Affordable & Comprehensive Health Benefits

BENEFITS GUIDEBOOK

2024

OSPREY
GUIDANCE YOU CAN TRUST

Schedule An Appointment Today with our Chamber Trusted Advisor at Osprey

Minimum Essential Coverage Health Plans

Medical Coverage

Full Time, Part Time, Seasonal, 1099's

AFFORDABLE | USABLE | ACA COMPLIANT

optionsplus

About Options Plus

WHAT IS A MEC PLAN?

MinimumEssentialCoverage(MEC)isemployer-sponsoredhealthinsurancecoveragethatlimitsyourcompany'sexposure to penalties under the Affordable Care Act.

BENEFITSTOTHEEMPLOYERBENEFITSTOTHEEMPLOYEEPREVENTIVE CARE

•LimitsexposuretoACApenalties•MeetsACAindividualmandate(NJ, •OptionsPlusMECPlanscover
•NounderwritingCA,RI,DC &morestatesto follow)theACAmandated preventive
•Lowparticipationrequirement•Easy to Usecareservicesforadults, women
•Bestnetpricing inthe market•Fullpreventivecarecoverageand children.
•Multiple plan designs & price points•Copayplanoptionswithunlimited
• Identicalplancoverageinallstates visits

PLAN HIGHLIGHTS

PRIMARY CARE VISITS
Allwellnessandpreventivetreatmentscoveredat 100%.

SPECIALIST VISITS
Seea specific kind ofdoctor such as internalmedicine, pediatrician,ora nurse practitioner, etc.

URGENT CARE
Easy access to quality healthcare for the times when yourprimarycarephysician'sofficesare closed

LABORATORY & X-RAYS
Labsandx-raysare alsocoveredthroughourplans!

DISCOUNT CARD
ReceivediscountsonbenefitslikeDental,Vision, DurableMedicalEquipment,HearingAids,&Fitness

VIRTUALCAREMEMBERSHIP|$0COPAY!
All-accesspass to your doctor through virtual office visits,phone calls,textmessagingandevenvideocalls-witha$0 copayandno deductible!

BEHAVIORALHEALTH/THERAPY|$50COPAY
Talkto a therapistby phone wheneveryou need one.*
*3x per year

A SECOND OPINION FREE
Reviewyourdiagnosiswith alicensedmedicalexpert byphone and onvideo chat

PRESCRIPTION COVERAGE
GenericRx,BrandRx,andDiscountRx

UNLIMITED VISITS | LOW COPAYS | BIG NETWORK

VALUE ADDED BENEFITS

ADDITIONAL PRODUCTS:

- Hospital Indemnity Coverage
- Dental Insurance
- Vision Insurance
- Discount Plans

ADDITIONAL SERVICES & FEATURES:

- Portal Access
- Bilingual Enrollment Materials
- IRS Reporting

MEC Plan Options

ACA Compliant | Minimum Essential Coverage (MEC) Plans

PLANS	WELLCARE MEC	
Employee Only	$65	
Employee +Spouse	$10	
Employee +Child(ren)	$5	
Family	$10	
MEDICALBENEFITS		
Wellness andPreventive	Covered at 100%	
Primary Care Visits	Use Telemedicine	
Specialists Visits	-	
Urgent Care Visits	-	
Laboratory Services	-	
X-Rays	-	
RxBENEFITS		
RxDiscount Plan	Included	
VIRTUALHEALTH BENEFITS		
Telemedicine	$0 Copay | Unlimited	
Virtual Behavioral Health	-	
MEC COMPANION CARD		
Dental	Included	
Vision	Included	
Durable Medical	Included	
Equipment Diabetic	Included	
Supplies	Included	
Fitness		

1.. Costs include plan documents, MultiPlannetwork, ID cards, enrollment guides, COBRA administration and claims management.
2.Plans exclude out-of-network services and cover only the services listed above and on the Preventive Care Benefits page.
3.Claims are repriced through the MultiPlanPHCS network. For services covered at a network discount, members will be responsible for paying the remaining balance after the network discount is applied. Discounts vary based on provider contracts.
4.Minimum participation requirement of 10 lives enrolled. 5.This plan is a Qualified Health Plan that meets the standards of Minimum Essential Coverage (MEC) under the Affordable Care Act (ACA).

MEC Plan Options

ACA Compliant | Minimum Essential Coverage (MEC) Plans

PLANS	OPTIMACARE MEC	ELITECARE MEC
Employee Only	$ 120	$151
Employee +Spouse	$ 212	$272
Employee +Child(ren)	$ 212	$272
Family	$ 307	$387
MEDICALBENEFITS		
Wellness andPreventive	Covered at 100%	Covered at 100%
Primary Care Visits	$15 copay | Unlimited	$15 copay | Unlimited
Specialists Visits	Network Discount	$15 copay | Unlimited
Urgent Care Visits	$50 copay|Unlimited	$50 copay |
Laboratory Services	Network Discount	Unlimited $50 copay
X-Rays	Network Discount	| Unlimited $50
RxBENEFITS		copay | Unlimited
Copay Level by Tier	$15/$30/$50/$75	$15/$30/$50/$75
VIRTUALHEALTH BENEFITS		
Telemedicine	$0 Copay |	$0 Copay |
Virtual Behavioral Health	Unlimited $50	Unlimited $50
MEC COMPANION CARD		Copay | 3x/year
Dental	Included	Included
Vision	Included	Included
Durable Medical Equipment	Included	Included
Diabetic Supplies	Included	Included
Fitness	Included	Included

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3.Claims are repriced through the MultiPlanPHCS network. For services covered at a network discount, members will be responsible for paying the remaining balance after the network discount is applied. Discounts vary based on provider contracts.
4.Virtual Health Benefits are offered through freshbenies. Members have access to 1) physician visits via phone or video, with prescriptions sent directly to the member's pharmacy, when medically necessary and 2) therapist consultations via video at $50 each (first 3 visits -$85 after
5.Minimum participation requirement of 10 lives enrolled.
6.This plan is a Qualified Health Plan that meets the standards of Minimum Essential Coverage (MEC) under the Affordable Care Act(ACA).

PROVIDER LOOKUP

FIND A PROVIDER FOR YOUR MEC PLAN

To locate providers participating in the PHCS and/or Multiplan networks:

Visit www.multiplan.us

Online Instructions:

Click “Find a Provider” located in the top right hand corner of the page.

Click on Select a Network.

A Pop Up appears to select Network. Select PHCS.

Select the plan type.

- Basic Plan: "Preventive Only"
- All Other Plans: "Specific Services"

Enter provider type: *i.e Primary Care, Ob-Gyn, Lab, etc.*

Enter zip code, then click on search and your directory will be provided.

WELLNESS & PREVENTIVE SERVICES

100% COVERED SERVICES

Preventive benefits foradults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood Pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over living in a community setting
- Hepatitis B screening for people at high risk
- HepatitisC screening for adults age18 to 79 years
- HIV screening for everyone age 15to 65, and other ages at increased risk
- PrEP(pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizationsfor adults —doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza), Hepatitis A, HepatitisB,Human Papillomavirus (HPV), Measles,Meningococcal, Mumps,Whooping Cough (Pertussis), Pneumococcal, Rubella,Shingles, and Tetanus
- Lung cancer screening for adults 55 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higherrisk
- Statin preventive medication for adults 40 to 75 years at high risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults with symptoms at high risk

Preventive benefits for women

- Bone density screening for all women over age 65 or women age64 and younger that have gone through menopause
- Breastcancergenetictestcounseling(BRCA)for women at higher risk (counseling only; not testing)
- Breast cancer mammography screenings:every 2 years for women over 50 and older or as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast Cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing wo men
- Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Cervical Cancer screening: Pap test (also called a Pap smear) for women 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all wo men

Preventive benefits for women (continued)

- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Expanded tobacco intervention and counseling for all pregnant tobacco users
- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for women

Preventive benefits for children

- Alcohol, tobacco,and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years,11 to 14 years, 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children: Age 0to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17years
- Blood screening for newborns
- Depression screening for adolescentsbeginning at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index(BMI)measurements taken regularly for all children
- Hematocritor hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screeningfor newborns
- PrEP(pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunizations for children from birth to age 18 —doses, recommended ages, and recommended populations vary: Chickenpox (Varicella); Diphtheria, Tetanus, and Pertussis(DTaP); Haemophilusinfluenza type B;Hepatitis A;Hepatitis B; Human Papillomavirus(HPV);Inactivated Poliovirus;Influenza (flu shot); Measles;Meningococcal;Mumps; Pneumococcal, Rubella; and Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 monthsto 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1to 4 years, 5 to 10 years, 11to 14 years, 15 to17 years
- Vision screening for all children
- Well-baby and well-child visits

For more information on preventive care benefits visit: **https://www.healthcare.gov/coverage/preventive-care-benefits/**

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- Vision screening for all children
- Well-baby and well-child visits

For more information on preventive care benefits visit: **https://www.healthcare.gov/coverage/preventive-care-benefits/**

CONVENIENT CARE ANYWHERE

optionsplus
MEC Plans & Discount Benefits

TELEMEDICINE

HEALTH CARE MADE EASY

Our telemedicine benefit provides you and your family access to board certified physicians around the clock (24/7/365) via telephone or secure video. Telemedicine physicians can give advice, diagnose or treat illness, and even prescribe medication right over the phone. With healthcare costs rising, an office visit with a PCP or Urgent Care Center can range from $155 to upwards of $300, and an ER visit can average almost $1,000*. With this benefit, there is no cost to you or your family for a consultation.

COMMON CONDITIONS TREATED

- Allergies
- Arthritic Pain
- Bronchitis
- Cold/Flu
- Conjunctivitis
- Diarrhea
- Ear Infections
- Gastroenteritis
- Headaches
- Insect Bites
- Sprains/Strains
- Respiratory Infections
- Sinus Infections
- Upset Stomach
- Urinary Tract Infections

And many other non-emergency conditions…

1 ACTIVATE YOUR ACCOUNT

Activate online or by calling member services. Once activated, you will need to setup you member profile and complete your electronic health record.

2 REQUEST A CONSULT

Login to your account online or call member services to request a consult anytime 24/7.

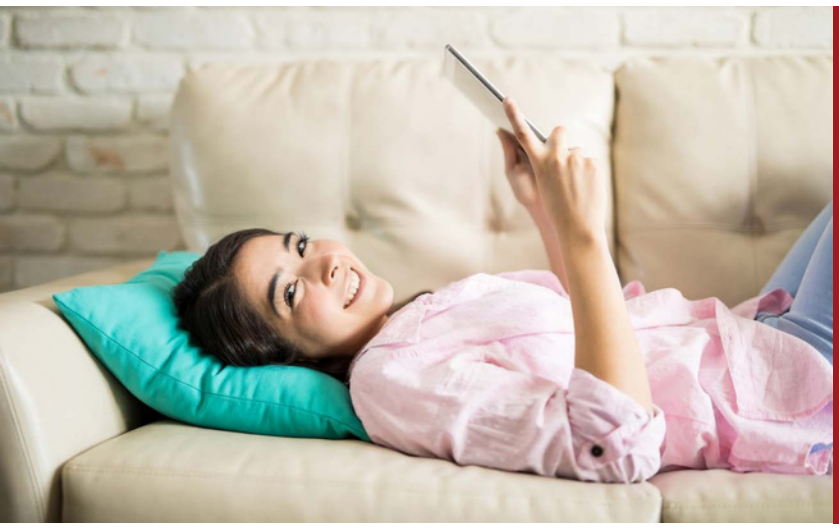
3 RECEIVE CARE

Receive diagnosis and treatment, giving you quality care and piece of mind where ever you are.

TALK TO A DOCTOR ANYTIME DAY OR NIGHT... FOR FREE.

THERAPY & COUNSELING FROM HOME

optionsplus
MEC Plans & Discount Benefits



BEHAVIORAL HEALTH

GETTING HELP JUST GOT EASIER.

Our Behavioral Health Benefit makes it easy to receive therapy and counseling from the comfort and privacy of your own home or office.

It can be difficult to wait days or weeks until your next appointment. Speak with one of our licensed psychiatrists or therapists online or by app.

