrollment process, **Professional Benefits Counselors/ Enrollers will only be available by appointment.**

During your appointment the Professional Benefits Counselor/Enroller will:

- Provide education on core and voluntary benefits
- Answer any questions you may have about different benefit plans
- Assist you with making a decision on benefits that best suit your needs

AFLAC GROUP ACCIDENT INSURANCE

Policy Number 24781

What is Accident Insurance?

Accident insurance helps cover out-of-pocket costs related to unexpected injuries like a broken arm or a severe burn. This type of insurance provides benefits for initial care, hospitalization, and follow-up care due to covered accidents. Benefits are paid directly to the employee (unless otherwise assigned), regardless of any other coverage employees have.

Aflac Accident Insurance

Aflac Accident Insurance pays you cash benefits for injuries relating to covered accidents for hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as: dismemberment, dislocation, fracture, ambulance services, physical therapy, and more. The lump-sum cash benefits can be used to help pay for deductibles, treatment, rent, and other needs as they are used at your discretion. By using Aflac Accident Insurance you can:

- Continue to help protect your savings, retirement plans, and 401(a) from depletion
- Help protect your home by paying for the mortgage, continue rental payments, or perform needed home repairs for your after care
- Keep up with your family's living expenses such as bills, electricity, and gas

For more information on the limitations and exclusions of this plan, please see plan certificate.

Plan Features

- Coverage for injuries on or off the job
- Guaranteed issue – No medical questions
- Level premiums – Rates do not increase with age
- No limitations for preexisting conditions
- $50 annual wellness benefit (available for all insured twice per calendar year)
- Benefits are paid regardless of any other medical insurance
- You may continue your coverage – Employees can continue coverage if they terminate or retire, provided the master group contract is in effect (see certificate for complete details)

Premium Rates (pre-tax)

COVERAGE	BI-WEEKLY PREMIUM
Employee	$8.01
Employee & Spouse	$13.38
Employee & Child(ren)	$16.88
Family	$22.25

Wellness Benefit

A $50 benefit is payable for the following wellness tests performed as a result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable twice per calendar year per insured.

- Annual physical exams
- Flexible Sigmoidoscopy
- Mammograms
- PSA Tests
- Pap Smears
- Ultrasounds
- Eye Examinations
- Blood Screening
- Immunizations

AFLAC GROUP ACCIDENT INSURANCE

Plan Benefits

INITIAL ACCIDENT TREATMENT CATEGORY - HIGH	EMPLOYEE	SPOUSE	CHILD
Initial Treatment - within 7 days of the accident, once per accident			
ER/Urgent Care	$200	$200	$200
ER/Urgent Care with X-Ray	$250	$250	$250
Doctor's Office	$100	$100	$100
Doctor's Office with X-Ray	$150	$150	$150
Ambulance - within 90 days of the accident, once per day, no maximum number of payments per accident			
Ground	$400	$400	$400
Air	$1,200	$1,200	$1,200
Major Diagnostic Testing - within six months of the accident Maximum of 1 diagnostic test per accident	$200	$200	$200
Emergency Room Observation - within 7 days of the accident, no maximum number of 24-hour observation periods per accident			
Short Observation Period (4-24 Hours)	$50	$50	$50
Long Observation Period (24+ Hours)	$100	$100	$100
Prescriptions - within six months of the accident Maximum of 2 filled prescriptions per accident	$5	$5	$5
Pain Management - within six months of the accident, 1 payment	$100	$100	$100
Blood/Plasma/Platelets - within six months of the accident Maximum of 3 days per accident	$200	$200	$200
Concussion - within six months of the accident, 1 payment	$500	$500	$500
Traumatic Brain Injury - within six months of the accident, 1 payment	$5,000	$5,000	$5,000
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a result of a covered accident	$10,000	$10,000	$10,000
Burns - within 6 months of the accident, 1 payment			
Second Degree Burns			
Less than 10%	$100	$100	$100
At least 10%, but less than 25%	$200	$200	$200
At least 25%, but less than 35%	$500	$500	$500
35% or more	$1,000	$1,000	$1,000
Third Degree Burns			
Less than 10%	$1,000	$1,000	$1,000
At least 10%, but less than 25%	$5,000	$5,000	$5,000
At least 25%, but less than 35%	$10,000	$10,000	$10,000
35% or more	$20,000	$20,000	$20,000

AFLAC GROUP ACCIDENT INSURANCE

Plan Benefits

INITIAL ACCIDENT TREATMENT CATEGORY - HIGH	EMPLOYEE	SPOUSE	CHILD
Emergency Dental Work - once per accident, within 6 months of the accident			
Repair with Crown	$200	$200	$200
Extraction	$50	$50	$50
Eye Injury - Removal of a foreign body	$250	$250	$250

Dislocations - once per accident, within 90 days of the accident

Dislocation	Open Reduction			Closed Reduction		
	EMPLOYEE	SPOUSE	CHILD	EMPLOYEE	SPOUSE	CHILD
Hip	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Knee	$3,900	$3,900	$3,900	$1,950	$1,950	$1,950
Shoulder	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Foot/Ankle	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Hand	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050
Lower Jaw	$1,800	$1,800	$1,800	$900	$900	$900
Wrist	$1,500	$1,500	$1,500	$750	$750	$750
Elbow	$1,200	$1,200	$1,200	$600	$600	$600
Finger/Toe	$480	$480	$480	$240	$240	$240

