Grand Traverse Pavilions
A COMMUNITY CARING FOR GENERATIONS

Grand Traverse Pavilions
Employee Benefit Guide 2021
January 1, 2021-December 31, 2021

pm Peterson McGregor
INSURANCE

2021 Employee Benefit Guide

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

MEDICAL

DENTAL

VISION

LIFE

VOLUNTARY

Pick the Best Benefits For You and Your Family

Grand Traverse Pavilions strives to provide a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits offered, so you can identify which offerings are best for you and your family.

The elections you make during open enrollment will become effective on 01/01/2021.

QUESTIONS? Please don't hesitate to reach out to the Human Resource Department.

Contents included in this document are as follows:

- Contact Information
- Plan Information
- Payroll Deductions
- Legislative Updates & Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see Important Notice from Grand Traverse Pavilions About Your Prescription Drug Coverage and Medicare for additional details..

The information in this guide applies to the Grand Traverse Pavilions Health and Welfare Plan, Plan number 501. This guide meets the requirements for a Summary of Material Modification as required by the Employee Retirement Security Income Act (ERISA). The company reserves the right to amend, modify, or terminate this Plan at any time and in any manner.

WHO IS ELIGIBLE FOR BENEFITS

Full time employees working a minimum of 30 hours per week, and their eligible dependents.

Eligible Dependents are defined as follows:

- Lawful spouse: The individual to whom you are legally married and who is not legally separated or divorced from you.

For Medical: Dependents who are less than 26 years old may be enrolled for coverage until the end of the year in which they turn 26 (married or unmarried). **For Dental:** Dependents who are less than 19 or 24 if a student, may remained enrolled until the end of the year they turn 19 or 24 respectively. **For Vision:** Dependents who are less than 26 years old may be covered until the end of the month they turn 26.

For New Hires: Coverage will begin on the 1st of the month following 60 days of employment.

STEPS OF OPEN ENROLLMENT

Review the benefit materials provided in your Enrollment packet.

After you have determined your benefit elections, you will need to enroll online through the BSwift portal.

OPEN ENROLLMENT PERIOD – November 16th-30th
OPEN ENROLLMENT MEETINGS –November 17th & 18th
EFFECTIVE DATE – 01/01/2021

Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change (see below).

MAKING CHANGES OUTSIDE OF OPEN ENROLLMENT

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Commencement or termination of adoption proceedings
- Change in your spouse's employment status or a change in coverage under another employer-sponsored plan

You have 30 days from the date of the qualifying event to notify HR of any changes that need to be made to your coverage.

We are committed to a comprehensive Employee Benefit Program that helps our employees stay healthy, feel secure, and maintain a work/life balance. We are excited about the benefit package available to our employees and we hope you are pleased with the plans available to you and your family!

Contact List for when you have questions or need assistance!

MEDICAL

Carrier:	Blue Care Network
Phone:	1-800-662-6667
Website:	www.bcbsm.com
Network List:	HMO
Group #:	00165637
ID Card:	Yes

DENTAL

Carrier:	Delta Dental
Phone:	1-800-542-0149
Website:	www.deltadentalmi.com
Network List:	PPO
Group #:	4984
ID Card:	No

VISION

Carrier:	EyeMed
Phone:	1-866-939-3633
Website:	www.eyemed.com
Network List:	EyeMed Insight
Group #:	1020002
ID Card:	Yes

LIFE AD&D

Carrier:	Unum
Phone:	1-800-275-8686
Website:	www.unum.com
Network List:	N/A
Group #:	0912779-001
ID Card:	No

AFLAC

Carrier:	AFLAC
Phone:	231-218-2391
Website:	www.aflac.com
Representative:	Joan McCormick
Email:	Joan_mccormick@us.aflac.com

FLEXIBLE SPENDING

Carrier:	TASC
Phone:	1-800-422-4661
Website:	www.tasconline.com
Network List:	N/A
Group #:	N/A
Debit Card:	Yes

PET INSURANCE

Carrier:	Nationwide
Phone:	1-877-738-7874
Website:	www.petinsurance.com/gtpavilions
Network List:	N/A
Group #:	N11048

PETERSON MCGREGOR INSURANCE

Joanna Fraser, Benefit Account Manager -Claims
(231)299-0448
jfraser@team-pma.com

Raquel Paulus, Employee Benefits Specialist-Sales
(231) 944-7030
rpaulus@team-pma.com

Payroll Deductions Chart

MEDICAL Option 1

Blue Care Network is our group medical plan provider. Please see benefit summary in BSwift for plan details.

Deductions per month
SINGLE: $35.93
DOUBLE: $653.20
FAMILY: $917.77

MEDICAL Option 2

Blue Care Network is our group medical plan provider. Please see benefit summary in BSwtft for plan details.

Deductions per month
SINGLE: $0.00
DOUBLE: $521.65
FAMILY: $753.31

MEDICAL Option 3

Blue Care Network is our group medical plan provider. Please see benefit summary in BSwift for plan details.

Deductions per month
SINGLE: $0.00
DOUBLE: $497.37
FAMILY: $722.96

DENTAL Base Plan

Delta Dental is our group dental plan provider. Please see benefit summary in BSwift for plan details.

Grand Traverse Pavilions pays 100% of the employee only rate for dental. Please contact Human Resources for cost information for double and family enrollments.

DENTAL High Plan

Delta Dental is our group dental plan provider. Please see benefit summary in BSwift for plan details.

Please contact Human Resources for cost information for the high plan.

VISION

EyeMed is our group vision plan provider. Please see benefit summary in BSwift for plan details.

Monthly Deduction Amounts
SINGLE: $6.84
DOUBLE: $12.99
FAMILY: $19.08

LIFE AD&D & VOLUNTARY

Unum is our group Life AD&D plan provider. Grand Traverse Pavilions is pleased to provide eligible employees with $5,000 in term life insurance. **This benefit is 100% paid for by Grand Traverse Pavilions.**

Unum is also our voluntary benefits provider. They offer a variety of voluntary plans you can enroll in such as short and long term disability.

For additional information please see the summaries posted in the BSwift portal.

AFLAC

AFLAC offers a variety of voluntary policies for you to purchase to protect your family from accident, critical illness and more.

For additional information please see the summaries posted in the BSwift portal.

Continued

Payroll Deductions Chart-Continued

FLEXIBLE SPENDING
TASC is our group flexible spending account provider. Please see benefit summary in BSwift for plan details.
Your cost for this benefit will depend on your annual election amount. Please see Human Resources for maximum contribution amount for 2021.

PET INSURANCE
Nationwide is our group pet insurance plan provider. Please see benefit summary in BSwift or plan details.
Your costs for this benefit will vary and depend on the plan selected, the number of pets enrolled and reimbursement level chosen.

MEDICAL

Each year Grand Traverse Pavilions analyzes our health care plan and sets renewal goals. We maintain a commitment to provide you and your dependents with a quality health care plan at an affordable cost. This year we are partnering with Blue Care Network to bring you the following options. Please review the information below to make the selection that works best for your family. The information below is a summary of your medical plans. For complete details please see the benefit summaries posted on the BSwift portal.

	Blue Care Network HMO Option 1	Blue Care Network HMO Option 2	Blue Care Network HMO Option 3
Deductible (Calendar Year)	In-Network	In-Network	In-Network
Single	$500	$1,500	$1,500
Family	$1,000	$3,000	$3,000
Coinsurance			
	90%*|10%	80%*|20%	70%*|30%
Coinsurance Maximum			
Single	$1,500	N/A	$2,000
Family	$3,000	N/A	$4,000
Out of Pocket Maximum+			
Single	$6,600	$6,350	$6,600
Family	$13,200	$12,700	$13,200
Covered Services^			
Office Visit	$25 copay	$20 copay	$35 copay
Online Visit	$25 copay	$20 copay	$35 copay
Specialist	$35 copay	$40 copay	$45 copay
Routine Preventive Care	100%	100%	100%
Outpatient Diagnostic Lab & X-ray	90% after deductible	80% after deductible	70% after deductible
Emergency Room	$100 copay	$150 copay after deductible	$250 copay after deductible
Urgent Care Facility	$40 copay	$50 copay	$50 copay
Hospitalization	90% after deductible	80% after deductible	70% after deductible
Pharmacy	Generic $20 Preferred $60 Non-Preferred $80 Preferred Specialty 20%($450 max) Non-Preferred Specialty 20% ($600 max)	Generic $10/$30 Preferred $60 Non-Preferred $80 Preferred Specialty 20% ($200 max) Non-Preferred Specialty 20% ($300 max)	Generic $10/$30 Preferred $60 Non-Preferred $80 Preferred Specialty 20% ($200 max) Non-Preferred Specialty 20% ($300 max)

*Most but not all services are covered at 90%/80%/70% after deductible. Certain covered services may have a lesser coinsurance. Please refer to your SBC for additional information.
+The coinsurance maximum limits the total amount of coinsurance you will pay for certain covered services during a coverage period and is included in the out of pocket maximum.
^The out of pocket maximum includes deductible, flat dollar copays and coinsurance amounts for all covered services– including cost sharing amounts for prescription drugs.