WHAT WE TREAT:

We provide care for many of the most common behavioral health concerns with the added benefits of privacy and convenience.

- Abuse
- Codependency
- Domestic Violence
- OCD
- Addiction
- Conduct Disorder
- Eating Disorders
- Parenting Issues
- ADHD/ADD
- Cognitive Behavioral
- Grief & Loss
- Relationships
- Anger Management
- Therapy LGBT Issues
- Sexuality
- Anxiety & Stress
- •Depression & Mood •Med. Management •Trauma & PTSD
- •Bipolar Disorder
- • Divorce
- •Men's & Women's Issues
- •And more

HOW IT WORKS:

1 LOG IN

LOG IN TO YOUR ACCOUNT

2 SCHEDULE APPOINTMENT

SCHEDULE AN APPOINTMENT WITH THE BEHAVIORAL HEALTH PROVIDER OF YOUR CHOICE

3 CHAT

VIDEO CHAT WITH YOUR PROVIDER AND RECEIVE A PERSONALIZED TREATMENT PLAN.

MEC COMPANION CARD

When I show my MEC COMPANION CARD...

my card shows me the *savings!*

Dental – save up to 50%

Accepted at over 80,000 provider locations nationwide, and covers all dental services and specialties, including orthodontia. Savings can be as high as 50%, and there is no limitation on services or use.

Vision – save up to 50%

Accepted by over 11,000 OUTLOOK vision providers. Cardholders receive up to 50% savings on lenses, frames, and other vision needs.

MRI & Imaging – save up to 75%

Members receive concierge appointment service and enjoy savings up to 75% and more on MRI, PET, and CT scans, as well as other imaging services at over 4,000 locations nationwide.

Lab – save up to 50%

Members save up to 50% using the online search tool to locate a lab and order their test. Actual savings are displayed immediately. Test results are available within 48-96 hours.

Hearing – save up to 70%

Members receive a free hearing test and up to 70% discount on hearing aids at 2,200 providers nationwide.

Diabetic Care Services – save up to 70%

A full line of diabetes testing supplies are delivered directly to the member's home.

Vitamins – save 5%

A wide range of vitamin and mineral supplements are delivered directly to the member's home at discounted rates.

Daily Living Products – save up to 10%

A wide range of medical supplies, safety equipment, and health products are delivered directly to the member's home at discounted rates.

MetLife

WEBSURANCE®
ONLINE BENEFIT ADMINISTRATORS

WEBSURANCE BENEFITS TRUST
Administered by Howell Benefit Services, Inc.
www.websurance.io

MetLife Dental Plans
Basic Plan
Premiere Plan

Dental Rate

Monthly MAC Rates		
Enrollment must be received on or before the 30th of the month prior to the Effective Date		
	Basic Dental	**Premium Dental**
Employee:	$28.83	$38.10
Employee + 1 Adult:	$66.44	$81.91
Employee + Child(ren):	$69.78	$85.99
Family:	$99.66	$122.87

WEBSURANCE BENEFITS TRUST

^

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Basic Plan

Network: PDP Plus

	In-Network1 % of Negotiated Fee2	Out-of-Network1 % of Maximum Allowable Charge*
Coverage Type		
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures)	0%	0%
Deductible†		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Person	$2,000	$2,000

Child is covered until end of year when turn age 26.
Type A services don't count towards the annual maximum benefit.

1In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist.
2Negotiatedfees referto the feesthatparticipatingdentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
†Applies to Type B Services.

^ Basic Plan for all States except for MT and AK.

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DN-ANY-PPO-DUAL

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category but is not a complete description of the Plan.

Plan Type	How Many/How Often
Type A — Preventive	
Prophylaxis (cleanings)	2 times in 12 months
Oral Examinations	2 times in 12 months
Topical Fluoride Applications	2 times in 12 months for a dependent child under age 19
X-rays	Full mouth X-rays; once in 5 calendar years Bitewings X-rays; For a child under 19: 1 time in 6 months Adult: 1 time in 12 months
Sealants	1 per molar in 36 months for a child under age 16
Type B — Basic Restorative	
Fillings	1 replacement per surface in 12 Months
Simple Extractions	
Oral Surgery	
Endodontics	Root canal treatment limited to 1 per tooth per lifetime
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	Periodontal scaling and root planing once per quadrant in any 24 month period Periodontal surgery once per quadrant in any 24 month period Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Crown, Denture and Bridge Repair/ Recementations	1 in 12 months
Space Maintainers	Space maintainers for dependent children up to his/her 19th birthday.

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - oScaling and polishing of teeth; or
  - oFluoride treatments;

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DN-ANY-PPO-DUAL

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-

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Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Questions & Answers

Q.Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q.How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

Q.What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q.May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q.Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

Q.How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Q.Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q.Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A.* Yes. Through international dental travel assistance services you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q.How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require

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Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q.Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

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WEBSURANCE BENEFITS TRUST

Premium Plan

Network: PDP Plus

	In-Network1 % of Negotiated Fee2	Out-of-Network1 % of Maximum Allowable Charge*
Coverage Type		
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%
Type D: Orthodontia	50%	50%
Deductible†		
Individual	$25	$25
Family	$75	$75
Annual Maximum Benefit		
Per Person	$2,500	$2,500
Orthodontia Lifetime Maximum		
Per Person ***	$1,000	$1,000

Child is covered until end of year when turn age 26.
Type A services don't count towards the annual maximum benefit.

1In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist.

2 Negotiatedfees refertothefeesthatparticipating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

†Applies to Type B & C Services.

*** Orthodontia excluded for adults. Available for dependent children up to age 19.

^ Premium Plan for all states except MT and AK.

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Dental Insurance

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List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category but is not a complete description of the Plan.

Plan Type	How Many/How Often
Type A — Preventive	
Prophylaxis (cleanings)	2 times in 12 months
Oral Examinations	2 times in 12 months
Topical Fluoride Applications	2 times in 12 months for a dependent child under age 19
X-rays	Full mouth X-rays; once in 5 calendar years Bitewings X-rays; For a child under 19: 1 time in 6 months Adult: 1 time in 12 months
Sealants	1 per molar in 36 months for a child under age 16
Type B — Basic Restorative	
Fillings	1 replacement per surface in 12 Months
Simple Extractions	
Oral Surgery	
Endodontics	Root canal treatment limited to 1 per tooth per lifetime
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	Periodontal scaling and root planing once per quadrant in any 24 month period Periodontal surgery once per quadrant in any 24 month period Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in 12 months
Space Maintainers	Space maintainers for dependent children up to his/her 19th birthday.
Crown, Denture and Bridge Repair/ Recementations	1 in 12 months
Type C — Major Restorative	
Implants	Replacement once 60 months
Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the plan Dentures and bridgework replacement; once every 5 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 5 years
Type D — Orthodontia	

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- Your children, up to age 19, are covered while Dental insurance is in effect.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary
- Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - oScaling and polishing of teeth; or
  - oFluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - oCovered under any workers' compensation or occupational disease law;
  - oCovered under any employer liability law;
  - oFor which the employer of the person receiving such services is not required to pay; or
  - oReceived at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - oClaim form completion;
  - oInfection control such as gloves, masks, and sterilization of supplies; or
  - oLocal anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;

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- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

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Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

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A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

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A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

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A. * Yes. Through international dental travel assistance services you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be ** considered under your out-of-network benefits. Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

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**Refer to your dental benefits plan summary for your out-of-network dental coverage.

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ONLINE BENEFIT ADMINISTRATORS

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www.websurance.io

Vision

Vision Rate

Monthly Rates for		
Enrollment must be received on or before the 30th of the month prior to the Effective Date		
	Basic Vision	**Premium Vision**
Employee:	$5.98	$7.78
Employee + 1 Adult:	$11.36	$14.78
Employee + Child(ren):	$11.66	$15.17
Family:	$15.05	$20.21
Rates listed in this proposal will remain in force until 12/31/2026		

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WEBSURANCE BENEFITS TRUST

BASIC PLAN

$0 Exam / $0 Materials Copay

FREQUENCY OF SERVICE: Last Date of Service			DEPENDENT AGE: 26 (EOBY)
	Employee	**Spouse**	**Children**
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	12 Months	12 Months	12 Months

BENEFITS: Employee can select either:	VBA Participating Provider Amount Covered/Benefit	Non-Participating Provider Amount Reimbursed
Vision Exam (Glasses or Contacts)	100%	$40
Clear Standard Lenses (Pair):		
Single Vision	100%	$40
Bifocal	100%	$60
Blended Bifocal	100%	$60
Trifocal	100%	$80
Progressives	Partially Covered	$80
Lenticular	100%	$120
Polycarbonate	100%	N/A
Scratch Coat-1 Yr	100%	N/A
Solid or Gradient Lens Tint	100%	N/A
Frame	100%	$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	$150	$150
Fitting Fee	15% off UCR	N/A
-OR-		
Medically Necessary Contacts	100%	$450
-AND-		
Lasik Surgery (once every 8 years)	N/A	$125

A Participation may vary by location. Check with your Provider for details.
B Available In-Network at no charge for children under age 19.
C Up to the program's $50 wholesale allowance.
D The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.
E Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

Limitations

This plan is designed to cover your visual needs rather than cosmetic options.

ADDITIONAL CHARGES

You may incur out-of-pocket charges when selecting any of the following:

- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $45)
- The coating of the lens or lenses (except 1 year scratch
- protection) A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective/Backside UV/Optifog

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

NOT COVERED

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

•Orthoptics or vision training

•Non-prescription lenses

•Two pair of glasses in lieu of bifocals

•Medical or surgical treatment of the eyes

•Any eye examination, or corrective eyewear, required by an employer as a condition of employment

•Services or materials provided as a result of any Worker's Compensation Law or similar legislation

•Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

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WEBSURANCE BENEFITS TRUST

PREMIUM PLAN

$0 Exam / $0 Materials Copay

Glasses & Contacts in Same Benefit Period

FREQUENCY OF SERVICE: Last Date of Service — DEPENDENT AGE: 26 (EOBY)

	Employee	Spouse	Children
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	12 Months	12 Months	12 Months

BENEFITS: Employee can select either:

	VBA Participating Provider Amount Covered/Benefit	Non-Participating Provider Amount Reimbursed
Vision Exam (Glasses or Contacts)	100%	$40
Clear Standard Lenses (Pair):		
Single Vision	100%	$40
Bifocal	100%	$60
Blended Bifocal	100%	$60
Trifocal	100%	$80
Progressives	Partially Covered **A**	$80
Lenticular	100%	$120
Polycarbonate	100% **B**	N/A
Scratch Coat-1 Yr	100%	N/A
Solid or Gradient Lens Tint	100%	N/A
Frame	100% **C**	$50
Elective Contacts	$150 **D**	$150
Material Allowance	15% off UCR **A**	N/A
Fitting Fee	100% **E**	$450
-OR-		
Medically Necessary Contacts -		
AND-		
Lasik Surgery (once every 8 years)	N/A	$125

A Participation may vary by location. Check with your Provider for details.

B Available In-Network at no charge for children under age 19.

C Up to the program's $50 wholesale allowance.

D The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

E Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

Limitations

This plan is designed to cover your visual needs rather than cosmetic options.

ADDITIONAL CHARGES

You may incur out-of-pocket charges when selecting any of the following:

- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $45)
- The coating of the lens or lenses (except 1 year scratch
- protection) A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective/Backside UV/Optifog

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

NOT COVERED

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

•Orthoptics or vision training

•Non-prescription lenses

•Two pair of glasses in lieu of bifocals

•Medical or surgical treatment of the eyes

•Any eye examination, or corrective eyewear, required by an employer as a condition of employment

•Services or materials provided as a result of any Worker's Compensation Law or similar legislation

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

Ancillary

Critical Illness
Accident
Hospital Indemnity

Ancillary

Critical Illness
Accident
Hospital Indemnity

PEACE OF MIND FOR THE UNEXPECTED

Even the best-laid plans can be thrown off by an unexpected emergency. Being prepared starts with an understanding of how both Wealth + Health℠ affect your quality of life, especially when it comes to healthcare costs. Transamerica's voluntary insurance benefits can help provide the protection you and your family need.