Fracture - once per covered accident, within 90 days of the accident

Fracture	Open Reduction			Closed Reduction		
	EMPLOYEE	SPOUSE	CHILD	EMPLOYEE	SPOUSE	CHILD
Hip/Thigh	$8,000	$8,000	$8,000	$4,000	$4,000	$4,000
Pelvis	$7,200	$7,200	$7,200	$3,600	$3,600	$3,600
Vertebrae/Sternum	$6,400	$6,400	$6,400	$3,200	$3,200	$3,200
Skull (Depressed)	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Leg	$4,800	$4,800	$4,800	$2,400	$2,400	$2,400
Forearm/Hand/Wrist	$4,000	$4,000	$4,000	$2,000	$2,000	$2,000
Foot/Ankle/Kneecap	$4,000	$4,000	$4,000	$2,000	$2,000	$2,000
Shoulder Blade/Collar Bone	$3,200	$3,200	$3,200	$1,600	$1,600	$1,600
Lower Jaw	$3,200	$3,200	$3,200	$1,600	$1,600	$1,600
Skull (Simple)	$2,800	$2,800	$2,800	$1,400	$1,400	$1,400
Upper Arm/Upper Jaw	$2,800	$2,800	$2,800	$1,400	$1,400	$1,400
Facial Bones (except teeth)	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Vertebral Processes/Sacrum	$1,600	$1,600	$1,600	$800	$800	$800
Coccyx/Rib/Finger/Toe	$640	$640	$640	$320	$320	$320

AFLAC GROUP ACCIDENT INSURANCE

Plan Benefits

INITIAL ACCIDENT TREATMENT CATEGORY - HIGH	EMPLOYEE	SPOUSE	CHILD
Lacerations - once per accident, within 7 days of the accident			
Lacerations requiring stitches			
Under 5 centimeters	$100	$100	$100
5 to 15 centimeters	$400	$400	$400
Over 15 centimeters	$800	$800	$800
Lacerations not requiring stitches	$50	$50	$50
Outpatient Surgery and Anesthesia (per day) - within 1 year of the accident			
Performed in a Hospital or Ambulatory Surgical Center No maximum number of payments per covered accident	$400	$400	$400
Performed in a Doctor's Office, Urgent Care Facility or Emergency Room Maximum of 2 payments per covered accident	$50	$50	$50
Facilities Fee for Outpatient Surgery - within one year of the accident Payable once per each Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center). Maximum of 5 payments per covered accident	$100	$100	$100
Inpatient Surgery and Anesthesia (per day) - within one year of the accident No maximum number of payments per covered accident	$1,000	$1,000	$1,000
Transportation - within 6 months of the accident Maximum of 3 payments per covered accident, Minimum of 100 Miles Distance Required			
Plane	$500	$500	$500
Any ground transportation	$200	$200	$200
(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.)			

HOSPITAL CATEGORY - HIGH	EMPLOYEE	SPOUSE	CHILD
Hospital Admission (per confinement) - once per accident, within six months of the accident Maximum number of admissions per covered accident: 1	$1,250	$1,250	$1,250
Hospital Confinement (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 365	$300	$300	$300
Hospital Intensive Care (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 30	$400	$400	$400
Intermediate Intensive Care Step-Down Unit (per day) - within six months of the accident Maximum days of confinement per covered accident: 30	$200	$200	$200
Family Member Lodging (per day) - within six months of the accident Maximum days of lodging per covered accident: 30 Minimum Required Distance (miles): 100	$200	$200	$200

AFLAC GROUP ACCIDENT INSURANCE

Plan Benefits

AFTER CARE CATEGORY - HIGH	EMPLOYEE	SPOUSE	CHILD
Appliances - within 6 months of the accident *No Maximum number of appliances per covered accident*			
Cane	$40	$40	$40
Ankle Brace	$40	$40	$40
Walking Boot	$100	$100	$100
Walker	$100	$100	$100
Crutches	$100	$100	$100
Leg Brace	$100	$100	$100
Cervical Collar	$100	$100	$100
Wheelchair	$400	$400	$400
Knee Scooter	$400	$400	$400
Body Jacket	$400	$400	$400
Back Brace	$400	$400	$400
Accident Follow-Up Treatment - within 6 months of the accident			
Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$50	$50	$50
Post Traumatic Stress Disorder (PTSD) - once per accident, within 6 months of the accident	$200	$200	$200
Rehabilitation Unit (per day) Maximum number of days per confinement: 31 No more than 62 days total per calendar year for each insured	$100	$100	$100
Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 10	$50	$50	$50
Chiropractic or Alternative Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$30	$30	$30
LIFE-CHANGING EVENTS CATEGORY - HIGH	**EMPLOYEE**	**SPOUSE**	**CHILD**
Dismemberment - once per accident, within 6 months of the accident			
Single Loss Double Loss Loss of one or more fingers or toes Partial Dismemberment (includes at least one joint of a finger or toe)	$12,500 $25,000 $1,250 $125	$5,000 $10,000 $500 $125	$2,500 $5,000 $250 $125
Paralysis - once per accident, diagnosed by a doctor within 6 months of the accident			
Paraplegia Quadriplegia	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000
Prosthesis - once per accident Maximum number of prosthetic devices per covered accident: 2	$3,000	$3,000	$3,000
Prosthesis Repair/Replacement - once per prosthetic device, within three years of initial Prosthesis payment	$3,000	$3,000	$3,000
Residence/Vehicle Modification - once per accident, within one year of the accident	$2,000	$2,000	$2,000