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance
BCN Classic HMO for Large Groups
00165637 GRAND TRAVERSE PAVILIONS
Effective Date: 01/01/2021

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan for fully insured plans.

Services must be provided or arranged by the member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select *Approving covered services.*

Deductible, Copays and Dollar Maximums	
Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$500 individual/$1,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$25 for office visit
	$40 for urgent care visits
	$100 for emergency room visits
	$35 for referral physician visits
Coinsurance	50% for select services as noted below
	10% for select services as noted below
Annual Coinsurance Maximum (ACM)	$1,500 per member/$3,000 per family per calendar year
	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per individual/$13,200 per family

Benefits Selected - CLSSLG :
15ECM,CI10%,D500,DSR10%,IMG150,VACR50,ER100,CO25,6600PM,6600PM,OPTHEP,2068CS,MOPD1X,35RP,UR40,WDEDFC

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	$25 Copay
Medical Online Visits	$25 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$35 Copay

Emergency Medical Care	
Hospital Emergency Room - Copay waived if admitted	$100 Copay
Urgent Care Center	$40 Copay
Retail Health Clinic	$40 Copay
Ambulance Services	90% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	90% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay
Radiation Therapy	90% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$25 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	90% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	90% after deductible

Benefits Selected - CLSSLG :
15ECM,CI10%,D500,DSR10%,IMG150,VACR50,ER100,CO25,6600PM,6600PM,OPTHEP,2068CS,MOPD1X,35RP,UR40,WDEDFC

Alternatives to Hospital Care	
Skilled Nursing Care	90% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$35 Copay

Surgical Services	
Surgery - includes all related surgical services and anesthesia	90% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	90% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	90% after deductible
Inpatient Substance Use Disorder	90% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$25 Copay
Outpatient Substance Use Disorder	$25 Copay

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied behavioral analyses (ABA) treatment	$25 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$35 Copay
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services	
Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$35 Copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$35 copay
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year
Infertility Counseling and Treatment	50% (Excludes In-vitro fertilization) after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	90%
Hearing Aid	Not Covered

Benefits Selected - CLSSLG :
15ECM,CI10%,D500,DSR10%,IMG150,VACR50,ER100,CO25,6600PM,6600PM,OPTHEP,2068CS,MOPD1X,35RP,UR40,WDEDFC

Prescription Drugs

Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1 - $20 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier 4 - 20% coinsurance (Max - $450 copay), Tier 5 -20% coinsurance (Max - $600 copay); 30 day supply

	Sexual Dysfunction drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	One time the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

For Internal Use Only

Pharmacy	0000C565	0158	

Benefits Selected - CLSSLG :
15ECM,CI10%,D500,DSR10%,IMG150,VACR50,ER100,CO25,6600PM,6600PM,OPTHEP,2068CS,MOPD1X,35RP,UR40,WDEDFC

Option 2

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance
BCN Classic HMO for Large Groups
00165637 GRAND TRAVERSE PAVILIONS
Effective Date: 01/01/2021

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan for fully insured plans.

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Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select *Approving covered services.*

Deductible, Copays and Dollar Maximums	
Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$1,500 individual/$3,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$50 for urgent care visits
	$150 for emergency room visits
	$40 for referral physician visits
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per individual/$12,700 per family

Benefits Selected - CLSSLG :
CI20%,D1500,DSR20%,IMG150,VACR50,ER150,CO20,6350PM,6350PM,P103CL,90D3X,40RP,UR50,WDRPOV

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	$20 Copay
Medical Online Visits	$20 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$40 copay

Emergency Medical Care	
Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$50 Copay
Retail Health Clinic	$50 Copay
Ambulance Services	80% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	80% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$20 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible

Benefits Selected - CLSSLG :
CI20%,D1500,DSR20%,IMG150,VACR50,ER150,CO20,6350PM,6350PM,P103CL,90D3X,40RP,UR50,WDRPOV

Alternatives to Hospital Care	
Skilled Nursing Care	80% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$40 copay after deductible

Surgical Services	
Surgery - includes all related surgical services and anesthesia	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	80% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	80% after deductible
Inpatient Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$20 Copay
Outpatient Substance Use Disorder	$20 Copay

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied behavioral analyses (ABA) treatment	$20 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services	
Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$40 copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$40 copay after deductible
	60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% (Excludes In-vitro fertilization) after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	80%
Hearing Aid	Not Covered

Benefits Selected - CLSSLG :
CI20%,D1500,DSR20%,IMG150,VACR50,ER150,CO20,6350PM,6350PM,P103CL,90D3X,40RP,UR50,WDRPOV

Prescription Drugs

Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1A - $10, Tier 1B - $30, T2- $60, T3- $80, T4- 20% coinsurance (max $200), T5- 20% coinsurance (max $300) 30 day supply

	Sexual Dysfunction Drugs - 50% coinsurance
	Contraceptives – T1A- 100%, Tier 1B - $30, T2 - $60, T3-$80; 30 day supply
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

For Internal Use Only

Pharmacy	0000C107	0158	

Benefits Selected - CLSSLG :
CI20%,D1500,DSR20%,IMG150,VACR50,ER150,CO20,6350PM,6350PM,P103CL,90D3X,40RP,UR50,WDRPOV

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Deductible, Copays and Dollar Maximums	
Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$1,500 individual/$3,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$35 for office visits
	$50 for urgent care visits
	$250 for emergency room visits
	$45 for referral physician visits
Coinsurance	50% for select services as noted below
	30% for select services as noted below
Annual Coinsurance Maximum (ACM)	$2,000 per member/$4,000 per family per calendar year
	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per individual/$13,200 per family

Benefits Selected - CLSSLG :
2KECM,CI30%,D1500,DSR30%,IMG150,VACR50,ER250,CO35,6600PM,6600PM,P103CL,90D3X,45RP,UR50,WDRPOV

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	$35 Copay
Medical Online Visits	$35 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$45 Copay

Emergency Medical Care	
Hospital Emergency Room - Copay waived if admitted	$250 Copay after deductible
Urgent Care Center	$50 Copay
Retail Health Clinic	$50 Copay
Ambulance Services	70% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	70% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$35 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	70% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible

Benefits Selected - CLSSLG :
2KECM,CI30%,D1500,DSR30%,IMG150,VACR50,ER250,CO35,6600PM,6600PM,P103CL,90D3X,45RP,UR50,WDRPOV

Alternatives to Hospital Care	
Skilled Nursing Care	70% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$45 copay after deductible

Surgical Services	
Surgery - includes all related surgical services and anesthesia	70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	70% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	70% after deductible
Inpatient Substance Use Disorder	70% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$35 Copay
Outpatient Substance Use Disorder	$35 Copay

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied behavioral analyses (ABA) treatment	$35 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$45 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services	
Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$45 Copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$45 Copay after deductible
	60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% (Excludes In-vitro fertilization) after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	70%
Hearing Aid	Not Covered

Benefits Selected - CLSSLG :
2KECM,CI30%,D1500,DSR30%,IMG150,VACR50,ER250,CO35,6600PM,6600PM,P103CL,90D3X,45RP,UR50,WDRPOV

Prescription Drugs

Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1A - $10, Tier 1B - $30, T2- $60, T3- $80, T4- 20% coinsurance (max $200), T5- 20% coinsurance (max $300) 30 day supply

	Sexual Dysfunction Drugs - 50% coinsurance
	Contraceptives – T1A- 100%, Tier 1B - $30, T2 - $60, T3-$80; 30 day supply
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

For Internal Use Only

Pharmacy	0000C108	0158	

Benefits Selected - CLSSLG :
2KECM,CI30%,D1500,DSR30%,IMG150,VACR50,ER250,CO35,6600PM,6600PM,P103CL,90D3X,45RP,UR50,WDRPOV

DENTAL

Your dental insurance will be provided through Delta Dental. You may see any provider you like, but staying in Network saves you money. To find participating providers, visit: www.deltadentalmi.com. The chart below provides a general summary of your plan benefits. For details please see the benefit summaries posted on the BSwift portal.