Because what good is wealth without the health to enjoy it?

Questions?

Visit: transamerica.com

Call: 855-244-8318

In this guide:

Transamerica Critical Illness Insurance℠
- Highlights
- Underwriting and Eligibility
- Product Details

Transamerica℠ Accident Insurance
- Highlights
- Underwriting and Eligibility
- Product Details

***Hospital Select*® II Hospital Indemnity Insurance**
- Highlights
- Underwriting and Eligibility
- Product Details

Limitations And Exclusions
- Transamerica Critical Illness Insurance
- Transamerica Accident Insurance
- Hospital Select II

About Transamerica Critical Illness Insurance℠

OFFER FLEXIBLE BENEFITS DESIGNED TO MEET THEIR NEEDS

A critical illness can come in many forms, leaving employees unable to work and provide for themselves and their families. So, when employees fall ill with a critical illness, they deserve help protecting their finances and their loved ones' futures.

Transamerica's critical illness insurance is modernized with expanded, customizable benefits and benefit amounts, as well as increased flexibility to select benefits that best meets the needs of your workforce.

HOW TRANSAMERICA'S CRITICAL ILLNESS INSURANCE WORKS

A supplement to major medical insurance, Transamerica's critical illness insurance is a flexible option that pays a lump-sum benefit that can be used to offset out-of-pocket costs not covered by major medical. You can also add a number of additional benefit options to provide additional protection.

CRITICAL ILLNESS INSURANCE HIGHLIGHTS

- No lifetime benefit maximum
- No waiting period
- Benefits paid directly to the employee
- Streamlined billing and self-administration without the need to reconcile at the policy level
- Easy payroll-deducted premiums
- Family options available
- Guaranteed issue available

This is a brief summary of Transamerica Critical Illness Insurance℠ – CI12 **underwritten by Transamerica Life Insurance Company (TLIC)**, Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series TMCI1200-1020 and TCCI1200-1020. Forms and numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Please refer to the policy, certificate, and riders for complete details.

Underwriting Offer and Eligibility

EMPLOYEE ELIGIBILITY

To be eligible for insurance, an employee must be 18 years or older and:

- Be actively employed, performing all regular duties at the place of business or another location directed by the employer
- Be continuously employed and meeting the minimum hourly and time requirements for benefit eligibility. These requirements will be defined on the Life and Health Group Application and Agreement
- Provide satisfactory evidence of insurance to us, if required
- Not be covered by any Title XIX program such as Medicaid

SPOUSE ELIGIBILITY

To be eligible for insurance, a spouse must be 18 years or older and:

- Be a legally married spouse, common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the employer and us
- Not be eligible as an insured under the policy
- Provide satisfactory evidence of insurance to us, if required
- Not be covered by any Title XIX program such as Medicaid

CHILD ELIGIBILITY

To be eligible for insurance, a child must be under the age of 26 and be any of the following:

- A natural child
- A legally adopted child or child who has been placed for adoption with the employee
- A stepchild or foster child
- A grandchild who lives with the employee
- A child for whom the employee has been appointed legal guardian
- A child for whom the employee is legally required to provide support
- Child must also not be covered by any Title XIX program such as Medicaid and provide satisfactory evidence of insurance to us, if required.

Insurance for child dependents may continue beyond the maximum age in the event of mental or physical impairment. Proof of incapacity and conditions may vary by state.

MINIMUM PARTICIPATION

At least 2 insured employees are required to establish and maintain an employer group. Other group types may require higher participation.

Underwriting Offer and Eligibility

UNDERWRITING LIMITS FOR GROUPS WITH 250 BENEFIT-ELIGIBLE EMPLOYEES

Guaranteed issue underwriting is only available the first time an employee is eligible to apply. If the employee applies for insurance at a later date, it is subject to simplified issue underwriting.

UNDERWRITING GUIDELINES FOR PLAN OPTION 1

GUARANTEED ISSUE (GI) MINIMUM PARTICIPATION	GUARANTEED ISSUE (GI) MAXIMUM ISSUE	SIMPLIFIED ISSUE (SI) MINIMUM PARTICIPATION	SIMPLIFIED ISSUE (SI) MAXIMUM ISSUE
20% issuable employee applications of a benefit-eligible class	$25,000	5 issuable employee applications of a benefit-eligible class	$50,000

OTHER CONSIDERATIONS

- This proposal is based on employer groups with 250 eligible employees only and may not be available to other group types and sizes.
- Employees residing in California, Georgia, Massachusetts, Minnesota, or Vermont are required to have a major medical plan in order to apply. Insurance cannot be issued to anyone who does not have a major medical plan.
- A Vermont proposal needs to be generated for employees residing in Vermont if:
  - More than 25% of employees reside in the state of Vermont; or
  - Face-to-face solicitation will be performed at a workplace in the state of Vermont
  - Impacted employees should enroll in Vermont approved insurance.
- Prior to sale, if the group is currently enrolled with another carrier, Underwriting will need an employee listing with the current enrolled benefit amounts and effective dates to review the following:
  - Approval of credit for time served
  - Guaranteed issue to the employees current benefit amount

Product Details

DEPENDENT INSURANCE	PLAN OPTION 1
Spouse/Adult Dependent	50% of the employee benefit amount
Child Dependent	50% of the employee benefit amount

BENEFIT CATEGORIES

The Benefit Amount is elected by the employee on the application or enrollment form. The benefit is a percentage of the Benefit Amount or the dollar amount shown below.

BENIGN TUMOR CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Benign Brain Tumor	100% 100%	
Benign Spinal Cord Tumor	100% 100%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

CANCER CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Invasive Cancer	100% 100%	
Non-Invasive Cancer	25% 25%	
Skin Cancer	$750 $750	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

CARDIOVASCULAR DISEASE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Coronary Artery Disease Requiring Angioplasty/Stent	10% 10%	
Coronary Artery Disease Requiring Bypass Grafts	25% 25%	
Coronary Invasive	100% 100%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

Product Details

CHILDHOOD DISEASE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Cerebral Palsy	100% N/A	
Cleft Lip/Palate	50% N/A	
Cystic Fibrosis	100% N/A	
Down Syndrome	100% N/A	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

FUNCTIONAL LOSS CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Sensory Loss	100% N/A	
Monoplegia	50% N/A	
Quadriplegia, Paraplegia, or Hemiplegia	100% N/A	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

HEART ATTACK CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Heart Attack	100% 100%	
Sudden Cardiac Arrest	100% 100%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

INFECTIOUS DISEASE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Anthrax	100% N/A	
Cholera	100% N/A	
Rocky Mountain Spotted Fever	100% N/A	
Encephalitis/Bacterial Meningitis	100% N/A	
Typhoid Fever	100% N/A	
Tuberculosis	100% N/A	
Malaria	100% N/A	
Os t e o mye lit is	100% N/A	
SARS – CoV-2	25% N/A	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

Product Details

KIDNEY FAILURE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
End Stage Renal Failure	100% N/A	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

MAJOR ORGAN TRANSPLANT CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Bone Marrow Transplant	100% 100%	
Major Organ Transplant (except Bone Marrow)	100% 100%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

PROGRESSIVE DISEASE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Alzheimer's Disease	100% N/A	
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	100% N/A	
Lupus	100% N/A	
Multiple Sclerosis	100% N/A	
Parkinson's Disease	100% N/A	
Primary Sclerosing Cholangitis (Walter Peyton's Disease)	100% N/A	
Other Dementia	100% N/A	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

SEVERE BURNS CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Severe Burns	100% 100%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

STROKE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
St ro ke	100% 100%	
Transient Ischemic Attack (TIA)	10% 10%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

Product Details

VASCULAR DISEASE CATEGORY		
	PLAN OPTION 1	
SUB-BENEFIT	First Occurrence Benefit Amount	Recurrent Benefit Amount
Abdominal/Thoracic Aortic Aneurysm	25% 25%	
Carotid Artery Disease	25% 25%	
Cerebral Aneurysm	25% 25%	
Renal Aneurysm	25% 25%	
Lifetime Category Maximum Per Insured Person	No Lifetime Maximum	

SUPPLEMENTAL BENEFITS

SECOND OPINION BENEFIT RIDER (RIDER FORM SERIES TROP1200-1020)	PLAN OPTION 1
Pays a second opinion benefit if an insured incurs expenses for a second medical opinion from a physician on recommended surgery or treatment following the positive diagnosis of a covered critical illness.	Benefit Amount: $250
Lifetime Maximum Per Insured	$2,000

Product Details

HEALTH SCREENING BENEFIT RIDER (RIDER FORM SERIES TRWE1200-1020)	PLAN OPTION 1
Pays a benefit once per insured per calendar year for undergoing a Health Screening Test, regardless of the number of tests the insured undergoes. Health Screening Test includes, but may not be limited to, one of the below listed tests performed under the supervision of or recommendation by a physician while this rider is in force.	**Benefit Amount: $50**
Cholesterol and Diabetes • Blood Test Total Cholesterol • Blood Test Total Triglycerides • Fasting Blood Glucose Test • Fasting Plasma Glucose Test	• Hemoglobin A1C • Serum Cholesterol Test LDL/HDL Levels • Two-hour Post-load Plasma Glucose Test
Cancer • Biopsies for Cancer • Bone Marrow Testing • Breast MRI • Breast Ultrasound • Breast Sonogram • Cancer Antigen 15-3 Blood Test for Breast Cancer (CA 15-3) • Cancer Antigen 125 Blood Test for Ovarian Cancer (CA 125) • Carcinoembryonic Antigen Blood Test for Colon Cancer (CEA) • Colonoscopy • Doppler Screening for Cancer • Endoscopy	• Flexible Sigmoidoscopy • Hemoccult Stool Specimen • Oral Cancer Screening • PAP Smears or Thin Prep PAP Test • Prostate-Specific Antigen (PSA) Test • Serum Protein Electrophoresis • Skin Cancer Biopsy • Skin Cancer Screening • Skin Exam • Virtual Colonoscopy
Cardiovascular Function • Carotid Doppler • Doppler Screening for Peripheral Vascular • Disease Echocardiogram (Echo)	• Electrocardiogram (ECG or EKG) • Electroencephalogram (EEG) • Stress Test on Bicycle or Treadmill
Imaging Studies • Chest X-Rays • Mammogram • Thermography	• Ultrasounds for Cancer Detection • Ultrasound Screening of the Abdominal Aorta for Abdominal Aortic Aneurysms
Periodic Physical and Blood Examinations • Routine Health Check-up • Exam Blood Chemistry Panel • Clinical Testicular Exam • Complete Blood Count (CBC) • Dental Exam • Digital Rectal Exam (DRE)	• Eye Exams • Hearing Test • Lipid Panel • Successful Completion of Smoking Cessation Program • Tests for Sexually Transmitted Infections (STIs)
Immunizations • Immunization	• Human Papillomavirus Vaccination (HPV)

Product Details

PROVISIONS

BENEFIT SEPARATION PERIOD	PLAN OPTION 1
First Occurrence Benefit Separation Period The number of days that must elapse between the date of diagnosis of two medically unrelated illnesses for benefits to be payable for the second illness as a first occurrence.	**30 days**
Recurrent Benefit Separation Period The number of days that must elapse between the date of diagnosis for the first time an insured is diagnosed and the second time they are diagnosed with the same covered illness.	**90 days**

If an insured is diagnosed with multiple covered conditions that are medically related as determined by a physician, the applicable benefit separation period, we will only pay one benefit which will be the higher critical illness benefit amount. If the last critical illness benefit payment under the certificate was less than 100% of the applicable benefit amount, we will waive the applicable benefit separation period.

Definitions

Availability of benefit categories and sub-benefits may vary by state.

CRITICAL ILLNESS BENEFIT

First Occurrence – The first time a covered critical illness is diagnosed on or after the insured's effective date.

First Occurrence Critical Illness – If an insured is diagnosed with the first occurrence of a critical illness, we will pay a lump sum benefit. The positive first occurrence diagnosis must be made after the effective date of the certificate, while the certificate is in force, and after the applicable benefit separation period has been satisfied.