AFLAC GROUP ACCIDENT INSURANCE

Limitations and Exclusions

Benefits will not be paid 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 semiprofessional capacity for pay or profit.
- 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.
  - 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.
- 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.

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.

You May Continue Your Coverage

Your coverage may be continued with certain stipulations.

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.

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Number 24781

Ready For Anything

Group Critical Illness Insurance pays you cash benefits to help cover critical illness costs as you see fit. Aflac's Critical Illness Insurance plan means that you will have added financial resources to help with medical costs or ongoing living expenses. You can use funds to help pay for procedures, specialized treatment costs, transportation needs, child care, or anything in-between. Some critical illnesses covered by the plan include:

- Heart attack
- Stroke
- Major human organ transplant
- End-stage renal failure
- Coma
- Paralysis
- Cancer (Internal or Invasive)
- Bone Marrow Transplant
- Sudden Cardiac Arrest
- Severe Burn
- Loss of Sight/Speech/Hearing
- Coronary Artery Bypass Surgery
- Non-Invasive Cancer

The covered conditions must be caused by underlying diseases as defined in the plan.

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

Optional Benefits Rider
(Inclusive in the plan)

Benign Brain Tumor

Advanced Alzheimer's Disease

Advanced Parkinson's Disease

Aflac's Group Critical Illness Insurance Benefit Highlights

- Guarantee issue benefit amounts of up to $30,000 for employee and $15,000 for spouse
- Child coverage is 50% of employee amount
- Child coverage is included in employee cost (no additional premium)
- Rates are based on attained age
- Coverage may be continued (see certificate for details)
- Skin Cancer – $250 (once per calendar year/insured)
- No preexisting condition exclusion

Health Screening Benefit

The Health Screening Benefit is payable once per calendar year for health screening tests performed as a 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. See the certificate for a list of covered health screening tests.

- **$50 annual health screening benefit** (not payable for dependent children)

Additional Benefits

Benefits for burns are only payable for burns due to, caused by, or attributed to, a covered accident.

Benefits for Coma, Paralysis, and Loss of Sight, Hearing, or Speech are payable for loss due to a covered underlying disease or a covered accident.

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Premium Rates (pre-tax)

EMPLOYEE NON-TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	$10,000	$20,000	$30,000
18-25	$1.83	$3.01	$4.19
26-30	$2.33	$4.02	$5.70
31-35	$2.66	$4.67	$6.68
36-40	$3.38	$6.11	$8.85
41-45	$4.03	$7.41	$10.80
46-50	$4.77	$8.88	$13.00
51-55	$7.23	$13.82	$20.40
56-60	$7.05	$13.46	$19.86
61-65	$14.28	$27.91	$41.55
66+	$25.08	$49.50	$73.93

SPOUSE NON-TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	$5,000	$10,000	$15,000
18-25	$1.24	$1.83	$2.42
26-30	$1.49	$2.33	$3.18
31-35	$1.66	$2.66	$3.67
36-40	$2.02	$3.38	$4.75
41-45	$2.34	$4.03	$5.72
46-50	$2.71	$4.77	$6.82
51-55	$3.94	$7.23	$10.52
56-60	$3.85	$7.05	$10.26
61-65	$7.47	$14.28	$21.10
66+	$12.86	$25.08	$37.29

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Premium Rates (pre-tax)

EMPLOYEE TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	$10,000	$20,000	$30,000
18-25	$2.36	$4.07	$5.79
26-30	$3.05	$5.46	$7.86
31-35	$3.75	$6.86	$9.96
36-40	$5.00	$9.34	$13.69
41-45	$5.97	$11.29	$16.61
46-50	$7.10	$13.54	$19.99
51-55	$11.05	$21.46	$31.86
56-60	$11.17	$21.68	$32.20
61-65	$22.12	$43.58	$65.05
66+	$38.02	$75.40	$112.77

SPOUSE TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	$5,000	$10,000	$15,000
18-25	$1.51	$2.36	$3.22
26-30	$1.85	$3.05	$4.26
31-35	$2.20	$3.75	$5.30
36-40	$2.82	$5.00	$7.17
41-45	$3.31	$5.97	$8.63
46-50	$3.87	$7.10	$10.32
51-55	$5.85	$11.05	$16.25
56-60	$5.91	$11.17	$16.43
61-65	$11.38	$22.12	$32.85
66+	$19.34	$38.02	$56.71

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Limitations and Exclusions

All limitations and exclusions that apply to the plan also apply to the riders unless amended by the riders. The plan is age-banded. That means your rates may increase on the policy anniversary date (January 1st).