	DELTA DENTAL BASE PLAN	DELTA DENTAL HIGH PLAN
Deductible (per calendar year)	In-Network	In-Network
Individual	$50	$50
Family	$150	$150
Benefit Maximum (all services combined)		
Individual (per person per year)	$1,000	$3,000
Covered Services		
Preventive Care (exams, cleanings, bitewing x-rays)	100%*	100%*
Basic Services (fillings, extractions)	80%	90%
Major Services (crowns, root canal, dentures)	50%	60%
Orthodontia	50%+	50%+

Claims paid to out of network providers are subject to balance billing and other out of pocket costs.

* Deductible waived on preventive services
+ There is a separate $1,000 lifetime maximum for orthodontic services

DELTA DENTAL

BASE PLAN

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 4984-0001, 0002, 0099
Grand Traverse Pavilions

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs – to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	up to age 19	up to age 19	up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.

- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first of the month following 60 days of employment.

Eligible People – All employees of the Contractor working at least 24 hours per week who select the Grand Traverse Pavilions - Low Plan (0001), Grand Traverse Pavilions Retirees - Low Plan (0002) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099).

Also eligible are your Spouse and your Children to the end of the month in which they turn 19, and your dependent unmarried children to the end of the month in which they turn 24 if a full-time student and eligible to be claimed by you as a dependent under the U.S. Internal Revenue Code during the current calendar year.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an Enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (excluding COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the day after termination.

DELTA DENTAL

HIGH PLAN

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 4984-1001, 1099
Grand Traverse Pavilions

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	90%	90%	90%
Endodontic Services – root canals	90%	90%	90%
Periodontic Services – to treat gum disease	90%	90%	90%
Oral Surgery Services – extractions and dental surgery	90%	90%	90%
Other Basic Services – misc. services	90%	90%	90%
Relines and Repairs – to prosthetic appliances	90%	90%	90%
Major Services			
Major Restorative Services – crowns	60%	60%	60%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	60%	60%	60%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	up to age 19	up to age 19	up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.

- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $3,000 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first of the month following 60 days of employment.

Eligible People – All employees of the Contractor working at least 24 hours per week who select the Grand Traverse Pavilions - High Plan (1001) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (1099).

Also eligible are your Spouse and your Children to the end of the month in which they turn 19, and your dependent unmarried children to the end of the month in which they turn 24 if a full-time student and eligible to be claimed by you as a dependent under the U.S. Internal Revenue Code during the current calendar year.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an Enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (excluding COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the day after termination.

VISION

Your voluntary vision insurance will be provided through EyeMed using the EyeMed Insight network. The chart below provides a general summary of your plan benefits. For details please see the full benefit summary posted on the BSwift portal.

Vision Benefits	Frequency	In-Network
Exam with dilation as necessary	12 months	$10 copay
Contact lens fit and follow up	12 months	$40 copay
Lenses	12 months	$20 copay
Frames	12 months	$130 allowance
Contact Lenses (instead of glasses)	12 months	$130 allowance
Lens Copays		
Single Vision	12 months	$20 copay
Bifocal	12 months	$20 copay
Trifocal	12 months	$20 copay
Standard Progressive	12 months	$75 copay
Premium Progressive	12 months	$105-$195 copay

Claims paid to out of network providers are subject to balance billing and other out of pocket costs.

Benefit eligibility is based on last date of service. For example, if you get an eye exam on 01/25/21 you won't be eligible for another one until 01/25/22.

Grand Traverse Pavilions

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $130 allowance, 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$20 Copay	Up to $30
Bifocal	$20 Copay	Up to $50
Trifocal	$20 Copay	Up to $70
Lenticular	$20 Copay	Up to $70
Standard Progressive Lens	$75 Copay	Up to $50
Premium Progressive Lens[Δ]	$105 Copay - $195 Copay	Up to $50
Tier 1	$105 Copay	Up to $50
Tier 2	$115 Copay	Up to $50
Tier 3	$130 Copay	Up to $50
Tier 4	$195 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$40	N/A
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $85	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $130
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $130
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 12 months	

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[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

CHOOSE A DOC

EyeMed members choose from the right mix of thousands of providers—independent eye doctors, your favorite retail stores and everything in between. Find your ideal fit at eyemed.com or the EyeMed Members App.

CREATE AN ACCOUNT

Get special offers with an account on eyemed.com. Enter your email, choose a password and sign up for emailed savings. Log in 24/7 to view your benefit details or health and wellness information.

MOBILIZE YOUR BENEFITS

The EyeMed Members App makes your benefits easy to understand—and even easier to use. Find an eye doctor near you, schedule an appointment and manage your vision benefits.

72%
AVERAGE SAVINGS

on eye exams and glasses for EyeMed members*

Learn more about enrolling in EyeMed vision benefits at **enroll.eyemed.com** and see more of the good stuff

**Based on a sample transaction on the Insight network with a covered exam and eyewear benefits*

eyeMed | INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL JCPenney | optical

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LIFE INSURANCE

Your Life AD&D insurance is provided through Unum. The information below provides a general summary of your plan benefits. For details please see the benefit summaries posted on the BSwift portal.

Grand Traverse Pavilions is proud to provide $5,000 of term life insurance to eligible employees. Please make sure your beneficiary information is up to date with Human Resources.

You have the opportunity to purchase additional coverage over and above the $5,000 provided by Grand Traverse Pavilions.

If you pass away will your spouse have enough money to stay in your current home? How about send your kids to college? Enjoy retirement as you had both planned?

Life insurance can provide peace of mind for your loved ones so they know they are protected even if the unthinkable were to happen by providing financially for them after you're gone.

For additional information on coverage and costs please see the enrollment portal.

Voluntary Supplemental Coverage

Your have the ability to purchase supplemental coverages for yourself and family from Unum. Plans that are available are listed below. For details please see the benefit summaries and costs posted on the BSwift portal.

In addition to life insurance you can also purchase the following voluntary products from Unum.

- Short term disability
- Long term disability
- Critical Illness
- Accident

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

All Employees

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is offering you this coverage at no cost to you. Unum is the leading provider of employee benefits, with more than 165 years of experience.[1] We'll be there to back our benefits and provide you with the support you need.

Who can get Term Life coverage?

If you are actively at work at least 24 hours per week, you can receive coverage for:

You	You can receive a benefit amount of $5,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You	You can receive an AD&D benefit amount of $5,000.

No questions or health exams required for AD&D coverage.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

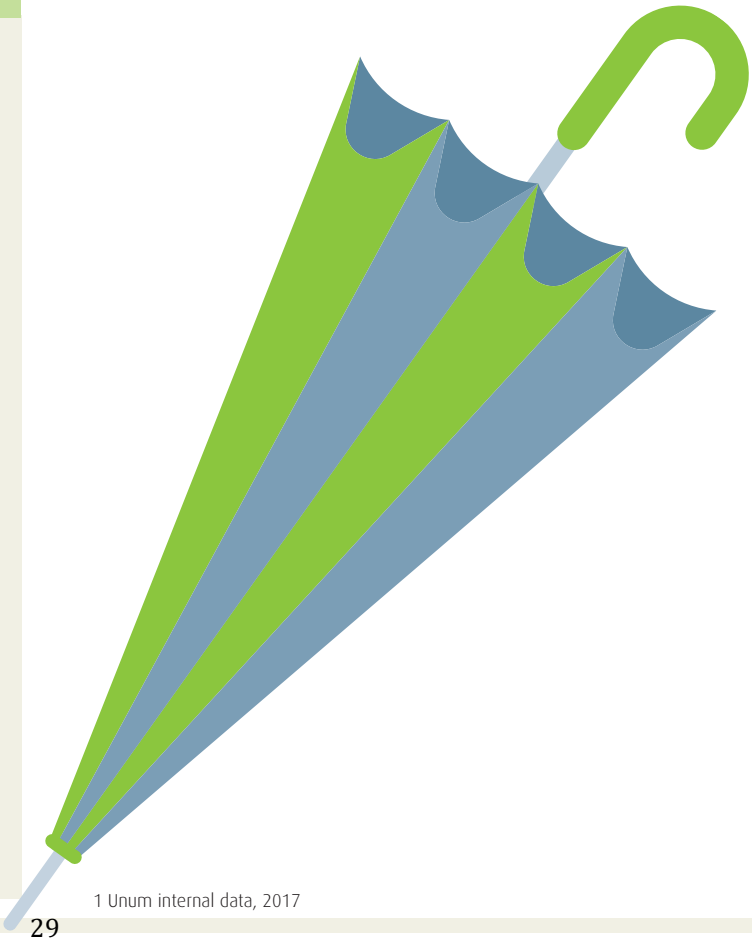
Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.