Recurrent Critical Illness – If an insured is diagnosed with a recurrent critical illness, we will pay a lump sum benefit. The positive recurrent diagnosis must be made after the effective date of the certificate, while the certificate is in force, and after the applicable benefit separation period has been satisfied. Only one recurrent critical illness benefit may be paid per insured for each critical illness.
Benefits may be subject to lifetime category maximums per insured person.

CRITICAL ILLNESS

An illness or condition listed in one of the covered condition categories. Positive diagnosis must be made by a physician.

BENIGN TUMOR COVERED CONDITION CATEGORY

Benign Brain Tumor – The presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.
Does not include:

- Acoustic neuromas
- Tumors of the skull
- Tumors of the spinal cord
- Pituitary adenomas
- Germinomas

Benign Spinal Cord Tumor – The presence of a non-cancerous tumor, located in the spinal cord.
Does not include:

- Tumors of the brain
- Tumors of the vertebrae
- Tumors of peripheral nerves

Benign Tumor Covered Condition Exclusions

This benign tumor category does not include tumors resulting from:

- Neurofibromatosis I or II
- Von Hippel Lindau disease
- Tuberous sclerosis
- Cowden disease

CANCER COVERED CONDITION CATEGORY

Invasive Cancer – The presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin.
Includes:

Definitions

- A malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness
- A cancer that is a leukemia or lymphoma
- Where an insured has terminal cancer and has a life expectancy of 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy

Non-Invasive Cancer – (Including Carcinoma in Situ) The presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Does not include skin cancer.

Includes:

- A malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness
- A tumor of the prostate classified as T1bN0M0, or T1cN0M0
- A Carcinoma in Situ classified as TisN0M0
- **Skin Cancer** – Any malignant growth that arises on the surface of the skin that is any of the following:
  - Basal cell carcinoma
  - Squamous cell carcinoma
  - Malignant melanoma that remains confined to the epidermis

- **Cancer Covered Condition Exclusions**

This cancer category does not include other conditions which may be considered precancerous including, but not limited to:

- Leukoplakia
- Hyperplasia
- Polycythemia vera
- Moles
- Lesions
- Similar diseases
-

CARDIOVASCULAR COVERED CONDITION CATEGORY

Coronary Artery Disease Requiring Angioplasty/Stent – Coronary artery disease requiring a balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. This benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries, carotid arteries, or other peripheral arteries is not coronary artery disease and does not qualify for this benefit.

Coronary Artery Disease Requiring Bypass Grafts – Coronary artery disease requiring a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Angiographic evidence to support the necessity for this surgery will be required. This benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries, carotid arteries, or other peripheral arteries is not coronary artery disease and does not qualify for this benefit. Also for the purposes of this benefit, a surgical operation to correct narrowing or blockage does not include the following:

- Balloon angioplasty
- Laser embolectomy
- Atherectomy
- Stent placement
- Any non-surgical procedures

Definitions

Coronary Artery Disease Requiring Heart Valve Repair or Replacement (Coronary Invasive) – Coronary artery disease requiring the aortic valve or mitral valve is repaired or replaced with a mechanical or bio-prosthetic heart valve by a procedure that is either of the following:

- A surgery in which a median sternotomy is performed
- A minimally invasive procedure in which a transcatheter valve repair or replacement, or minimal incision valve surgery is performed

If the insured is diagnosed with more than one cardiovascular disease covered condition at the same time or on the same day for which a benefit is payable, we will pay the applicable benefit for one cardiovascular disease covered condition, which will be for the covered condition that pays the highest benefit amount.

CHILDHOOD DISEASE COVERED CONDITION CATEGORY

Childhood Disease Covered Condition Exclusions

We will not pay benefits for:

- A suspected or probable diagnosis of a childhood covered condition
- A childhood covered condition that is diagnosed for a stillborn child
- A childhood covered condition that is diagnosed during pregnancy which is later terminated due to abortion or miscarriage

FUNCTIONAL LOSS COVERED CONDITION CATEGORY

Sensory Loss – Loss of sight, hearing or speech.

Paralysis – Quadriplegia, paraplegia, hemiplegia or monoplegia that is expected to last for a continuous 6-month
period or longer from the date of diagnosis to determine if paralysis is permanent. A benefit will not be paid for paralysis that results from a stroke or psychiatric related causes.

Functional Loss Covered Condition Exclusions

- We will not pay benefits for a functional loss covered condition for any of the following:
- A functional loss covered condition that is associated with the total and irreversible loss of all brain function (brain death)
- A functional loss covered condition that is a dismemberment of an extremity
- A functional loss covered condition caused by a congenital birth defect
- Any functional loss covered condition for which, in general medical opinion or practice, surgery, an adaptive device or other corrective measure could restore function

HEART ATTACK COVERED CONDITION CATEGORY

Myocardial Infarction – The ischemic death of a portion of the heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by either of the following criteria:

- The presence of three or more of the following indicators:

  a)Pain, pressure, fullness, discomfort, or squeezing in the center of the chest

  b)Radiating pain to the shoulder, neck, back, arm or jaw

  c)New EKG changes indicative of myocardial infarction

  d)Diagnostic increase of specific cardiac markers typical for heart attack

  e)Confirmatory imaging studies

- In the event of death, an autopsy confirmation identifying heart attack as the cause of death will be accepted

D efinitions

Sudden Cardiac Arrest – The sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly and unexpectedly stops beating because of an internal electrical disturbance of the heart, which results in an insured being pronounced deceased by a physician.

If an insured sustains a myocardial infarction and sudden cardiac arrest which are diagnosed at the same time or on the same day and for which a heart attack benefit is payable, we will pay the critical illness benefit for only one of the heart attack covered conditions; which will be for the heart attack covered condition that pays the highest benefit amount.

Additional proof of loss requirements for heart attack covered conditions may be required.

INFECTIOUS DISEASE COVERED CONDITION CATEGORY

Proof of SARS – CoV-2 infection requires a clinical diagnosis that is substantiated in writing by a physician and must include additional documentation showing any of the following:

- The insured was confined in a hospital as an inpatient in an intensive care unit (ICU) for 5 consecutive days
- The insured has died from SARS – CoV-2 while confined in a hospital as an inpatient in an intensive care unit (ICU)

KIDNEY FAILURE COVERED CONDITION CATEGORY

End Stage Renal Failure – The end stage failure which presents a chronic, irreversible failure of both kidneys, and requires treatment by renal dialysis.

The date of diagnosis of a kidney failure covered condition will be the earlier of:

- The date the insured receives the first kidney dialysis treatment
- The date the insured is placed on the transplant list

MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY

Bone Marrow Transplant – The irreversible failure of an insured's bone marrow for which replacement of the bone marrow (stem cells) from a human donor is medically necessary.

Major Organ Failure Requiring Transplant (Other Than Bone Marrow) – The irreversible failure of an insured's heart, lung, pancreas, kidney (entire renal function), or any combination of such organs, for which a physician has determined that there is medical evidence to support the complete replacement of such organ with an entire organ from a donor. It can also be the irreversible failure of an insured's liver for which a physician has determined that there is medical evidence to support the complete or partial replacement of the liver or liver tissue from a human donor. The need for a transplant must be due to sever organ disease. Documentation of the diagnosis is required that shows the insured has either been placed on the transplant list or such major organ transplant procedure has been performed.

The date of diagnosis of a major organ transplant covered condition will be the earlier of:

The date an insured is placed on the transplant list

- The date an insured undergoes a major organ transplant procedure
- If an insured is placed on the transplant list and then subsequently undergoes a major organ transplant procedure on

the same organ for which the insured was on the transplant list, we will treat this as a single diagnosis of a major organ transplant covered condition.

Two or more organs transplanted on the same day or during the same surgery shall be deemed one diagnosis of a major organ transplant covered condition.

We will not pay benefits for a major organ transplant covered condition for an insured:

Definitions

- If we have paid an initial benefit for a kidney failure covered condition to the insured and the organ for which a major organ transplant procedure is performed is a kidney
- If we have paid an initial benefit for invasive cancer for the same cancer condition for which a major organ transplant of bone marrow replacement is performed
- If prior to the insured's insurance becoming effective, the insured had been placed on a transplant list for the
- same organ for which the major organ transplant procedure is performed
- For a transplant involving organs received from non-human donors
- For a transplant involving implantation of medical devices or mechanical organs

For a transplant involving islet cell transplants

PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

Alzheimer's Disease – A clinically established diagnosis of Alzheimer's Disease that is based upon a sever cognitive
impairment of such progressive nature that it results in an insured's inability to independently perform (without hands-on assistance) 2 or more of the activities of daily living.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's) – A neurodegenerative neuromuscular disease that results in the progressive loss of motor neurons that control voluntary muscles.

Lupus – A systemic autoimmune disease that occurs when the body's immune system attacks its own tissues and organs, causing inflammation affecting many different body systems, including the joints, skin, kidneys, blood cells, brain, heart and lungs.

Multiple Sclerosis (MS) – A chronic and progressive disease involving damage of the sheaths of nerve cells in the brain and spinal cord (central nervous system). MS symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue.

Parkinson's Disease – A progressive nervous system disorder that affects movement and results in an insured's inability to independently perform (without hands-on assistance) 2 or more of the activities of daily living for a continuous period of 90 days.

Primary Sclerosing Cholangitis (Walter Payton's Disease) – A chronic, long-term, disease that slowly damages the bile ducts.

Other Dementia – The development of multiple progressive cognitive defects manifested by memory impairment and other cognitive disturbances and for which one or more of the following tests document changes to the specific areas of the brain that result in cognitive disturbances: electroencephalogram (EEG); or imaging studies, including computed tomography (CT), magnetic resonance imaging (MRI), fluorodeoxyglucose positron emission tomography (FDG Pet Scan) or amyloid positron-emission tomography scan. Cognitive Disturbances are defined as the following intellectual impairments: aphasia, apraxia, agnosia, disturbance in executive functioning.

Other dementia includes the following types of neurological conditions:

- Lewy body dementia
- Progressive supranuclear palsy
- Corticobasal degeneration
- Parkinson's disease dementia
- Frontotemporal dementia
- Primary progressive aphasia
- Normal-pressure hydrocephalus
- Rapidly progressive dementia as in Creutzfeldt-Jakob disease

Other dementia does not include:

D efinitions

- Alzheimer's disease
- Substance-induced conditions
- A form of dementia that is a mental and nervous condition, such as schizophrenia or psychoses
- Any form of Parkinson's disease other than Parkinson's disease dementia
- Reversible dementias such as those caused by thyroid or other hormonal abnormalities, or vitamin deficiencies

For the purposes of this category, Activities of Daily Living include the following activities: bathing, continence, dressing, eating, toileting, transferring.

SEVERE BURN COVERED CONDITION CATEGORY

Severe Burns – Insured has sustained a burn that is at least a third-degree burn and covers at least 20% of the total body surface area.

STROKE COVERED CONDITION CATEGORY

Stroke - A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage, or embolization of brain tissue from an extracranial source. The diagnosis must be based on documented irreversible neurological deficits and confirmatory neuroimaging studies. A stroke does not include cerebral symptoms due to:

- Transient Ischemic Attack (TIA)
- Reversible neurological deficit
- Migraine
- Cerebral injury resulting from trauma or hypoxia
- Vascular disease affecting the eye, optic nerve or vestibular functions

Transient Ischemic Attack (TIA) – A temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- There are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery
- There is no evidence of cerebral tissue damage on diagnostic imaging
- The reversible functional neurological impairments are confirmed by a clinical diagnosis

VASCULAR DISEASE COVERED CONDITION CATEGORY

Abdominal Aortic Aneurysm – Located in the abdominal (lower) part of the aorta

Thoracic Aortic Aneurysm – Located in the thoracic (upper) part of the aorta

Carotid Artery Aneurysm – Located in the portion of the carotid artery that is in the neck

Cerebral Aneurysm – Located in an artery in the brain

Renal Aneurysm – Located in the renal artery

About Transamerica Accident Insurance

BECAUSE ACCIDENTS HAPPEN

An accident can happen to anyone, at any time. When employees are able to protect their finances — even when unexpected accidents happen — they can worry less and focus more on what's important. That's why Transamerica offers the voluntary benefits employees need to help provide financial protection against the unexpected. So when accidents happen, our accident insurance helps with out-of-pocket costs major medical insurance won't cover — whether it's a minor injury or something more severe.