Cancer Diagnosis Limitation Benefits are payable for cancer and/or noninvasive 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:

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

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

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

Terms You Need to Know

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

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

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

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by:

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

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

Cancer (internal or invasive) also includes:

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

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging
  - Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

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

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

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit. Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging
  - These conditions are not payable under the Cancer (internal or invasive) Benefit. Cancer, non-invasive cancer, or skin cancer must be diagnosed in one of two ways:
  - 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.

- Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
- A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
- Medical evidence exists to support the diagnosis, and
- A doctor is treating you for cancer or carcinoma in situ

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

Civil Union: In Washington DC, Civil Union is defined as a relationship similar to marriage that is recognized by law. In Illinois, a Civil Union is defined as a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

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

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples,or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).
- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place.

Dependent means your spouse or your dependent child.

Spouse is your legal wife or husband, (In Delaware, Illinois, Nevada, Oregon, or Washington DC - or a person who is in a legally recognized domestic partnership, civil union, or similar relationship with you), who is listed on your application.

Dependent children are your or your spouse's natural children, stepchildren, children of domestic partners, legally adopted children, or children placed for adoption, who are younger than age 26 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly dependent) on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days (in Indiana, 120 days) following the dependent child's 26th birthday.

- In South Dakota, this limit will not apply to any child who is incapable of self-sustaining employment and is chiefly dependent upon the insured for support and maintenance.
- In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.
- In New Mexico, coverage may be provided for the children of custodial and non-custodial parents.
- In Illinois, coverage of an unmarried dependent child who is underage 30 and who served in the military will not terminate if he/she is an Illinois resident, served as a member of the active or reserve components of any United States Armed Forces branch, and has received a release or discharge (other than a dishonorable discharge).

To be eligible for coverage, the eligible dependent must submit to us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

- In Louisiana, dependent children must be unmarried and may also include grandchildren who are in the legal custody of and residing with a grandparent. Regarding the Age 26 limit exception - we will not require proof of incapacity and dependency more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

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

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.
- In Montana, for purposes of treatment, you have full freedom of choice in the selection of any licensed physician, physician

assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, licensed social worker, psychologist, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse.
- In New Mexico, a doctor is also a practitioner of the healing arts.

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

- In South Dakota, a doctor who is your family member may treat you if that doctor is the only doctor in the area and acts within the scope of his or her practice.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:
- Son
- Daughter
- Mother
- Father
- Sister
- Brother

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

Domestic Partner:

In Washington DC, Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state or local domestic partner registry with you.

In Nevada, Domestic Partner is defined as a person who is party to a valid domestic partnership, has not terminated that domestic partnership, and meets the requisites for a valid domestic partnership.

In order to enter into a valid domestic partnership, it is necessary that the two persons register with the state of Nevada when it is established, by having previously furnished proof to the state of Nevada,that both persons have a common residence, neither person is married or a member of another domestic partnership, the two persons are not related by blood in a way that would prevent them from being married to each other in the state of Nevada, both persons are at least 18 years of age, and both persons are competent to consent to the domestic partnership. Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

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

Heart Attack (Myocardial Infarction) does not include:
- Any other disease or injury involving the cardiovascular system.
- Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:
- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal.

(In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.) Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic irreversible failure of both kidneys to function. Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:
- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

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

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:
- Bronchiectasis
- Cardiomyopathy
- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

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

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Pathologist is a doctor who is licensed:
- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy. A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

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

AFLAC GROUP CRITICAL ILLNESS INSURANCE

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

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

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

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging. Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:
  - Computed Axial Tomography (CAT scan) images, or
  - Magnetic Resonance Imaging(MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.
Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction). Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.
  - In Ohio, Unable to Work is defined as the inability to perform duties of any gainful occupation for which you are reasonably fitted by training, experience, and accomplishment.Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

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

Optional Benefits Rider
(Inclusive in the plan)

Date of Diagnosis is defined as follows:
Advanced Alzheimer's Disease: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.
Advanced Parkinson's Disease: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.
Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
Optional Benefit is one of the illnesses defined below and shown in the rider schedule:
Advanced Alzheimer's Disease means Alzheimer's Disease that causes the insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease.
To be incapacitated due to Alzheimer's Disease, the insured must: Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the insured to be incapacitated. Parkinson's Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the insured must:
Exhibit at least two of the following clinical manifestations:
Muscle rigidity

Tremor

Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and Require substantial physical assistance from another adult to perform at least three ADLs.

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

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor. Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:
Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment; Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs; Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment; Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment; Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment; Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

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.

individual guaranteed renewable policy.

Notice to Consumer: The coverages provided by Continental

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Policy Number 24781

What is Hospital Indemnity Insurance?

Hospital Indemnity Insurance offers cash benefits to help cover expenses associated with covered illnesses and accidents that confine you to a hospital. With cash paid directly to you, unless otherwise assigned, benefits can cover a range of out-of-pocket expenses like child care, groceries, utility bills, and more. Aflac's Hospital Indemnity Insurance is intended to enhance your current coverage as it is not affected by current personal coverage. It also provides coverage for newborn children for 60 days from their date of birth[1].