1 Unum internal data, 2017

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Term Life Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

All Employees

How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

Why is this coverage so valuable?

If you previously purchased coverage, you can increase it up to $150,000 to meet your growing needs — with no health questions or exams.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit. These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlement, and may be taxable. Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 24 hours per week, you may apply for coverage for:

You	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. If you previously purchased coverage, you can increase it up to $150,000, your guaranteed issue amount, with no health questions. If you previously declined coverage, you may have to answer some health questions.
Your Spouse	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. If you previously purchased coverage for your spouse, they can increase their coverage up to $25,000, their guaranteed issue amount, with no health questions or exams, if eligible (see delayed effective date). If you previously declined spouse coverage, some health questions may be required.
Your Children	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday – or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000.

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life for you and your dependents will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

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Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Short Term Disability Insurance

can pay you a weekly benefit if you have a covered disability that keeps you from working.

All Employees

How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments for up to 25 weeks.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

What's covered?

This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for short term disability claims:[1]

- Normal pregnancy
- Injuries (excluding back)
- Joint disorders
- Cancer
- Digestive disorders

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Consider your weekly expenses

Food	$_____
Transportation (gas, car payments, repairs)	_____
Child care/elder care	_____
Mortgage/rent	_____
Utilities (electric, water, cable, phone)	_____
Medical costs (co-pays, medications)	_____
Insurance (health, life, car, home)	_____
Total weekly expenses	$_____

Cesarean section benefit

If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks unless you return to work before the end of the time.

1 Unum internal data, 2018. **Note:** Causes are listed in ranked order.

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 24 hours per week. **Coverage amounts** Choose from $100 to $700 a week, (in $50 increments). You can cover up to 60% of your weekly income. *See the Legal Disclosures for more information

! If you didn't get coverage when you were first eligible, you'll have to answer medical questions now. If you're newly eligible, you are guaranteed coverage now with no medical questions. If you already have coverage, you can increase it up to the maximum available with no medical questions. New coverage may be subject to pre-existing condition limitations.

Elimination period (EP)

This is the number of days that must pass between your first day of a covered disability and the day you can begin to receive your disability benefits.

Your benefits would begin after you become disabled for 7 days.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 25 week benefit duration.

Disability worksheet

Disability benefits worksheet

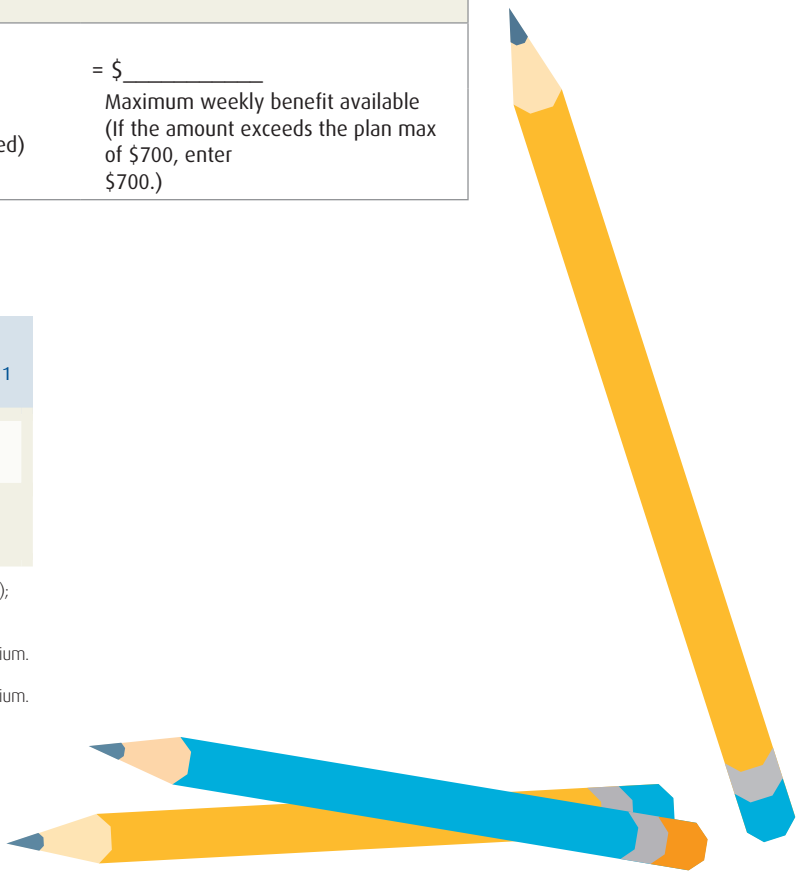
Calculate your weekly disability benefit.

$_____ Enter your annual earnings	÷ 52 =	$_____ Your weekly earnings	x	60% (Max % of income covered)	= $_____	Maximum weekly benefit available (If the amount exceeds the plan max of $700, enter $700.)

Unum has been a leading provider in **group disability benefits** for over **4** decades.[1]

- #1 Individual Disability[2] Whole/Universal Life[3]
- #2 Group Disability[4]
- #3 Voluntary Benefits[5] Critical Illness[6]

1 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976-1990" (1977-1991); Gen Re, "U.S. Group Disability Market Surveys 1991-2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014-2016 Annual Sales and In Force" (2015-2017).
2 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
3 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).
4 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
5,6 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).



Exclusions and limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Grand Traverse Pavilions for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Definition of disability

You are considered disabled when Unum determines that, due to sickness or injury:

- You are limited from performing the material and substantial duties of your regular occupation; and
- You have a 20% or more loss in weekly earnings

You must be under the regular care of a physician in order to be considered disabled. The loss of a professional or occupational license or certification does not, in itself, constitute disability.

"Substantial and material acts" means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Pre-existing conditions

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws
- State compulsory benefit laws
- Automobile liability insurance policy
- Motor vehicle insurance policy or plan
- No fault motor vehicle plan
- Legal judgments and settlements
- Salary continuation or sick leave plans, if applicable
- Other group or association disability programs or insurance
- Social Security or similar governmental programs

Exclusions and limitations

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- War, declared or undeclared or any act of war
- Active participation in a riot
- Intentionally self-inflicted injuries;
- Loss of professional license, occupational license or certification;
- Commission of a crime for which you have been convicted;
- Any period of disability during which you are incarcerated;
- Any occupational injury or sickness (this will not apply to a partner or sole proprietor who cannot be covered by law under workers' compensation or any similar law);
- Excluded pre-existing conditions (see definition).

The loss of a professional or occupational license does not, in itself, constitute disability.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan.

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Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Accident Insurance

can pay you money for covered accidental injuries and their treatment.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

What's included?

Wellness Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Ages 17 and up
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

Unum has been a leading provider in **group disability benefits** for over **4** decades.[1]

- #1 Individual Disability[2] Whole/Universal Life[3]
- #2 Group Disability[4]
- #3 Voluntary Benefits[5] Critical Illness[6]

1 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976-1990" (1977-1991); Gen Re, "U.S. Group Disability Market Surveys 1991-2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014-2016 Annual Sales and In Force" (2015-2017).
2 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
3 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).
4 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
5,6 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Accident Insurance – Schedule of Benefits

Covered injuries	Benefit amount
Fractures	
Open Reduction (dependent on location of injury)	$150 to $7,500
Closed Reduction (dependent on location of injury)	$75 to $3,750
Chips	25% of closed amount
Dislocations	
Open Reduction (dependent on location of injury)	$300 to $6,000
Closed Reduction (dependent on location of injury)	$150 to $3,000
Burns	
At least 10 square inches, but less than 20 square inches	2nd degree – $0 3rd degree – $2,500
At least 20 square inches, but less than 35 square inches	2nd degree – $0 3rd degree – $5,000
35 or more square inches of the body surface	2nd degree – $1,000 3rd degree – $10,000
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit
Skin graft for any other accidental traumatic loss of skin	
At least 10 square inches, but less than 20 square inches	$150
At least 20 square inches, but less than 35 square inches	$250
35 or more square inches of the body surface	$500
Concussion	$150
Coma	$10,000
Ruptured disc	$800
Knee cartilage	
Torn with surgical repair	$750
Exploratory surgery or cartilage shaved, only	$150
Laceration	$25–$600
Tendon/ligament and rotator cuff	
Surgical repair of one	$800
Surgical repair of two or more	$1,200
Exploratory surgery without repair	$150
Dental work, emergency	
Extraction	$100
Crown	$300
Eye injury	$300

Accident coverage is a limited policy.