OFFER MORE PROTECTION WITH TRANSAMERICA ACCIDENT INSURANCE

Transamerica's supplemental accident insurance works side-by-side with major medical insurance to help cover injuries and treatments due to a covered accident. It assists with recovery costs, including those accrued from treatments such as acupuncture, chiropractic, mental health, and much more, accelerating their paths to feeling better. A flexible option that can help strengthen a benefits package, it allows you to customize the plan design at the covered condition level. This tailored approach helps you better meet the needs of each employee.

TRANSAMERICA ACCIDENT INSURANCE HIGHLIGHTS

- Added benefits available, including benefits for organized sports, mental health, acupuncture/chiropractic, and observation
- Insurance for individuals and families
- Ability to tailor the plan design at the covered condition level
- Can match and improve on an existing plan design
- Easy payroll-deduction premiums
- Streamlined billing and self-administration without the need to reconcile at the policy level

See Product Details for more information

This is a brief summary of Transamerica Accident InsuranceSM – AC11 **underwritten by Transamerica Life Insurance Company (TLIC)**, Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series TMAC1100-1220 and TCAC1100-1220. Forms and numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Please refer to the policy, certificate, and riders for complete details.

Underwriting Offer and Eligibility

EMPLOYEE ELIGIBILITY

To be eligible for insurance, an employee must be 18 years or older and:

- Be actively employed, performing all regular duties at the place of business or another location directed by the employer
- Be continuously employed and meeting the minimum hourly and time requirements for benefit eligibility. These requirements will be defined on the Life and Health Group Application and Agreement
- Not be covered by any Title XIX program such as Medicaid

SPOUSE ELIGIBILITY

To be eligible for insurance, a spouse must be 18 years or older and:

- Be a legally married spouse, common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the employer and us
- Not be hospitalized, not be confined at home under a physician's care, or not receiving or applying to receive disability benefits from any source
- Not be eligible as an insured under the policy
- Not be covered by any Title XIX program such as Medicaid

CHILD ELIGIBILITY

To be eligible for insurance, a child must be under the age of 26 years and be any of the following:

- A natural child
- A legally adopted child or child who has been placed for adoption with the employee
- A stepchild or foster child
- A grandchild who lives with the employee
- A child for whom the employee has been appointed legal guardian
- A child for whom the employee is legally required to provide support

Child must also not be hospitalized, not be confined at home under a physician's care, or not receiving or applying to receiv disability benefits from any source; and not be covered by any Title XIX program such as Medicaid.

Insurance for child dependents may continue beyond the maximum age in the event of mental or physical impairment. Proof of incapacity and conditions may vary by state.

MINIMUM PARTICIPATION

At least 3 insured employees are required to establish and maintain an employer group. Other group types may require higher participation.

EVIDENCE OF INSURABILITY

Insurance is offered on a Guaranteed Issue basis. As long as the eligibility requirements are met, insurance will be issued.

Underwriting Offer and Eligibility

OTHER CONSIDERATIONS

- This proposal is based on employer groups with 250 eligible employees only and may not be available to other group types and sizes.
- A Vermont proposal needs to be generated for employees residing in Vermont if:
  More than 25% of employees reside in the state of Vermont; or
  Face-to-face solicitation will be performed at a workplace in the state of Vermont
  Impacted employees should enroll in Vermont approved insurance.

Product Details

COVERED BENEFITS

INITIAL TREATMENT AND DIAGNOSIS BENEFITS	
BENEFITS	**PLAN OPTION 1**
Initial Accident Treatment	
Received in an Emergency Room	**$150**
Received in a Physician's Office	**$75**
Received in an Urgent Care Center or Similar Facility	**$150**
Am bul ance	
Ground	**$300**
Air	**$900**
Laceration	
Without Stitches	**$62.50**
With Stitches – Less than 7.5 centimeters	**$125**
With Stitches – 7.5 centimeters to 20 centimeters	**$31 2 .5 0**
With Stitches – More than 20 centimeters	**$625**
Diagnosis Benefits	
Medical Diagnostic Imaging	**$150**
Blood, Plasma, and Platelets	**$200**
X-Ray	**$75** **MAXIMUM 3 PER ACCIDENT**
Lab Test	**$75** **MAXIMUM 3 PER ACCIDENT**

Product Details

BODILY INJURY BENEFITS – HEAD, NECK AND SHOULDER	
BENEFITS	**PLAN OPTION 1**
Brain Injury	
Concussion/Mild Traumatic Brain Injury	**$250**
Concussion/Moderate or Severe Traumatic Brain Injury	**$250**
Collar Bone Dislocation	
Open Reduction	**$1,600**
Closed Reduction	**$800**
Collar Bone Fracture	
Open Reduction	**$1,500**
Closed Reduction	**$750**
D ental	
Extraction	**$50**
Repaired with Crown	**$250**
Eye Injury	
Non-Surgical Removal of Foreign	**$50**
Object Surgical Repair	**$250**
Face (other than Jaw) Fracture	
Open Reduction	**$1,500**
Closed Reduction	**$750**
Lower Jaw Dislocation	
Open Reduction	**$1,600**
Closed Reduction	**$800**
Lower Jaw Fracture	
Open Reduction	**$2,400**
Closed Reduction	**$1,200**
Upper Jaw Fracture	
Open Reduction	**$2,400**
Closed Reduction	**$1,200**
Nose Fracture	
Open Reduction	**$1,500**
Closed Reduction	**$750**

Product Details

BODILY INJURY BENEFITS – HEAD, NECK AND SHOULDER	
BENEFITS	**PLAN OPTION 1**
Shoulder/Shoulder Blade Dislocation	
Open Reduction	**$2,400**
Closed Reduction	**$1,200**
Shoulder/Shoulder Blade Fracture	
Open Reduction	**$3,300**
Closed Reduction	**$1,500**
Skull (other than Face, Jaw or Nose) Fracture	
Depressed Fracture	**$5,100**
Simple Fracture	**$2,700**

Product Details

BODILY INJURY BENEFITS - LIMBS	
BENEFITS	**PLAN OPTION 1**
Ankle or Foot (other than Toes) Dislocation	
Open Reduction	**$2,000**
Closed Reduction	**$960**
Ankle or Foot (other than Toes) Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**
Upper Arm Fracture	
Open Reduction	**$3,600**
Closed Reduction	**$1,800**
Forearm Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**
Elbow Dislocation	
Open Reduction	**$1,600**
Closed Reduction	**$800**
Elbow Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**
Fingers Dislocation	
Open Reduction	**$525**
Closed Reduction	**$225**
Fingers Fracture	
Open Reduction	**$525**
Closed Reduction	**$225**
Hand (other than Fingers or Wrist) Dislocation	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**
Hand (other than Fingers or Wrist) Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**

Product Details

BODILY INJURY BENEFITS - LIMBS	
BENEFITS	**PLAN OPTION 1**
Heel Fracture	
Open Reduction	**$525**
Closed Reduction	**$225**
Knee Dislocation	
Open Reduction	**$3,300**
Closed Reduction	**$1,800**
Kneecap Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**
Leg Fracture	
Open Reduction	**$3,900**
Closed Reduction	**$2,100**
Toes Dislocation	
Open Reduction	**$525**
Closed Reduction	**$225**
Toes Fracture	
Open Reduction	**$975**
Closed Reduction	**$525**
Wrist Dislocation	
Open Reduction	**$1,600**
Closed Reduction	**$800**
Wrist Fracture	
Open Reduction	**$3,200**
Closed Reduction	**$1,600**

Product Details

BODILY INJURY BENEFITS – TORSO	
BENEFITS	**PLAN OPTION 1**
Coccyx (Tailbone) Fracture	
Open Reduction	**$750**
Closed Reduction	**$375**
Hip Dislocation	
Open Reduction	**$6,000**
Closed Reduction	**$3,000**
Hip Fracture	
Open Reduction	**$6,000**
Closed Reduction	**$3,000**
Pelvis Fracture	
Open Reduction	**$5,700**
Closed Reduction	**$2 ,70 0**
Rib Dislocation	
Open Reduction	**$975**
Closed Reduction	**$525**
Rib Fracture	
Open Reduction	**$975**
Closed Reduction	**$525**
Sternum (Breastbone) Fracture	
Open Reduction	**$975**
Closed Reduction	**$525**
Vertebrae/Vertebral Processes Fracture	
Open Reduction	**$4,800**
Closed Reduction	**$2,400**

Product Details

HOSPITALIZATION BENEFITS	
BENEFITS	**PLAN OPTION 1**
Admission Benefit	
Non-Intensive Care Unit	**$1,200**
Intensive Care Unit	**$2,400**
Daily Benefit	
Non-Intensive Care Unit	**$180 LIMITED TO 365 DAYS PER ACCIDENT**
Intensive Care Unit	**$360 LIMITED TO 15 DAYS PER ACCIDENT**
Step-Down Unit	**$180 LIMITED TO 5 DAYS PER ACCIDENT**
Inpatient Rehabilitation Unit	**$180 LIMITED TO 30 DAYS PER ACCIDENT**
Observation Room	**$180 LIMITED TO 2 DAYS PER ACCIDENT**

Product Details

RECOVERY SERVICES BENEFITS	
BENEFITS	**PLAN OPTION 1**
Appliance	**$250**
Residence Modification	**$400**
Vehicle Modification	**$400**
Family Lodging (per day)	**$60 LIMITED TO 30 DAYS PER ACCIDENT**
Acupuncture Care (per visit)	**$50 LIMITED TO 10 VISITS PER ACCIDENT**
Chiropractic Care (per visit)	**$50 LIMITED TO 10 VISITS PER ACCIDENT**
Follow-Up Treatment (per visit)	**$100 LIMITED TO 3 VISITS PER ACCIDENT**
Mental Health Care (per visit)	**$50 LIMITED TO 5 VISITS PER ACCIDENT**
Pain Management – Epidural	**$50 LIMITED TO 3 TREATMENTS PER ACCIDENT**
Prosthetic Devices	
One Prosthetic	**$400**
Multiple Prosthetics	**$800**
Re pa i rs	**$400**
Therapy Services (per visit)	**$50 LIMITED TO 10 VISITS PER ACCIDENT**
Transportation	**$200 LIMITED TO 3 TRIPS PER ACCIDENT**

Product Details

MAJOR INJURIES	
BENEFITS	**PLAN OPTION 1**
Burns	
Second Degree Burns covering 25%-35% of total body surface	**$200**
Second Degree Burns covering more than 35% of total body surface	**$600**
Third Degree Burn measuring at least 6 square centimeters but less than 10 square centimeters	**$600**
Third Degree Burn measuring at least 10 square centimeters but less than 25 square centimeters	**$1,600**
Third Degree Burn measuring at least 25 square centimeters but less than 35 square centimeters	**$3,600**
Third Degree Burn measuring more than 35 square centimeters	**$5,000**
Skin Graft (pays a percentage of the applicable Burn benefit)	**25%**
Coma	
Non-Induced	**$1 0,0 0 0**
Induced	**$1 0,0 0 0**
Persistent Vegetative State (PVS)	**$1 0,0 0 0**
Paralysis	
Quadriplegia	**$10,000**
Triplegia	**$5,000**
Paraplegia	**$5,000**
Hemiplegia	**$5,000**
Diplegia	**$5,000**
Monoplegia	**$5,000**
Surgery	
Explorator	**$200**
y Major	**$1,000**
Surgery on Tendons, Ligaments, Rotator Cuffs	
Arthroscopic Surgery with No	**$125**
Repair Surgery with One Repair	**$31 2 .5 0**
Surgery with Two or More Repairs	**$625**
Surgery on Ruptured Discs or Torn Knee Cartilage	
Shaved Cartilage or Arthroscopic Surgery with No	**$125**
Repair Surgery with One Repair	**$31 2 .5 0**
Surgery with Two or More Repairs	**$625**