How it Works: Hospital Admission

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. The insurance will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. The insurance will not pay benefits for admission of a newborn child following their birth; however, the insurance will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he or she 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

Payable each day an insured person is confined to a hospital as an inpatient because of a covered accidental injury or a covered sickness. If the insured person becomes confined again within six months due to the same or related condition as the first confinement, Aflac will treat this confinement as the same period of covered injury/sickness. This benefit is payable for only one hospital confinement at a time even if the stay is caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.*

Hospital Intensive Care

Payable for each day that an insured person is confined in a hospital intensive care unit because of a covered accidental injury or a covered sickness. This benefit is payable in addition to the Hospital Confinement Benefit. Aflac will pay benefits for only one confinement in a hospital's intensive care unit at a time, even if it is caused by more than one covered accidental injury, more than one covered sickness or a covered accidental injury and a covered sickness. If benefits were fully paid out for one condition and an insured person becomes confined to a hospital's intensive care unit again within six months because of the same or related condition, Aflac will treat this confinement as the same period of injury/sickness.

Intermediate Intensive Care Step-Down Unit

Payable for each day that an insured person is confined in an intermediate intensive care step-down unit because of a covered accidental injury or a covered sickness. Aflac 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, more than one covered sickness or a covered accidental injury and a covered sickness. If the insured person becomes confined again within six months because of the same or related condition, Aflac will treat this confinement as the same period of injury/illness.

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

The insured person must be admitted to a hospital within six months of the date of the covered accident for benefits to be payable.

[1]Applies to newly adopted children as well. Refer to the plan for complete details

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Premium Rates (post-tax)

HOSPITAL INDEMNITY INSURANCE - MID	
Coverage	BI-WEEKLY Premium
Employee	$8.25
Employee & Spouse	$15.73
Employee & Child(ren)	$12.54
Family	$20.02

Plan Benefits

HOSPITALIZATION BENEFITS - MID	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	$1000
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	$100
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$100
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$75

Premium Rates (post-tax)

HOSPITAL INDEMNITY INSURANCE - HIGH	
Coverage	BI-WEEKLY Premium
Employee	$14.58
Employee & Spouse	$29.40
Employee & Child(ren)	$23.05
Family	$37.87

Plan Benefits

HOSPITALIZATION BENEFITS - HIGH	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	$2000
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	$200
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$200
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$100

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Limitations and Exclusions

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

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 (except in Illinois).
  - In Connecticut: a riot is not excluded.
  - In Oklahoma: War, or any act of war, declared or undeclared, when serving in the military, armed forces, or an auxiliary unit thereto. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
  - In Missouri, Montana, and Vermont: committing or attempting to commit suicide, while sane.
  - In Minnesota: this exclusion does not apply.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
  - In Missouri: injuring or attempting to injure oneself intentionally which is obviously not an attempted suicide.
  - In Vermont: injuring or attempting to injure oneself intentionally, while sane.
- 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.
  - In Connecticut: voluntarily participating in, committing, or attempting to commit a felony.
  - In Illinois: committing or attempting to commit a felony or being engaged in an illegal occupation.
  - In 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 Pennsylvania: committing or attempting to commit a felony, or being engaged in an illegal occupation.
  - In South Dakota: voluntarily committing a felony.
- 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.
  - In South Dakota: this exclusion does not apply.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- In Washington D.C. and Washington: Services related to 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.
- In Tennessee, or if the pregnancy was the result of rape or incest, or if the fetus is non-viable.
- 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

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

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.

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AFLAC SHORT-TERM DISABILITY INSURANCE

What is Short-Term Disability Insurance?

Short-Term Disability Insurance pays out a percentage of your salary if you become temporarily disabled. If you are unable to work for a short period of time, due to illness or injury that happens outside of work, benefits will be payable to help you. Benefits offer money for expenses that may come up because of medical treatment or ongoing living expenses. Coverage does not replace core health insurance as it is a limited benefit.

Short-Term Disability benefits begin after you meet the definition of disability and satisfy the waiting period. Benefit payments can continue while you are disabled up to the maximum benefit duration you select. Please refer to the Short-Term Disability brochure for the full plan and exclusion details.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one sickness, more than one injury, or a sickness and an injury. Aflac reserves the right to meet with the covered employee while a claim is pending, or to use an independent consultant and physician's statement to determine whether the covered employee is qualified to receive disability benefits.

Here's How Aflac Can Help

The financial obligations of not being able to work can be overwhelming. Disability insurance plays an integral and important role in your financial planning to help you keep your savings.

Aflac provides benefits for both total and partial disability. Even if you're able to work, partial disability benefits may be available to help compensate for lost income.

Aflac does not coordinate benefits with other companies. Regardless of any other disability insurance you may have, including Social Security, we will pay you directly.

Disability due to pregnancy and childbirth is a payable covered sickness. Disability benefits for childbirth will be payable only after the plan has been in force for nine months. The maximum period allowed for Disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to complications of pregnancy.

Why Aflac® Group Short-Term Disability is Best for You

Aflac's Group Short-Term Disability Insurance plan can help make the difference. It's a source of monthly income you may need to help take care of your bills while you take care of yourself. You choose the plan that's right for you based on your financial needs and income. Aflac offers an option for a 3-month, 6-month and 12-month plan of guaranteed-issue, Group Short-Term Disability coverage. **That means no health questions are required for coverages up to $4,000, with a maximum income replacement of 60% of salary for nonoccupational injuries, for all actively at work eligible employees.** Aflac pays you a cash benefit for each day you are disabled.