Emergency and hospitalization benefits	Benefit amount
Ambulance (ground, once per accident)	$400
Air ambulance	$1500
Emergency room treatment	$150
Emergency treatment in physician office/urgent care facility	$75
Hospital admission (admission or intensive care admission once per covered accident)	$1,000
Intensive care admission (same as above)	$1,500
Hospital confinement (per day up to 365 days)	$200
Intensive care confinement (per day up to 15 days)	$400
Medical imaging test (once per accident)	$200
Outpatient surgery facility service (once per accident)	$300
Pain management (epidural, once per accident)	$100

Treatment and other services	Benefit amount
Surgery benefit	
Open abdominal, thoracic	$1,500
Exploratory (without repair)	$150
Hernia repair	$150
Physician follow-up visit (2 visits per accident)	$75
Chiropractic visit (up to 3 visits per calendar year)	$25
Therapy services (up to 10 per accident)	
Occupational therapy	$25
Speech therapy	$25
Physical therapy	$25
Prosthetic device or artificial limb	
One	$750
More than one	$1,500
Appliance (once per accident)	$100
Blood, plasma and platelets	$400
Travel due to accident Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip	$0.40 per mile
Lodging (per night up to 30 days per accident)	$150
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	$100

Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee–$150,000; spouse–$60,000; child–$30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	$15,000
Loss of one hand and one foot; or	$15,000
Loss of one hand or one foot;	$7,500
Loss of two or more fingers, toes or any combination; or	$1,500
Loss of one finger or toe	$750
Catastrophic accidental dismemberment† — once per lifetime, not payable with catastrophic loss Loss of both hands or both feet; or loss of one hand and one foot	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
Accidental loss — paralysis, sight, hearing and speech Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	$15,000
Loss of sight of both eyes; or	$15,000
Loss of sight of one eye; or	$7,500
Loss of the hearing of one ear	$7,500
Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
†Catastrophic accidental loss benefit — payable after fulfilling a 365 day elimination period.	

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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Level 2 with AD&D

Accident Insurance

See Schedule of Benefits for a complete listing of what is covered.

THIS IS A LIMITED BENEFITS POLICY.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- participating or attempting to participate in a felony, being engaged in an illegal occupation or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the exclusions listed above, Unum will also not pay the catastrophic accidental dismemberment or catastrophic accidental loss benefit for the following injuries that are caused by or are the result of:

- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy. Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS IS A LIMITED BENEFITS POLICY

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GA-1 et al. or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a benefit payment in one lump sum. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions. If you have a different condition later, you can receive another benefit.
- This insurance pays you once for each eligible illness. However, the diagnoses must be at least 90 days apart, and the conditions can't be related to each other.

What's covered?

- Heart attack
- Blindness
- Major organ failure
- End-stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery (pays at 25% of lump sum benefit)
- Coma that lasts at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Occupational HIV
- Permanent paralysis of at least two limbs due to a covered accident

Coverage is also included for:

- Cancer
- Carcinoma in situ — pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You can keep coverage if you leave the company or retire. You'll be billed at home.

What else is included?

A Wellness Benefit

Every year, each family member who has Critical Illness coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms
- And other tests listed in your policy

Please refer to the policy for complete details about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Effective date of coverage: Coverage becomes effective on the first day of the month in which payroll deductions begin. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Who can get coverage?

Coverage is guaranteed up to the stated amount. If you don't sign up now but decide to apply later, you may have to answer medical questions.

You	Choose $10,000 or $ 20,000 of coverage. Coverage is guaranteed up to $20,000 if you apply during this enrollment. If you do not sign up now but decide to apply later, you may have to answer medical questions.
Your spouse	Spouses from ages 17 and up can get $10,000 of coverage during this enrollment. Coverage is guaranteed as long as you have purchased coverage for yourself.
Your children	Dependent children from newborns to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses, plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Unum has been a leading provider in **group disability benefits** for over **4** decades.[1]

- #1 Individual Disability[2] Whole/Universal Life[3]
- #2 Group Disability[4]
- #3 Voluntary Benefits[5] Critical Illness[6]

1 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976-1990" (1977-1991); Gen Re, "U.S. Group Disability Market Surveys 1991-2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014-2016 Annual Sales and In Force" (2015-2017).
2 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
3 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).
4 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
5,6 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).

Exclusions and limitations

Waiting period

The benefit for this coverage is subject to a 30-day waiting period following the effective date of the insured's coverage. This does not apply to coma, occupational HIV and permanent paralysis or specific covered childhood diseases.

Pre-existing conditions

Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of a sickness or injury, whether diagnosed or not, for which you received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed drugs or medicine to be taken in the 12 months just prior to your effective date) will not be paid during the first 12 months the policy is inforce.

Reduction of benefits

Any coverage inforce prior to the insured's 70th birthday will be reduced on the policy anniversary date following the insured's 70th birthday. The insured's face amount will be reduced to 50% of the face amount the insured had prior to the policy anniversary date. Any coverage inforce after the policy anniversary date following the insured's 70th birthday will not be subject to a benefit reduction on subsequent policy anniversary dates.

Exclusions and Limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- Participating or attempting to participate in a felony or being engaged in an illegal occupation; or
- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not; or
- Participating in war or any act of war, whether declared or undeclared; or
- Committing acts of terrorism; or
- Being under the influence of or addicted to intoxicants or narcotics. This would not include physician-prescribed medication, taken in the prescribed dosage; or
- Having a date of diagnosis during the benefit waiting period.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- Date this policy is canceled;
- Date you are no longer in an eligible group;
- Date your eligible group is no longer covered;
- Date of your death;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy.

Coverage on your dependent children ends on the earliest of the date your coverage under this policy ends or the date a dependent child no longer meets the definition of dependent children.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and imitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form CI-1 or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Aflac
Group Accident Insurance

Accident protection made for you.

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.

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This brochure is subject to the terms, conditions, and limitations of Policy Series C70000. In Arkansas, C70100AR. In Idaho, C70100ID. In Oklahoma, C70100OK. In Oregon, C70100OR. In Pennsylvania, C70100PA. In Texas, C70100TX. In Virginia, C70100VA.

Underwritten by:
Continental American Insurance Company (CAIC)

Aflac®

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 ACCIDENTAL DEATH RIDER

	BENEFIT AMOUNT
ACCIDENTAL DEATH BENEFIT (within 90 days after the accident*) Payable if a covered accidental injury causes the insured to die. The spouse benefit is 50% of the employee benefit shown. The child benefit is 20% of the employee benefit shown. We will pay 200% of the amount payable if the insured: • Is a fare-paying passenger on a common carrier; • Is injured in a covered accident; and • Dies within 90 days* after the covered accident.	$50,000

EXCLUSIONS

Please refer to the the Initial Accident Treatment insert for exclusions applicable to this coverage.

DEFINITIONS

Common Carrier means:

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

Please refer to the Initial Accident Treatment insert for other definitions applicable to this coverage.

*In Oregon and Utah, within 180 days after the accident; in Pennsylvania, there is no limitation on the number of days.

GROUP ACCIDENT INSURANCE AFTER CARE BENEFITS – HIGH

	BENEFIT AMOUNT
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	$40
Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar	$100
Wheelchair, Knee Scooter, Body Jacket, Back Brace	$400
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
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
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.	$100 per day
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.	$50
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.	$30

EXCLUSIONS

For a complete list of exclusions please refer to the Initial Accident Treatment insert.

DEFINITIONS

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.

Please refer to the Initial Accident Treatment insert for other definitions applicable to this coverage.

Note: In New Hampshire, all mentions of "Treatment" refer to "Care".

GROUP ACCIDENT INSURANCE HOSPITALIZATION BENEFIT – HIGH

	BENEFIT AMOUNT
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.	$1,250 per confinement
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.	$300 per day
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.	$400 per day
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.	$200 per day
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.	$200 per day

EXCLUSIONS

For a complete list of exclusions please refer to the Initial Accident Treatment insert.

DEFINITIONS

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.

Please refer to the Initial Accident Treatment insert for other definitions applicable to this coverage.

Note: In New Hampshire, all mentions of “Treatment” refer to “Care”.