Product Details

ACCIDENTAL DEATH BENEFITS	
BENEFITS	**PLAN OPTION 1**
Accidental Death Benefit	
Other Accidental Death (other than Automobile or Common Carrier)	**EMPLOYEE: $1 0,0 0 0**
	SPOUSE: $1 0,0 0 0
	CHILD: $1 0,0 0 0
Automobile Accident While wearing seatbelt and airbag deployed	**EMPLOYEE: $22,000**
	SPOUSE: $22,000
	CHILD: $22,000
Automobile Accident While wearing seatbelt without airbag being deployed	**EMPLOYEE: $20,000**
	SPOUSE: $20,000
	CHILD: $20,000
Automobile Accident While not wearing seatbelt	**EMPLOYEE: $15,000**
	SPOUSE: $15,000
	CHILD: $15,000
Common Carrier Accident	**EMPLOYEE: $30,000**
	SPOUSE: $30,000
	CHILD: $30,000
Transportation of Remains	**$400**

Product Details

DISMEMBERMENT BENEFITS	
BENEFITS	**PLAN OPTION 1**
One or more fingers or one or more toes	**EMPLOYEE: $500**
	SPOUSE: $500
	CHILD: $500
One eye, hand, foot, arm, or leg	**EMPLOYEE: $2,000**
	SPOUSE: $2,000
	CHILD: $2,000
Two eyes, hands, or feet	**EMPLOYEE: $1 0,0 0 0**
	SPOUSE: $1 0,0 0 0
	CHILD: $1 0,0 0 0
Two arms or two legs	**EMPLOYEE: $1 0,0 0 0**
	SPOUSE: $1 0,0 0 0
	CHILD: $1 0,0 0 0
Speech and hearing in both ears	**EMPLOYEE: $1 0,0 0 0**
	SPOUSE: $1 0,0 0 0
	CHILD: $1 0,0 0 0
Both arms and both legs	**EMPLOYEE: $1 0,0 0 0**
	SPOUSE: $1 0,0 0 0
	CHILD: $1 0,0 0 0

SURVIVOR BENEFITS	
BENEFITS	**PLAN OPTION 1**
Career	**$700**
Enrichment Child	**$300**
Care Center Child	**$700**
Education	

Product Details

SUPPLEMENTAL BENEFITSPLAN OPTION 1 ORGANIZED SPORTING ACTIVITY BENEFIT RIDER (RIDER FORM SERIES TRST1100-1220)	
If an insured receives an accidental bodily injury while participating as a registered member in an organized sporting activity, and benefits are payable for that accident, the benefits we pay will increase based on the Organized Sporting Activity Benefit Percentage shown, not to exceed the Benefit Maximum.	**ORGANIZED SPORTING ACTIVITY BENEFIT PERCENTAGE: 25%** **BENEFIT MAXIMUM: NO LIFETIME MAXIMUM**
WELLNESS BENEFIT RIDER (RIDER FORM SERIES TRWE1300-1220)	
Pays a benefit once per specified insured (in the corresponding plan option) per calendar year for undergoing a Wellness Test, regardless of the number of tests the insured undergoes. Wellness Test includes, but may not be limited to, one of the below listed tests performed under the supervision of or recommendation by a physician while this rider is in force.	**EMPLOYEE: $50** **SPOUSE: $50** **CHILD: N/A**

Cholesterol and Diabetes

- Blood Test Total Cholesterol
- Blood Test Total Triglycerides
- Fasting Blood Glucose Test
- Fasting Plasma Glucose Test
- Hemoglobin A1C
- Serum Cholesterol Test LDL/HDL Levels
- Two-hour Post-load Plasma Glucose Test

Product Details

SUPPLEMENTAL BENEFITS	PLAN OPTION 1
WELLNESS BENEFIT RIDER (RIDER FORM SERIES TRWE1300-1220)	
Cancer	
• Biopsies for Cancer • Bone Marrow Testing • Breast MRI • Breast Ultrasound • Breast Sonogram • Cancer Antigen 15-3 Blood Test for Breast Cancer (CA 15-3) • Cancer Antigen 125 Blood Test for Ovarian Cancer (CA 125) • Carcinoembryonic Antigen Blood Test for Colon Cancer (CEA) • Colonoscopy • Doppler Screening for Cancer • Endoscopy	• Flexible Sigmoidoscopy • Hemoccult Stool Specimen • Oral Cancer Screening • PAP Smears or Thin Prep PAP Test • Prostate-Specific Antigen (PSA) Test • Serum Protein Electrophoresis • Skin Cancer Biopsy • Skin Cancer Screening • Skin Exam • Virtual Colonoscopy
Cardiovascular Function	
• Carotid Doppler • Doppler Screening for Peripheral Vascular • Disease Echocardiogram (Echo)	• Electrocardiogram (ECG or EKG) • Electroencephalogram (EEG) • Stress Test on Bicycle or Treadmill
Imaging Studies	
• Chest X-Rays • Mammogram • Thermography	• Ultrasounds for Cancer Detection • Ultrasound Screening of the Abdominal Aorta for Abdominal Aortic Aneurysms
Periodic Physical and Blood Examinations	
• Routine Health Check-up • Exam Blood Chemistry Panel • Clinical Testicular Exam • Complete Blood Count (CBC) • Dental Exam • Digital Rectal Exam (DRE)	• Eye Exams • Hearing Test • Lipid Panel • Successful Completion of Smoking Cessation Program • Tests for Sexually Transmitted Infections (STIs)
Im m uni zati ons	
• Immunization	• Human Papillomavirus Vaccination (HPV)

Rate Sheet

PREMIUM RATES	AC11.2022.04.PROD,SHARED,AWS.DE.0.00.NS
	PLAN OPTION 1
Coverage Type	24-HOUR
Rate Frequency	Monthly
Employee	$6.99
Employee and Spouse	$12.17
Employee and Children	$15.91
Employee and Family	$21.08

**HSA Compatible – Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.

Issue State: Delaware
Rate generation date: September 14, 2023 SIC Code: 3999

Definitions

The benefits described below are payable when an insured is treated for bodily injuries resulting from an accident for which benefits are payable. All benefits will be paid to the insured, unless otherwise stated or when the insured has assigned benefits. Benefits may vary by state.

INITIAL TREATMENT AND DIAGNOSIS BENEFITS

Each of the following Initial Treatment and Diagnosis Benefits will be payable once per insured per accident.

Initial Accident Treatment Benefit – A benefit will be paid if an insured receives treatment for a bodily injury.
Treatment must be received within 4 days of the accident and must be provided by a physician in any of the following:

- A physician's office
- Hospital emergency room
- An urgent care center

Ambulance Benefit – A benefit will be paid for ambulance transportation by a licensed ambulance service if, because of an accident, the insured is transferred by ambulance to the nearest hospital for treatment within 4 days of the accident.

Laceration Benefit – A benefit will be paid if an insured receives treatment for a laceration within 4 days of the accident.

Medical Diagnostic Imaging – A benefit will be paid if an insured undergoes one of the following due to a bodily injury:

- CT (Computerized Tomography) scan
- MRI (Magnetic Resonance Imaging)
- EEG (Electroencephalogram)

Imaging must be performed within 90 days of the accident.

Blood, Plasma, and Platelets – A benefit will be paid if an insured requires blood, plasma, or platelets for the treatment of a bodily injury. Immunoglobulins are not covered. Treatment must be received within 14 days of the accident.

X-Ray – A benefit will be paid if an insured undergoes an X-Ray due to a bodily injury. X-Ray's must be performed within 4 days of the accident.

Lab Test – A benefit will be paid if an insured undergoes a lab test due to a bodily injury. Lab tests must be performed within 4 days of the accident.

BODILY INJURY BENEFITS

Each of the following Bodily Injury benefits will be payable once per insured per accident.

Brain (Concussion/Traumatic Brain Injury) – A benefit will be paid if an insured is diagnosed with a concussion by a physician within 4 days of the accident.

Dislocation or Fracture – A benefit will be paid if an insured requires correction of a dislocation or fracture by a physician. Benefit varies by the location of the dislocation or fracture. Correction can be made through an open reduction (surgical repair) or closed reduction (manipulative repair) and must be repaired by a physician within 14 days of the accident. If more than one dislocation and/or fracture is repaired, the benefit paid will be

Definitions

1.5 times the larger benefit amount. Dislocations not corrected under general anesthesia will be reduced to 50% of the applicable benefit amount. Chip Fractures pay 10% of the applicable fracture benefit amount and must be diagnosed by a physician through the use of an X-Ray.

Dental – A benefit will be paid if an insured sustains broken teeth in an accident. Treatment must be received
within 180 days of the accident.

Eye Injury – A benefit will be paid if the insured sustains eye damage in an accident. Treatment must be received from a physician within 180 days of the accident.

HOSPITALIZATION BENEFITS

Admission Benefit – A benefit will be paid if an insured is admitted to a hospital for treatment of a bodily injury. The Admission Benefit is paid in addition to the Hospital Confinement Daily Benefit. Only one Admission Benefit is payable per insured per accident. We will only pay the Intensive Care Unit Admission Benefit if the initial admission is to the Intensive Care Unit. For all other admissions, the normal Admission Benefit will be paid.

Daily Benefit – A benefit will be paid for each day an insured is hospital confined due to an accident. Confinement must begin within 31 days of the accident. An additional benefit will be paid for each 24-hour period the insured is confined in any of the following:

- An Intensive Care Unit
- A Step-Down Unit
- An Observation Room

Inpatient Rehabilitation Unit – A benefit will be paid for each day an insured is confined in a rehabilitation facility following a period of hospital confinement. The benefit is not payable for the same days that the hospital confinement benefit is payable.

Daily benefits are subject to limits shown in the Product Details.

RECOVERY SERVICES BENEFITS

Appliance – A benefit will be paid for a medical appliance recommended by a physician as an aid in personal
locomotion as the result of an accident. This benefit is not payable for prosthetic devices. Benefit is payable
once per insured per accident.

Residence and Vehicle Modification – A benefit will be paid if an insured suffers total disability due to a bodily injury within 365 days of the accident. This benefit is payable once per insured per accident. The modification must be made within 2 years from the date of the accident causing the injury.

The benefit will be payable for the modification to the insured's primary residence to make the residence
- accessible or private passenger automobile to make it drivable or ridable only if the modification is all the
- following:
- Made by a person or persons with experience in such modifications
- Recommended by a physician or recognized organization associated with the total disability
Certified by a physician that the modification is needed to accommodate the total disability.

In compliance with the applicable laws or requirements for the approval by the appropriate government
authorities

Definitions

Family Lodging – A benefit will be paid per day, up to a maximum of 30 days per accident, for one motel/hotel room for an immediate family member to accompany the insured if hospital confinement is within 90 days of an accident for the treatment of a bodily injury. Benefits are payable only for the same time- period the insured is hospital confined in a facility 50 or more miles from the insured's primary residence. The local attending physician must prescribe the treatment.

Acupuncture Care – A benefit will be paid if an insured receives acupuncture treatment on the advice of a physician due to an accident. Acupuncture treatments must begin within 180 days of the accident and be completed within 1 year after the accident.

Chiropractic Care – A benefit will be paid if an insured receives chiropractic treatment on the advice of a physician due to an accident. Chiropractic treatments must begin within 180 days of the accident and be completed within 1 year after the accident.

Follow-Up Treatment – A benefit will be paid if an insured first receives treatment for a bodily injury within 4 days of the accident and later requires additional treatment for the same injury. Treatments must be furnished by a physician in the physician's office or in a hospital on an outpatient basis. Follow-up treatment must begin within 180 days of, and be completed within, the 12-month period following the later of the following dates:

- The accident
- Discharge from the hospital
- Discharge from an extended care facility

Mental Health Care – A benefit will be paid if an insured has received treatment for a covered accident and requires psychological or psychiatric care for a mental health condition triggered by the accident. Treatment must begin within 3 months of the covered accident.

Pain Management – A benefit will be paid if an insured is prescribed and receives an injection administered into the spine or a nerve ablation or block for pain management due to an accident.