AFLAC SHORT-TERM DISABILITY INSURANCE

Guarantee Issue and You

- 3-month benefit duration with a 7/7-day elimination period;
- 6-month benefit duration with a 7/7-day elimination period; or
- 12-month benefit duration with a 90/90-day elimination period
- Guaranteed Issue up to $4,000 with no health questions asked for all actively at work eligible employees.

When to File a Claim

The plan considers you disabled if, due to a covered sickness or injury, you are unable to perform the material and substantial duties of your Full-Time Job (see plan for details).

Group Plan Benefits

COVERAGE OPTIONS - CUSTOMIZE THE POLICY YOU NEED	
Benefit	**Description**
Monthly Benefit Payment	$300 to $6,000 (subject to income requirements)
Guarantee Issue Amounts	Monthly benefit up to $4,000
Maximum Income Replacement	60% of the employee's base annual pay
Partial Disability Benefit Period	3, 6, or 12 months

Premium Rates (post-tax)

BI-WEEKLY PREMIUM PER UNIT ($100 OF MONTHLY BENEFIT)			
Age	7/7 EP† 3 Mo Period	7/7 EP 6 Mo Period	90/90 EP 12 Mo Period
18-49	$1.02	$1.26	$0.48
50-64	$1.02	$1.38	$0.66
65-74	$1.26	$1.74	$0.96

All benefits are subject to the Limitations and Exclusions, Preexisting Condition Limitations, and other plan terms.

† Elimination Period (EP): The period of time between the onset of a disability, and the time you are eligible for benefits.

AFLAC SHORT-TERM DISABILITY INSURANCE

Limitations and Exclusions

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

We will not pay benefits for loss caused by Pre-Existing Conditions (except as stated in the provision below).

We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot. War does not include acts of terrorism;
2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
3. An intentionally self-inflicted
4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated;
5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft;
6. Mental Illness as defined;
7. Alcoholism or drug addiction;
8. An Injury that arises from any employment;
9. Injury or Sickness that is covered by Worker's Compensation.

Pre-Existing Condition Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the Effective Date.

For a condition to have been Pre-existing a Doctor must have advised, diagnosed, or treated the covered employee, or symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

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.

We will not pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the 12-month period after the Effective Date.

We will not reduce or deny a claim for benefits for any Disability due to a pre-existing condition that was diagnosed more than 12 months after the Effective Date.

Pregnancy Limitation

Within the first nine months of the Effective Date of coverage, we will not pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth will be payable. The maximum Period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

Terms You Need to Know

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Benefit Period is the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of disability. Each new Benefit Period is subject to a new Elimination Period.

Complications of Pregnancy refers to:

Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are: 1. Acute nephritis; 2. Nephrosis; 3. Cardiac decompensation; 4. Missed abortion; 5. Disease of the vascular, hemopoietic, nervous, or endocrine systems; and 6. Similar medical and surgical conditions of comparable severity.

Further Complications of Pregnancy include:

1. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement;
2. Ectopic pregnancy that is terminated; and
3. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include the following conditions:

1. Multiple gestation pregnancy;
2. false labor;
3. occasional spotting; and
4. morning sickness.

Other similar conditions associated with the management of a difficult pregnancy are not considered Complications of Pregnancy. Cesarean deliveries are not considered Complications of Pregnancy. Effective Date is the date shown on the Certificate Schedule, provided you are actively at work, or if not, it is the date you are actively at work as an eligible employee.

AFLAC SHORT-TERM DISABILITY INSURANCE

Elimination Period is the number of continuous days at the beginning of your Period of Disability for which no benefits are payable. Each new Benefit Period is subject to a new Elimination Period.

Injury refers to a bodily injury not otherwise excluded that is directly caused by a covered accident, is not caused by Sickness, disease, bodily infirmity, or any other cause, and occurs while coverage is in force.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause.

Mental Illnesses and Emotional Disorders: includes but are not limited to the following bipolar

- bipolar affective disorder (manic-depressive syndrome),
- delusional (paranoid) disorders,
- psychotic disorders,
- somatoform disorders (psychosomatic illness),
- eating disorders,
- schizophrenia,
- anxiety disorders,
- depression,
- stress,
- post-partum depression,
- personality disorders, and
- adjustment disorders or other condition usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Partial Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job.

To qualify as Partial Disability: you are able to work at any job earning less than 80 percent of the Annual Income of your Full-Time Job at the time you became disabled.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition that is not caused by an Injury, first manifested and first treated after the Effective Date of coverage, and occurs while coverage is in force.

Termination Coverage will terminate on the earliest of:

- The date the master policy is terminated,
- The 31st day after the premium due date if the required premium has not been paid,
- The date you cease to meet the definition of an employee as defined in the master policy,
- The date you no longer belong to an eligible class,
- Reach the age of 75.

Total Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job.

To qualify as Total Disability:

- You may not be working at any job.