GROUP ACCIDENT INSURANCE INITIAL ACCIDENT TREATMENT BENEFIT – HIGH

	BENEFIT AMOUNT
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
Urgent care facility with X-Ray / without X-Ray	$250/$200
Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	$150/$100
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
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
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
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 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
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
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
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

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
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
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
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
At least 10% but less than 25%	$200
At least 25% but less than 35%	$500
35% or more	$1,000
Third Degree	
Less than 10%	$1,000
At least 10% but less than 25%	$5,000
At least 25% but less than 35%	$10,000
35% or more	$20,000
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
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
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
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
5-15 centimeters	$400
Under 5 centimeters	$100
Lacerations not requiring stitches	$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
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
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
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
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
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.

EXCLUSIONS

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 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.

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.

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GROUP ACCIDENT INSURANCE LIFE CHANGING EVENTS BENEFITS – HIGH

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)	**BENEFIT AMOUNT**
Employee	$12,500
Spouse	$5,000
Child(ren)	$2,500
DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)	
Employee	$25,000
Spouse	$10,000
Child(ren)	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	
Employee	$1,250
Spouse	$500
Child(ren)	$250
PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)	
Employee	$125
Spouse	$125
Child(ren)	$125

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	$5,000
Quadriplegia	$10,000

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. 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. * 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.	$3,000
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: • The sight of one eye; • The use of one hand/arm; or • The use of one foot/leg.	$2,000

EXCLUSIONS

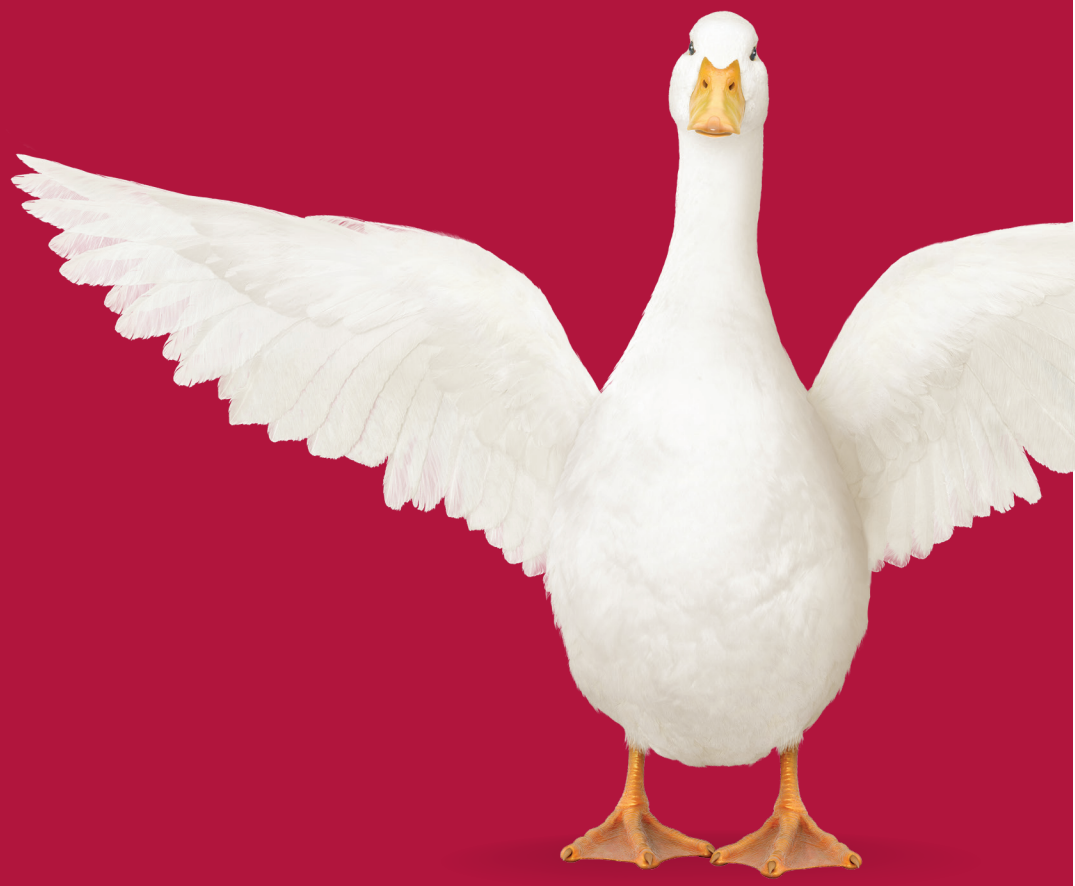
For a complete list of exclusions and definitions applicable to this coverage, please refer to the Initial Accident Treatment insert.

Aflac

Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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



Aflac®

AG210751 R5

IV (12/19)

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.

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

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

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

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

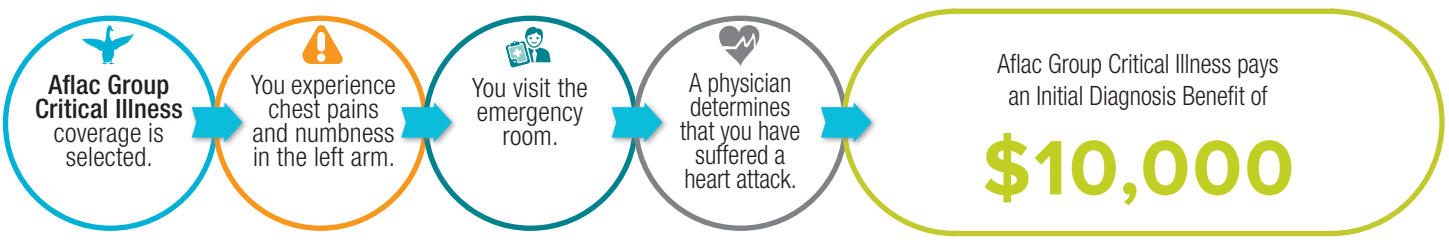
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- 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%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	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.

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 $50 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.**

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

LIMITATIONS AND EXCLUSIONS

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:

- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
  - In Alaska: injuring or attempting to injure oneself intentionally
- Suicide – committing or attempting to commit suicide, while sane or insane;
  - In Illinois and Minnesota: this exclusion does not apply
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job:
  - In Arizona: participating in or attempting to commit a felony, or being engaged in an illegal occupation;
  - In Illinois and Pennsylvania: Illegal Occupation - committing or attempting to commit a felony or being engaged in an illegal occupation;
  - In Michigan: Illegal Occupation – the commission of or attempt to commit a felony, or being engaged in an illegal occupation;
  - In Nebraska: being engaged in an illegal occupation, or commission of or attempting to commit a felony;
  - In Ohio: committing or attempting to commit a felony, or working at an illegal job
- Participation in Aggressive Conflict:
  - War (declared or undeclared) or military conflicts; In Oklahoma: War, or act of war, declared or undeclared when serving in the military service or an auxiliary unit thereto
  - 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
  - In Arizona: Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician
  - In Michigan, Nevada, and South Dakota: this exclusion does not apply

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

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.

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

Skin cancers are not payable under the Cancer (internal or invasive) Benefit or the Non-Invasive Cancer Benefit. 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

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:

- 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).
- 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.
- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- 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.
- 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, husband, or partner in a legally recognized union. Dependent children are your or your spouse's natural children, step-children, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (In Arizona, on the effective date of coverage). Newborn children are automatically covered from the moment of birth. Refer to your certificate for details.

A doctor does not include you or any of your family members. In Arizona, however, a doctor who is your family member may treat you. 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.

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) 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 meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

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.

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

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).

Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

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.

This brochure is subject to the terms, conditions, and limitations of Policy Series C21000. In Arkansas, C21100AR. In Oklahoma, C21100OK. In Oregon, C21100OR. In Pennsylvania, C21100PA. In Texas, C21100TX.

Aflac

Group Hospital Indemnity

INSURANCE

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

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

Aflac®

AG80075MMI R5

IV (11/19)

AFLAC GROUP HOSPITAL INDEMNITY

Policy Series C80000

HI G

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.

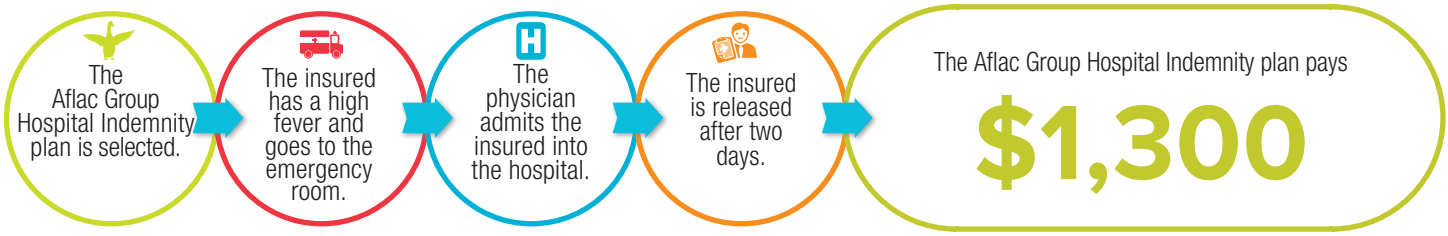
That's how the Aflac Group Hospital Indemnity plan can help.