Prosthetic Devices – A benefit will be paid for a prosthetic device due to a covered accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or for cosmetic prosthetic devices such as hair wigs. We will not pay for joint replacement, such as an artificial hip or knee. The insured must receive the prosthetic device(s) or artificial limb(s) within 24 months of the accident.

Repair – A benefit will be paid if an insured loses or damages their existing prosthetic device or artificial limb as a result of an accident. Repair must be made within 365 days of the accident. This benefit is not payable for any of the following:

Hearing aids

- Dental aids (including false teeth)
- Eyeglasses
- Cosmetic prostheses such as hair wigs
- Joint replacement such as artificial hip or knee

Therapy Services – A benefit will be paid if, as a result of an accident, a physician advises an insured to seek
treatment from any of the following:

- A physical therapist
- An occupational therapist

Definitions

A speech therapist
Therapy must begin within 180 days of the accident. All treatments must be completed within 1 year after the a cci de nt.

Transportation – A benefit will be paid for round-trip transportation if an insured requires confinement in a hospital more than 50 miles from the insured's primary residence as the result of an accident. The local attending physician must prescribe the treatment and the treatment must not be available locally. Travel and hospital confinement must occur within 90 days of the accident.

MAJOR INJURIES

Each of the following Major Injuries benefits will be payable once per insured per accident.

Burns – A benefit will be paid if an insured suffers burns due to an accident. If multiple burns exist, the highest benefit for the most severe burn will be paid. When applicable, the Skin Graft benefit will be paid in addition to the burn benefit. Burns must be treated by a physician within 4 days of the accident.

Coma – A benefit will be paid if an insured suffers a coma due to an accident. The benefit amount varies by whether the coma was induced or non-induced. The coma must last for a minimum of 10 consecutive days before this benefit is payable.

Paralysis – A benefit will be paid if an insured becomes paralyzed due to an accident. Paralysis must last a minimum of 30 consecutive days before this benefit is payable.

Major Surgery – A benefit will be paid if an insured undergoes an open abdominal, cranial, or thoracic surgery performed by a physician within 1 year of the accident. Laparoscopic procedures are excluded.

Exploratory Surgery – A benefit will be paid if an insured undergoes minimally invasive surgery performed by a physician within 1 year of the accident using manual and instrumental means of investigating an area of the body suspected of disease when a specific diagnosis is not possible through noninvasive or simple biopsy techniques. Laparoscopic procedures are included.

Surgery on Tendons, Ligaments, Rotator Cuffs – A benefit will be paid if, as a result of an accident, an insured undergoes surgery for tendons, ligaments, or rotator cuffs that are detached, torn, ruptured, or severed. Surgery must be performed by a physician within 1 year of the accident.

Surgery on Ruptured Discs or Torn Knee Cartilage – A benefit will be paid if an insured undergoes surgery for a disc in the spine that is ruptured or knee cartilage that is torn. Surgery must be performed by a physician within 1 year of the accident.

ACCIDENTAL DEATH BENEFITS

Benefits for the loss of life resulting from bodily injuries resulting from an accident. Accidental death must be independent of disease or bodily infirmity or any other cause, other than an accident.

Accidental Death – A benefit will be paid for the insured's accidental death. The accident must occur while insurance is in force. Such accidental death must occur within 12 months of the accident. The benefit will be paid to the beneficiary.

Only one Accidental Death benefit will be paid per insured, the highest applicable benefit, as described below:

Definitions

- Automobile Accident – Accidental death resulting from an accident that occurs while the insured is driving or riding as a passenger in an automobile. Automobile is defined as a four-wheeled private passenger motor vehicle licensed for use on public highways and is not being used to transport passengers for hire. The Automobile Accident benefit will not be payable if the insured is the driver of the automobile and does not hold a current and valid driver's license.
- Common Carrier Accident – Accidental death resulting from an accident that occurs while the insured was riding as a fare-paying passenger on public transportation. Public Transportation is defined as a public passenger conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regularly scheduled passenger routes with a definite schedule of departures and arrival times. Common carrier vehicles are limited to commercial airplanes, trains, buses, trolleys, subways, ferries, and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis, limousines, and privately chartered vehicles are not common carriers.
- Other Accidental Death – Accidental death resulting from any other bodily injury other than Automobile Accident or Common Carrier Accident.

Transportation of Remains – A benefit will be paid if, as a result of an accident, the insured dies more than 200 miles from their primary residence and expenses are incurred to transport the insured's body to a mortuary near their primary place of residence. This benefit is payable once per insured and only if the Accidental Death Benefit is payable. This benefit will be paid to the person incurring the expense.

DISMEMBERMENT BENEFITS

A benefit will be paid if an insured suffers a dismemberment due to an accident. Dismemberment must occur within 12 months of the accident. A dismemberment is defined as a bodily injury that is independent of disease or bodily infirmity and results in the complete severance of a body extremity or the complete loss of sight, speech, or hearing.

SURVIVOR BENEFITS

The following benefits are paid to the survivor upon the accidental death of an insured. For purposes of these benefits, Survivor is defined as any of the following:

- Surviving insured – if the spouse is deceased from the accidental death
- Surviving spouse – if the insured is deceased from the accidental death
- Legally appointed guardian of each surviving child – if both the insured and spouse are deceased from the accidental death

The survivor does not need to be insured under this certificate to receive survivor benefits.

Career Enrichment Benefit – A benefit will be paid if the survivor enrolls in a professional or trade training program on a full-time basis within 24 months of the accidental death. The training program must be for the purpose of obtaining an independent source of income or enriching the survivor's ability to earn a living. The training program must be at an accredited college, university, a 2-year college, vocational, or trade school. This benefit will be paid each year for up to 4 years while the survivor remains enrolled in a training program. Satisfactory proof of enrollment must be provided annually. If there is no survivor, a one-time benefit of $200 will be paid to the beneficiary.

Child Care Center Benefit – A benefit will be paid when the following conditions are met:

- The surviving child must be within the ages of newborn through 12 years
- The survivor pays a child care center for day care, within 90 calendar days after the date of the accidental death

Definitions

- The day care is necessary in order for the survivor to work or to obtain training for work
  This benefit will be paid each year for up to 4 years while the surviving child is enrolled in a child care center, provided the child remains enrolled in a child care center during that time. This benefit will be paid in equal installments over the 4-year period. Separate benefits will be paid for each surviving child who meets the requirements for this benefit. Satisfactory proof of enrollment must be provided annually. If there is no surviving child between the ages of newborn through 12 years, a one-time benefit of $200 will be paid to the beneficiary.

  For purposes of this benefit, the child care center must be an appropriately licensed facility or home that meets all of the following conditions:

- Provides supervision for more than 6 persons (other than persons who reside there) under the age of 13 years for less than 24 hours per day
- Receives a payment for providing dependent care services
- Has a Taxpayer Identification Number
- **Child Education Benefit** – A benefit will be paid when the following conditions are met:

  The surviving child must be within the ages of 17 years through 21 years

- The surviving child must be enrolled or must enroll within 2 years of the accidental death, as a regular, full time student at an accredited college, university, 2-year college, vocational, or trade school
- This benefit will be paid each year for up to 4 years while the surviving child is enrolled in school. This benefit will continue to be paid only while the surviving child remains a full-time student. This benefit will be paid in equal installments over the 4-year period. Separate benefits will be paid for each surviving child who meets the requirements for this benefit. Satisfactory proof of student status must be provided annually. If there is no surviving child between the ages of 17 years through 21 years, a one-time benefit of $200 will be paid to the beneficiary.

About *Hospital Select II* Hospital Indemnity Insurance

OFFER EXTRA BENEFITS — AND ADDED REASSURANCE

When employees are able to protect their finances and loved ones, they're free to focus on what's important. But unexpected medical costs following a hospital stay can be financially — and emotionally — devastating.

Transamerica's *Hospital Select II* hospital indemnity insurance gives you one more valuable option for your benefits package – and helps your employees know that a hospital stay won't have to jeopardize their family's financial future.

HOW *HOSPITAL SELECT II* WORKS

A supplement to traditional medical insurance, *Hospital Select II* hospital indemnity insurance pays a cash benefit that can be used to help cover deductibles, lost income due to missed work, and other expenses that can come up because of hospitalization. You can also add a number of additional riders to provide additional benefits.

HOSPITAL SELECT II HIGHLIGHTS

- Benefits for full-time, part-time, hourly, seasonal, and temporary workers and their eligible family members
- No co-insurance, co-pays, waiting period, or deductibles
- No health questions, exams, or blood tests
- Payroll-deducted premiums starting at $10 per month for employee insurance benefits
- Streamlined billing and self-administration without the need to reconcile at the policy level
- Benefits paid in addition to any other insurance the insured may have
- No pre-existing condition limitations

See Product Details for more details

This is a brief summary of *Hospital Select® II* hospital indemnity insurance policy **underwritten by Transamerica Life Insurance Company (TLIC)**, Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series TMHI1000-0118 and TCHI1000-0118. Forms and numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate, and riders for complete details.(H)

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Underwriting Offer and Eligibility

EMPLOYEE ELIGIBILITY UnderwritingOfferandEligibility

To be eligible for insurance, an employee must:

- Be at least 18 years old
- Not be covered by any Title XIX program such as Medicaid
- Be on active service, performing in the usual manner all of the regular duties of his or her occupation at one of the places of business where he or she normally works or at some location directed by the employer; and be continuously employed for the amount of time and working the minimum number of hours per week as you require to be eligible for benefits. These requirements will be defined on the Life and Health Group Application and Agreement.

SPOUSE ELIGIBILITY UnderwritingOfferandEligibility

To be eligible for insurance, a spouse must:

- Be at least 18 years old
- Be a legally married spouse, common law marriage partner, domestic partner, or civil union partner if legally recognized in the governing jurisdiction or as otherwise agreed upon between you and us
- Not be disabled (must be able to perform the majority of the normal activities of a person of like age in good health)
- Not be covered by any Title XIX program such as Medicaid

CHILD ELIGIBILITY UnderwritingOfferandEligibility

Children must be under the age of 26 and be any of the following:

- The insured's natural child
- A legally adopted child or a child who has been placed with the insured for adoption
- A stepchild or foster child
- A child for whom the insured is appointed legal guardian or for whom the insured is legally required to provide support

Child must also not be covered by any Title XIX program such as Medicaid.

If applicable, child will also include any children of your other adult dependent in the same manner as a stepchild.

If an insured has reached age 26, but is incapable of self-support because of mental or physical impairment, we will continue the child's insurance under the following conditions:

1. The child must be incapacitated
2. We must receive proof of incapacity within 31 days after insurance would otherwise terminate
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the two-year period following the date the child attains age 26
4. Your insurance must remain in force

MINIMUM PARTICIPATION UnderwritingOfferandEligibility

At least 3 eligible employee applications are required to establish and maintain an employer group with monthly list bill administration, other group types and administrative requirements may require higher participation.

EVIDENCE OF INSURABILITY UnderwritingOfferandEligibility

Insurance is Guaranteed Issue when an applicant first becomes eligible for insurance.

Insurance applied for at a later date will be considered a Late Enrollee. Late Enrollee applications are underwritten on an

accept/reject basis. If an employee answers “yes” to the questions on the application, we will decline the application for all persons for whom insurance is being requested. If there is a “yes” answer to the questions for the spouse, the spouse only will be declined insurance. If there is a “yes” answer to the questions for a dependent child, that one child will be declined insurance.

OTHER CONSIDERATIONS Underwriting Offer and Eligibility

Please be aware of the following:

- This proposal is based on employer groups with 250 eligible employees only and may not be available to other group types or sizes
- **Please note that at this time we are only able to offer insurance to New Mexico residents if there are one hundred (100)or fewer eligible employees residing in New Mexico. If there are more than one hundred (100) eligible employees residing in New Mexico currently, or at any time in the future, we are not able to offer insurance to those individuals. We will rely on each employer to alert Transamerica if there are more than one hundred (100) eligible employees residing in New Mexico currently, or at any time in the future.**

  We are also not able to offer insurance to any members of non-employer groups that are residing in New Mexico.
- For Massachusetts Residents: This product DOES NOT MEET CREDITABLE COVERAGE STANDARDS and WILL NOT SATISFY the Massachusetts individual mandate that you have health insurance
- A Vermont proposal needs to be generated for employees residing in Vermont if:
  - More than 25% of employees reside in the state of Vermont; or
  - Face-to-face solicitation will be performed at a workplace in the state of Vermont
  - Impacted employees should enroll in Vermont approved insurance

Product Details

Hospital Select II hospital indemnity insurance pays employees a cash benefit to help cover costs associated with a hospital stay. *Hospital Select II* is a voluntary policy intended to supplement the major medical insurance in your benefits package. The following benefits are included in your plan option(s). Unless otherwise noted, all benefits and maximums are per insured person.