You and Your refers to an employee as defined in the Plan.

Portability

When you end employment with the employer and your coverage would otherwise terminate, you may elect to continue your coverage under the plan. You may continue the coverage that you had on the date your employment ended, including any in-force Spouse or Dependent Child coverage. The following conditions must be met for you to keep your certificate in force:

• Within 31 days after the date your insurance would otherwise terminate,you must notify the Company. Notification may be via written notice sent to P.O. Box 427, Columbia, South Carolina, 29202; or by calling the Customer Service number at 800.433.3036.

• You must pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter. Insurance will end on the earlier of these dates:

• 31 days after the date you fail to pay any required premium.

• The date the group policy is terminated.

However, coverage may not be continued if:

• You fail to pay any required premium, or

• The Group Policy terminates.

Notification of any changes in the plan will be provided directly to you.

ARAG LEGAL INSURANCE PLAN

Legal Is Everywhere

Life is full of legal situations. Some you plan for — like creating a will or buying a home — and others are more unexpected — like fighting a traffic ticket or getting your deposit back from a difficult landlord.

With legal insurance you can avoid paying *legal fees that on average cost $368 an hour. Legal insurance from ARAG® makes it affordable to get the legal help you need - as network attorney fees are 100% paid-in-full for most covered matters. The plan provides peace of mind knowing that attorney fees for most covered legal matters are taken care of when you work with a network attorney. Benefit from a wide range of coverage and services to protect your family and receive the peace of mind that comes with knowing you've got a place to turn for legal help.

Get Connected to Affordable, Professional Legal Help

When something in life comes with legal issues, ARAG will help you get connected to an attorney who is part of a nationwide network of more than 14,000 attorneys.

They can provide legal advice and counsel, make calls or write letters on your behalf, review and create documents, even represent you if needed. For additional details when something in life comes with legal issues, visit **ARAGlegal.com/myinfo** and enter Access Code 18107cfl to learn more about what these plans offer, research specific legal topics, and more.

Premium Rates (post-tax)

BI-WEEKLY PREMIUMS		
Coverage	UltimateAdvisor	UltimateAdvisor Plus
Family	$8.42	$10.15

*The national average hourly rate for attorneys with 11 to 15 years of experience is $368. "The Survey of Law Firm Economics: 2018 Edition." The National Law Journal and ALM Legal Intelligence, October 2018.

Pre-existing And Personal Legal Matters

For any legal matters not covered and not excluded, you may be eligible to receive a minimum 25% reduced fee off a network attorney's normal hourly rate.

Call for Questions or Legal Assistance

When you have a question about plan benefits or not sure what the next step is, call a specialist in our award-winning Customer Care Center. They can walk you through plan-specific coverage, offer next steps, and help you get connected with a local network attorney in your area. Call 800-247-4184 to speak with an ARAG Customer Care Specialist.

ARAG LEGAL INSURANCE PLAN

Plan Benefits

	UltimateAdvisor	UltimateAdvisor Plus
Civil Damage Claims (Defense)		
Civil Damage	✓	✓
Pet-Related Matters	✓	✓
Consumer Protection Issues		
Auto Repair	✓	✓
Buying a New or Used Vehicle	✓	✓
Consumer Fraud - New Benefit	✓	✓
Consumer Protection for Goods or Services	✓	✓
Home Improvement/Contractor Issues	✓	✓
Insurance Disputes	✓	✓
Criminal Matters		
Habeas Corpus	✓	✓
Juvenile Matters	✓	✓
Misdemeanor Matters		✓
Parental Responsibilities	✓	✓
Debt-Related Matters		
Bankruptcy (Chapter 7 & 13)	✓	✓
Debt Collection	✓	✓
Garnishment	✓	✓
Mechanic's Lien - Enhanced	✓	✓
Student Loan Debt Collection - Enhanced	✓	✓
Family Law		
Adoption	✓	✓
Alimony (up to 8 hours) - New Benefits		✓
Child Custody (up to 8 hours) - New Benefits		✓
Child Support (up to 8 hours) - New Benefits		✓
Child Visitation (up to 8 hours) - New Benefits		✓
Divorce/Annulment/Separation - Contested (up to 20 hours) - Enhanced	✓	✓
Divorce/Annulment/Separation - Uncontested	✓	✓
Domestic Violence/Restraining Order - New Benefit	✓	✓
Elder Law - New Benefit	✓	✓
Guardianship/Conservatorship	✓	✓
Incapacity	✓	✓
Name Change	✓	✓
Pre-marital Agreements	✓	✓
School Issues	✓	✓
Government Benefits		
Medicare/Medicaid Disputes	✓	✓
Social Security Disputes	✓	✓
Veterans Benefits Disputes	✓	✓

ARAG LEGAL INSURANCE PLAN

Plan Benefits (continued)