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 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 first day of 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. 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).	$1,000
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$150
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$150
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$75

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.

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

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

We will not pay for loss due to:

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

TERMS YOU NEED TO KNOW

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

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage. Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Dependent Children are 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. Newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered for 60 days also. See certificate for details. Dependent children must be younger than age 26, however this limit will not apply to any insured dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance.

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

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

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

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

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

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

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

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

NOTICES

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

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HEALTH SCREENING BENEFIT / $50 PER DAY UP TO THE BENEFIT MAXIMUM

Benefit Maximum: once per calendar year

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.

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

TASC®

Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions and vaccinations
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- You can choose to enroll in a Healthcare FSA, Dependent Care FSA, and more
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.
With less tax taken, your take-home pay increases!

Consider this example:
(For illustration only)

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA	With FSA
($600 spent using post-tax dollars)	($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of $166 every month!

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators/tasc-flexsystem-calculator/

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

It's easy to start saving with a TASC FSA.

Just follow 3 simple steps:

1. DECIDE how much you want to contribute for the upcoming plan year

The more you contribute, the lower your taxable income will be. In spite of this, it's important to be conservative when choosing your annual contribution based on your anticipated qualified expenses since:

- The money you contribute to your benefit account can only be used for eligible FSA expenses.
- Any unused FSA funds at the close of the plan year are not refundable to you. (Note: If your employer offers a Carryover option, up to $500 in unused contributions to a Healthcare FSA can carry over to the next year.)

PLANNING TIPS

START by making a conservative estimate of how much you expect to spend on eligible out-of-pocket expenses for the year.

COMPARE your estimate to the IRS limits at **www.tasconline.com/benefits-limits.** If your estimate is higher than these annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the enrollment process

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year.

Your total annual contribution to a **Healthcare FSA** will be available to you immediately at the start of the plan year. Alternatively, your **Dependent Care FSA** funds are only available as payroll contributions are made.

SPECIAL FEATURES

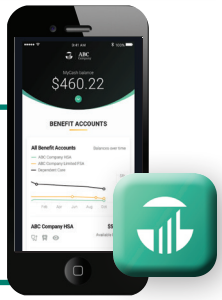
Individual Giving Account: Every participant receives a complimentary TASC giving account.

Identify Theft Protection: All active participants receive TASC Identity Theft Protection.

3. ACCESS your funds easily using the TASC Card

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast — within 12 hours — when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!



Track and manage all TASC benefits and access numerous helpful tools, anywhere and anytime—with just one app!

GET IT ON Google Play | Download on the App Store | Search for "TASC" (green icon)

TASC®

Save up to 30% on eligible expenses

Enroll in a TASC Flexible Spending Account (FSA) so you can use pretax dollars to pay for common, everyday expenses and reduce your taxable income.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents.
NOTE: If you (or your spouse) enroll in an HSA Plan, you may only enroll in a Limited-Purpose Healthcare FSA (LPFSA). The eligible expenses under an LPFSA are limited to Dental and Vision expenses only.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Baby Formula, Nutritionals, Electrolytes & Food
- Bandages & dressings
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles & co-insurance
- Diabetic care & supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- First aid kits & supplies
- Flu shots
- Hearing aids & hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs & deterrants (gum, patch)
- Treatment for alcoholism or drug dependency
- Vaccinations
- X-ray fees

Eligible OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs are now reimbursable via FSA, HRA, and HSA without a prescription or physician's note if purchased on or after 01/01/2020.
Eligible OTC products include items that are for medical care and are primarily for a medical purpose, ans are compliant with federal tax rules under IRS Code Section 213(d).

- Allergy, cough, cold, flu & sinus medications
- Anti-diarrheals, anti-gas medications & digestive aids
- Canker/cold sore relievers & lip care
- Family planning items (contraceptives, pregnancy tests, etc.)
- Feminine care products (tampons, pads, etc)
- Foot care (corn/wart medication, antifungal treatments, etc.)
- Hemorrhoid creams & treatments
- Hydrogen peroxide & rubbing alcohol
- Itch relief (calamine lotion, Cortizone cream, etc.)
- Nasal spray
- Oral care (denture cream, pain reliever, teething gel, etc.)
- Pain relievers - internal/external (Tylenol, Advil, Bengay, etc.)
- Skin care (sunscreen w/SPF15+, acne medication, etc.)
- Sleep aids & stimulants (nasal strips, etc.)
- Stomach & nausea remedies (antacids, Dramamine, etc)
- Wound Treatments/Washes (Hydrogen Peroxide, Iodine)

Continued on next page...

Use your TASC Card to pay for eligible expenses at the point of purchase instead of paying out-of-pocket and requesting a reimbursement.

Eligible Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Eligible Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents

For more information regarding eligible expenses, please review IRS Publication 502/503 at **irs.gov** or ask your employer for a copy of your Summary Plan Description (SPD).

Eligible Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/ maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose (non-compression)
- Varicose vein treatment
- Veneers
- Vitamins & dietary supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

457 can supplement your pension and help you have a more comfortable retirement.

What is 457?

A 457 deferred compensation plan is a supplemental retirement-savings program that offers a tax-advantaged way to invest for potentially more retirement income. Pre-tax contributions and any earnings are taxed as ordinary income when withdrawn.*

Why join a 457 plan?

By investing through your employer's 457 deferred comp plan, you may be able to fill a potential gap between what your pension provides and income you may need. Consider this: a 65-year-old couple retiring this year may need $220,000 (in today's dollars) to cover medical expenses throughout retirement.[1]

How do you put money in your account?

That's the easiest part! Your contributions are automatically deducted before taxes from your pay, contributed to your 457 plan account, and then invested as you direct.*

Deferred comp is designed for long-term investing. However, if you leave employment with your 457 plan sponsor, you can withdraw money without paying a 10% penalty. Consider that, if you're thinking about early retirement.

What about the risks of investing?

Investing involves market risk, including possible loss of principal. But you also face several other risks. While your Nationwide Retirement Specialist cannot offer investment, tax or legal advice, we'll help you put the various risks into perspective and explain strategies that may help you deal with them.

How do I get started in a 457 plan?

Contact your Nationwide Retirement Specialist:

Chris Minkin JD, CRC
(989) 714-1661
chris.minkin@nationwide.com

Retirement Specialists are registered representatives of Nationwide Investment Services Corporation, member FINRA.

**Note: If your employer's 457 plan offers and you take advantage of a Roth option, your contributions are taken after taxes are applied, but withdrawals of contributions and their potential earnings would be tax-free (subject to certain conditions).*

Sources: [1]Source: Fidelity Benefits Consulting, 2014.

Nationwide®

ENROLL TODAY

MERS 457 Supplemental Savings Program

MERS® Municipal Employees' Retirement System

About the Program

The MERS 457 Supplemental Retirement Program offers you a flexible retirement account you manage. You decide how much to contribute, how to invest the assets, and how to plan for the future. One of the benefits of the program is that you have access to your account when you leave employment, even if that's before age 60.

Contributions

The MERS 457 Program is flexible because you determine how much you want to contribute, either a flat dollar amount or a percentage of pay, and you can start, stop, increase or decrease your contributions, without fees or penalties. Your contributions can be made pre-tax or Roth (if your employer has adopted this option). *So how do you decide? Let's start with the basics.*

With a **pre-tax** election you make contributions with pre-tax dollars, so you get a tax break up front, helping to lower your current income tax bill. Your money—both contributions and earnings—grow tax-deferred until you withdraw them. At that time, withdrawals are considered to be ordinary income and taxed at your current tax rate.

With a **Roth** contribution, it's basically the reverse. You make your contributions with after-tax dollars, meaning there's no upfront tax deduction. However, withdrawals of both contributions and earnings are tax-free at age 59½, as long as you've held the account for five years.

So it all comes down to deciding when it's better for you to pay the taxes—now or later. You can access online calculators on the MERS website to help you determine the best option for your goals.

Why Should You Enroll?

Help meet your retirement goals
Experts suggest that you should plan on needing at least 80% of your current income in retirement, so chances are you're going to need to rely on personal savings, over and above your Social Security and other retirement benefits.

Low cost
As a nonprofit organization, the MERS program is the most cost-effective way of saving – putting more of your money to work for you.

It's easy!
You contribute through the convenience of automatic payroll deduction.

One-stop planning
Experienced retirement educators are available to help with any questions you may have.

Our convenient online calculators enable you to estimate what your financial future may look like and help you decide what makes the most sense to reach your goals. Find the *457 Savings Calculator* under Resources at *www.mersofmich.com*.

Who is MERS?

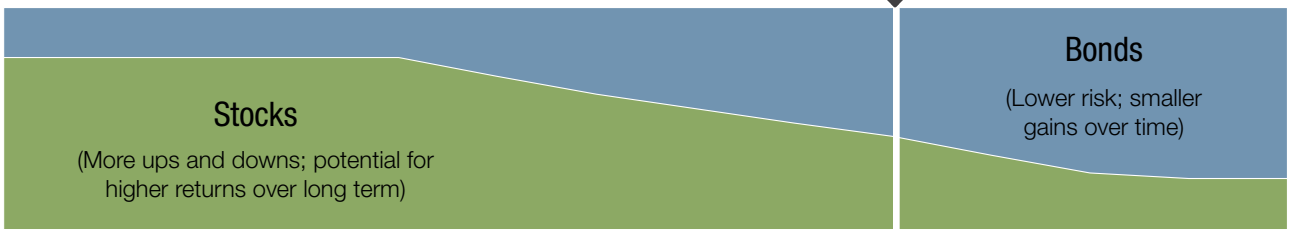
MERS is an independent, professional retirement services company that serves local units of government across the state of Michigan. MERS listens and works in partnership with our members to deliver a superior value that meets our members' needs.

Invest Your Money

While you can't control the markets, you can control where your money is invested. Initially, your money will be invested in an age-appropriate **Retirement Strategy** fund to help you work toward your retirement goals.

How the Retirement Strategy Fund Works

First, you select the year you expect to retire.



Early Career

The fund starts out in mostly stocks where higher gains are expected and the risk of losses can be absorbed over time.

Nearing Retirement Age

The fund automatically shifts to more bonds. They earn less, but the risk of sudden losses is reduced.

During Retirement

Your money stays invested where stable earnings can help offset your withdrawals over time.

You can change your investment allocation online after you sign-up for your myMERS account. For more information on your investment options, please visit our website.

Name Your Beneficiaries

Once your enrollment has been processed, you will be able to designate beneficiaries by logging into your *myMERS* account. This is an important step to ensure your funds are handled appropriately should something happen to you. You may name a spouse, non-spouse, child(ren), a trust and/or charity as a beneficiary.

MERS Helps You Become Retirement Ready

myMERS Online Account offers you a secure login that connects you to your account information, calculators, webinars, and other resources to help you stay on the right retirement track. Visit our website today at ***www.mersofmich.com***.

MERS Service Center is available to assist you with your questions at **800.767.MERS (6377)** or send us a private message through Facebook.

Free, Local Seminars, called *Pizza & Planning*, are held throughout the state during the year. These, along with webinars and Facebook Live events, can provide important information on your MERS plans.

Sign up by visiting the MERS website.

This publication contains a summary description of MERS benefits, policies or procedures. MERS has made every effort to ensure that the information provided is accurate and up to date (as of the date of publication 09/19/2019). If this publication conflicts with the relevant provisions of the Plan Document, the Plan Document controls. MERS, as a governmental plan, is exempted by state and federal law from registration with the SEC. However, it employs registered investment advisors to manage the trust fund in compliance with Michigan Public Employee Retirement System Investment Act. Past performance is not a guarantee of future returns. Please make independent investment decisions carefully and seek the assistance of independent experts when appropriate.

My Pet Protection® from Nationwide®

Now with options to meet every budget.

my pet protection®

Our popular My Pet Protection pet insurance plans now feature more choices and more flexibility

- ✓ Get **cash back** on eligible vet bills
  Choose from three levels of reimbursement: 90%, 70% or 50%*
- ✓ Available **exclusively for employees**
  These plans aren't available to the general public
- ✓ **Same price for pets of all ages**
  Your rate won't go up because your pet had a birthday
- ✓ Use **any vet**, anywhere
  No networks, no pre-approvals
- ✓ Optional **wellness coverage** available
  Includes spay/neuter, dental cleaning, exams, vaccinations and more

Choose the reimbursement level that fits your needs

Problems such as upset stomach are among the most common reasons dogs and cats go to the vet. The average cost for this kind of visit is **$424**. Here's how My Pet Protection would cover the bill.*

90%
reimbursement

You pay: $43
Nationwide pays: $381

70%
reimbursement

You pay: $128
Nationwide pays: $296

50%
reimbursement

You pay: $212
Nationwide pays: $212

Examples reflect reimbursement after $250 annual deductible has been fulfilled.

Get more—enjoy these extras when you protect your pet with a Nationwide pet insurance policy

- **vethelpline**: Unlimited, 24/7 access to a veterinary professional ($150 value).
- Multiple-pet discounts available.†
- **VitusVet**: Mobile claims submission with the free VitusVet app.
- Fast, convenient electronic claim payments.
- Access to our award-winning magazine, *The Companion*.
- Discounts on hand-picked pet products and services.

Get a fast, no-obligation quote today at **http://www.petinsurance.com/gtpavilions**

Nationwide®
is on your side

Choose the level of coverage that fits your needs

Get 90%, 70% or 50% reimbursement on these vet bills and more.*

	my pet protection® with wellness	my pet protection®
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	

Both plans feature a $250 annual deductible and have a maximum annual benefit of $7,500.

Pre-existing conditions are not covered. Any illness or injury a pet had prior to start of policy will be considered pre-existing.*

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed.

Get a fast, no-obligation quote today at **http://www.petinsurance.com/gtpavilions**

To enroll your bird, rabbit, reptile or other exotic pet, call 877-738-7874.

*Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. †Pet owners receive a 5% multiple-pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets.

19GRMPP907050

Nationwide® is on your side

Legislative Updates

The Women's Health and Cancer Rights Act
The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:
- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and co-pays consistent with other coverage provided by the Plan.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting the mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

Mental Health Parity Act

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the Grand Traverse Pavilions Medical Plans are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

Health Insurance Portability and Accountability Act

We, in accordance with HIPAA, protect your Protected Health Information (PHI). We will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

Continuation Required By Federal Law for You and Your Dependents

Federal law enables your or your dependents to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact Human Resources.

HIPAA Special Enrollment Rights

Loss of Other Coverage – If you are declining enrollment for yourself and/or dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents other coverage. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after your other coverage ends or after the employer stops contributing toward the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and/or your dependents. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after the marriage, birth, adoption or placement for adoption. Contact Human Resources to request a special enrollment.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

For More Information or Assistance
To request special enrollment or obtain more information, please contact Human Resources.

REMEMBER: The Affordable Care Act requires most individuals to obtain health coverage or pay a penalty. Due to the passage of the Tax Cuts and Jobs Act in 2017 the penalty starting in 2019 going forward will be $0.

NOTICE OF PATIENT PROTECTIONS

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Blue Care Network generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Network at 1-800-662-6667.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at 1-800-662-6667.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid - Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid - Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Important Notice from Grand Traverse Pavilions About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Grand Traverse Pavilions, and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Grand Traverse Pavilions has determined that the prescription drug coverage offered by Grand Traverse Pavilions Medical Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Grand Traverse Pavilions medical plan coverage will not be affected.

Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the Grand Traverse Pavilions medical plan during the open enrollment period under the Medical Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Grand Traverse Pavilions. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Grand Traverse Pavilions changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2021

Name of Entity: Grand Traverse Pavilions

Contact: Lindsey Terrill
Phone: 231-932-3090

Office Address: 1000 Pavilions Circle, Traverse City, MI 49684

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Lindsey Terrill.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Grand Traverse Pavilions, 1000 Pavilions Circle. Traverse City, MI 49684 Lindsey Terrill 231-932-3090

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This privacy notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Your Information. Your Rights. Our Responsibilities.

This privacy notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you -We can use your health information and share it with other professionals who are treating you.

Run our organization -We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services -We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues -We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research -We can use or share your information for health research.

Comply with the law -We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director -We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests -We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions -We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Lindsey Terrill 231-932-3090.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Peterson McGregor
INSURANCE