	UltimateAdvisor	UltimateAdvisor Plus
Landlord/Tenant Matters		
Contracts/Lease Agreements	✓	✓
Eviction	✓	✓
Security Deposits	✓	✓
Tenant Disputes with a Landlord	✓	✓
Real Estate (Primary & Secondary Residence has been added)		
Building Codes	✓	✓
Buying/Selling a Home	✓	✓
Easements	✓	✓
Foreclosure	✓	✓
Home Equity Loans	✓	✓
Neighbor Disputes	✓	✓
Real Estate Disputes	✓	✓
Refinance	✓	✓
Zoning/Variances/Eminent Domain	✓	✓
Small Claims Court		
Small Claims Court Issues	✓	✓
Tax Issues		
IRS Audit Protection	✓	✓
IRS Collection Defense	✓	✓
Property Tax (Primary & Secondary Residence)	✓	✓
State and Local Audit Protection	✓	✓
State and Local Collection Defense	✓	✓
Traffic Matters without DWI		
Drivers License Suspension, Revocation, Restoration	✓	✓
Traffic Tickets	✓	✓
Wills and Estate Planning		
Codicil	✓	✓
Complex Will	✓	✓
Durable/Financial Power of Attorney	✓	✓
Estate Administration (up to 9 hours)	✓	✓
Health Care Power of Attorney	✓	✓
Irrevocable Trust	✓	✓
Revocable Trust	✓	✓
Standard Will	✓	✓
General Coverages		
Credit Record Correction - New Benefit	✓	✓
Document Preparation (Deeds, Mortgages, Affidavits, Demand Letters, Promissory Notes, HIPAA Authorization, Bill of Sale)	✓	✓
Document Review	✓	✓
General In-Office Services (up to 4 hours per year)		✓
Personal Property Protection	✓	✓

ARAG LEGAL INSURANCE PLAN

Pre-existing and Personal Legal Matters Not Listed Above

For any legal matters not covered and not excluded, you may be eligible to receive at least 25% off the network attorney's normal rates.

For additional details regarding your plan's specifically-covered services, visit **ARAGlegal.com/myinfo** and enter Access Code 18107cfl.

Call for Questions or Legal Assistance

You can also get assistance from trusted professionals and an award-winning Customer Care Center, with specialists who will help you navigate your legal issues. Call 800-247-4184 for assistance. You'll benefit from the following services:

Plan Benefits (continued)

	UltimateAdvisor	UltimateAdvisor Plus
Other Services		
Call a network attorney who can provide legal advice and help you better understand your covered legal issues and how to address them. Plus, they can help you review or prepare documents, including a Standard Will.	✓	✓
Receive **Financial Education and Counseling Services** on a wide range of financial topics - cash and debt management, budgeting, retirement planning, student loan debt, and more - from a certified Financial Counselor.		✓
With **Immigration Services**, you can speak with a network attorney over the phone who can offer legal advice and consultation about the filing and processing of applications or petitions, assist with document review and preparation, provide guidance regarding immigration benefits, asylum, business visas, and much more.	✓	✓
Rely on **Identity Theft Services** provided by Customer Care Specialists who have earned the Certified Identity Theft Risk Management Specialist (CITRMS)* designation. They can guide you through the steps of prevention and are there to assist you in recovery if your identity is stolen.	✓	✓
Look to **Caregiving Services** including legal advice, annual check-up, reduced fee and CareScout services from Eldercare Specialists to assist you with your parents' and grandparents' everyday lives.		✓
With **Tax Services**, stress less about taxes - and the complicated legal and financial issues that often come with them - with this service that provides year-round access to experienced tax specialists.		✓

Visit **ARAGlegal.com/myinfo** and enter Access Code 18107cfl to learn more about what these plans offer, research specific legal topics, and more. Or call 800-247-4184 to speak with an ARAG Customer Care Specialist.

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits, or exclusions, call our toll-free number.

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal, and sometimes sensitive, information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect.

Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. **Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.**

FBMC's privacy statement is as follows:

I. **We collect only the customer information necessary to consistently deliver responsive services.**
FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

1. Information provided on enrollment and related forms, for example, name, age, address, Social Security number, email address, annual income, health history, marital status, and spousal and beneficiary information.
2. Responses from you and others, such as information relating to your employment and insurance coverage.
3. Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
4. Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. **Under federal law, you have certain rights with respect to your protected health information.**
You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. **We maintain safeguards to ensure information security.**
We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. **We limit how, and with whom, we share customer information.**
We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information as we otherwise would. The words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

BENEFITS PROVIDER DIRECTORY

Aflac®

Supplemental Benefits Provider

Columbia, SC

Group Accident, Short-Term Disability, Critical Illness & Hospital Indemnity

Customer Service: 1-800-433-3036

www.aflacgroupinsurance.com

www.myaflac.com

Individual Coverage is underwritten by Aflac. | WWHQ | 1932 Wynnton Rd | Columbus, GA 31999

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Group coverage is underwritten by Continental American Insurance Company (CAIC), a wholly-owned subsidiary of Aflac Incorporated. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. AGC1902199 R2 EXP 9/22

ARAG®

Legal Insurance Plan

500 Grand Avenue
Suite 100
Des Moines, IA 50309

1-800-247-4184

www.ARAGlegal.com/myinfo

and enter Access Code 18107cfl

FBMC BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Contact 1-866-849-COFL (2635)
cofl.fbmcbenefits.com

This guide does not contain a complete listing of all terms, conditions, or exclusions of the benefits listed herein, nor does it constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable. Please refer to the policy and/or certificate of coverage for more information.