DAILY IN-HOSPITAL INDEMNITY BENEFIT	PLAN OPTION 1
Pays each day an insured person is confined to a hospital (but not an emergency room, an outpatient stay, or a stay in an observation unit or recovery room) as the result of a covered accident or sickness.	**$100**
Waiver of Observation Unit Exclusion Rider If included on the plan design, the Daily In-Hospital Indemnity Benefit will also pay each day an insured person is confined to an observation unit for at least 24 hours as the result of a covered accident or sickness.	**INCLUDED**
Calendar Year Maximum	**31 Days per confinement**

INCLUDED RIDERS	
INTENSIVE CARE INDEMNITY BENEFIT RIDER (RIDER FORM SERIES CRCICU00)	**PLAN OPTION 1**
Pays each day an insured person is confined to an intensive care unit as the result of a covered accident or sickness. This benefit is paid in addition to the Daily In-Hospital Benefit.	**$100**
Calendar Year Maximum	**31 days**
WELLNESS INDEMNITY BENEFIT RIDER (RIDER FORM SERIES CRHWEL00)	**PLAN OPTION 1**
Pays each day an insured person undergoes a health screening test as defined in the policy.	**$50 1**
Calendar Year Maximum	**day**

Product Details

HOSPITAL ADMISSION INDEMNITY BENEFIT RIDER (RIDER FORM SERIES TRHA1100-1021)	PLAN OPTION 1
Hospital Admission Indemnity Benefit	
Pays each day an insured person is first admitted to a hospital (but not an emergency room, an outpatient stay, or a stay in an observation unit or recovery room) as a result of a covered accidental injury or sickness. Does not pay for a newborn child's admission. This benefit is paid in addition to the Daily In-Hospital Benefit.	**$1,000**
Waiver of Observation Unit Exclusion Rider If included on the plan design, the Hospital Admission Indemnity Benefit will also pay each day for an insured person's stay in an observation unit for at least 24 hours as the result of a covered accidental injury or sickness.	**INCLUDED**
Maximum Number of Days per Calendar Year	**1**
Intensive Care Unit Admission Indemnity Benefit	
Pays each day an insured person is first admitted to an ICU as a result of a covered accidental injury or sickness. Does not pay for a newborn child's admission. This benefit is paid in addition to the Daily In-Hospital Benefit.	**$2,000**
Maximum Number of Days per Calendar Year	**1**

Product Details

PLAN OPTION 1 : MONTHLY RATES *HOSPITAL SELECT II*			HIP-HS2-HSA.2023.01.PROD,SHARED,AWS.DE.0.0.OVR.D8	
AGE EMPLOYEE		EMPLOYEE AND SPOUSE	EMPLOYEE AND CHILD(REN)	EMPLOYEE, SPOUSE, AND CHILD(REN)
All Ages	$10.66	$22. 24	$17.09	$26.33

The illustrated rates DO NOT contain a pre-existing condition limitation.
The above rates are quoted for groups with 250 eligible lives. Should this plan design sell and the submitted group size is different, rates may be different. Issue State: Delaware
Rate generation date: September 14, 2023
SIC Code: 3999

** HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.

LIMITATIONS AND EXCLUSIONS

TRANSAMERICA®

TRANSAMERICA CRITICAL ILLNESS INSURANCE℠

Limitations and Exclusions

Limitations and exclusions may vary by state.

We do not pay benefits for losses caused by, or as a result of, the following:

- As a result of the insured voluntarily participating or attempting to participate in an illegal occupation
- As a result of the insured intentionally causing a self-inflicted injury
- As a result of the insured committing or attempting to commit suicide, whether sane or insane
- As a result of an insured's participation in a war or any act of war, declared or undeclared, riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority
- For any loss that occurred while on active duty status in the armed forces of any country. If you notify us of such active duty, we will refund any premiums paid for any period for which no benefits are provided as a result of this exclusion
- As a result of an insured's commission of a felony
- As a result of an insured's participation in a contest of speed in power driven vehicles, parachuting, or hang gliding
- As a result of an insured's traveling in or descending from any vehicle or device for aerial navigation, unless as a fare paying passenger on a scheduled or a charter flight operated by a scheduled airline
- As a result of an insured's being intoxicated as defined by the laws of the jurisdiction in which the loss occurred or under the influence of a controlled substance unless administered by a physician or taken according to a physician's instructions

Under no condition will we pay any benefits for losses incurred prior to the effective date.

CONVERSION OPTION

If an employee loses eligibility for this insurance for any reason other than nonpayment of premium, they will have the option to convert this group insurance to a policy we are issuing for the purpose of conversions. The premium for the converted policy will be based on resident state, age, and class of risk at the time of conversion and the type and amount of insurance provided. Conversion option is not available for the insured's dependents without the insured.

SECOND OPINION BENEFIT RIDER

This rider will terminate on the earliest of:

- The date we receive the employer's request to terminate the rider
- The date the certificate terminates

HEALTH SCREENING BENEFIT RIDER

This rider will terminate on the earliest of:

- The date we receive the employer's request to terminate the rider
- The date the certificate terminates

Limitations and Exclusions

TERMINATION OF INSURANCE

Employee insurance will terminate on the earliest of:

- The date the group master policy terminates
- The date the employee ceases to be eligible for insurance
- The date of the employee's death
- The premium due date on which we fail to receive the employee's premium, subject to the grace period provision
- The date we receive the employee's request to terminate the insurance, or the effective date of termination requested, if later

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates
- The premium due date on which we fail to receive the employee's premium from the employer, subject to the grace period provision
- The date the dependent no longer meets the definition of dependent
- The date of the dependent's death
- The date the group master policy is modified to exclude dependent insurance
- The date we receive the employee's request to terminate their dependent insurance, or the effective date of termination requested, if later

We may terminate the insurance of any insured person who submits a fraudulent claim.

TERMINATION OF THE GROUP MASTER POLICY

The group master policy will terminate at the earliest of the following:

- If the employer submits a 60-day advance written request to us to terminate the policy, the policy will terminate on the date specified in the request
- If we give a 60-day advance written notice to the employer that we intend to terminate the policy, the policy will terminate on the date specified in the notice
- If any premium payable by the employer is not paid within its grace period, the policy will terminate on the day after the end of the grace period
- The policy will terminate on the 32nd day after we have given the employer written notice of our intent to terminate if the employer:

a. Fails to comply with any terms of the policy or the policyholder application

b. Fails to fulfill any obligations or duties under or pertaining to the insurance

c. Fails to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to the insurance

OTHER INSURANCE WITH US

If an insured has more than one specified disease health policy, certificate, or similar insurance with us, only one, chosen by the insured or insured's estate, will be effective. We will refund all premiums paid for all other such insurance from the date of the duplication, less any benefits paid from such date.

TRANSAMERICA ACCIDENT INSURANCE℠

Limitations and Exclusions

Limitations and exclusions may vary by state.

We will not pay benefits for any accident that is caused by or occurs as a result of any of the following:

- Driving any taxi (including ride share programs such as Uber and Lyft) for wage, compensation, or profit
- Mountaineering, parachuting, or hang gliding
- Voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes
- Alcoholism or drug addiction
- Participating in any sport or sporting activity for wage, compensation, profit, or racing any type of vehicle in an organized event
- Traveling in or descending from any vehicle or device for aerial navigation, unless as a fare paying passenger on a scheduled or a charter flight operated by a scheduled airline
- War, or any act of war, whether declared or undeclared
- Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred
- Actively participating in a riot, civil commotion, civil disobedience, or unlawful assembly
- Committing, attempting to commit, or voluntarily taking part in a felony or assault, or engaging in an illegal occupation
- Intentionally self-inflicting a bodily injury or attempting suicide, while sane or insane
- Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no insurance is provided as a result of this exception

CONVERSION OPTION

If an employee loses eligibility for this insurance for any reason other than nonpayment of premium, they will have the option to convert this group insurance to a policy we are issuing for the purpose of conversions. The premium for the converted policy will be based on resident state, age, and class of risk at the time of conversion and the type and amount of insurance provided. Conversion option is not available for the insured's dependents without the insured.

ORGANIZED SPORTING ACTIVITY BENEFIT RIDER

For purposes of this rider, Organized Sporting Activity means any regularly scheduled non-professional athletic event associated with school programs and non-school programs that are governed by an organization with a set of written rules, officiated by someone certified to act in that capacity, and overseen by a legal entity such as a public-school system or sports conference. The legal entity must have a set of bylaws and competition must be on a regulation playing surface. Participation must be on an amateur basis and require formal registration.

An organized sporting activity includes the following:

Exhibition game

- Club sports
- Intramural sports
- Intercollegiate sports
- Com pe ti ti ons
- Team practice, training, workout sessions
- Try outs
- Any supervised or sponsored sports activity
-

Limitations and Exclusions

Organized sporting activities do not include the following:

- Playing, coaching, or officiating for pay
- Personal, non-team related practice, training, workout sessions
- Unstructured play such as pick-up games or spontaneous play
- Activity that is outside of the insured's membership role
- Activities the employee is paid to play
- Racing any type of vehicle in an organized event
- Travel to and from the Organized Sporting Activity

The following benefits are excluded from the benefit amount increase:

- Coma
- Paralysis
- Accidental Death & Dismemberment
- Wellness

This rider will terminate on the earliest of:

The date we receive the employer's request to terminate the rider

- The date the certificate terminates

WELLNESS BENEFIT RIDER

This rider will terminate on the earliest of:

The date we receive the employer's request to terminate the rider

- The date the certificate terminates

TERMINATION OF INSURANCE

Employee insurance will terminate on the earliest of:

The date the group master policy terminates

- The date the employee ceases to be eligible for insurance
- The date of the employee's death
- The premium due date on which we fail to receive the employee's premium, subject to the grace period provision
- The date we receive the employee's request to terminate the insurance, or the effective date of termination requested, if later

Dependent insurance will terminate on the earliest of:

The date the employee's insurance terminates

- The premium due date on which we fail to receive the employee's premium from the employer, subject to the grace period provision
- The date the dependent no longer meets the definition of dependent

The date of the dependent's death

- The date the group master policy is modified to exclude dependent insurance
- The date we receive the employee's request to terminate their dependent insurance, or the effective date of termination requested, if later
- We may terminate the insurance of any insured person who submits a fraudulent claim.

Limitations and Exclusions

TERMINATION OF THE GROUP MASTER POLICY

The group master policy will terminate at the earliest of the following:

- If the employer submits a 60-day advance written request to us to terminate the policy, the policy will terminate on the date specified in the request
- If we give a 60-day advance written notice to the employer that we intend to terminate the policy, the policy will terminate on the date specified in the notice
- If any premium payable by the employer is not paid within its grace period, the policy will terminate on the day after the end of the grace period
- The policy will terminate on the 32nd day after we have given the employer written notice of our intent to terminate if the employer:

a) Fails to comply with any terms of the policy or the policyholder application

b) Fails to fulfill any obligations or duties under or pertaining to the insurance

c) Fails to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to the insurance

OTHER INSURANCE WITH US

If an insured has more than one accident policy, certificate, or similar insurance with us, only one, chosen by the insured or insured's estate, will be effective. We will refund all premiums paid for all other such insurance from the date of the duplication, less any benefits paid from such date.

HOSPITAL SELECT ®II
HOSPITAL INDEMNITY INSURANCE

Limitations and Exclusions

HOSPITAL SELECT II

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 30 days will be treated as a
new and separate confinement.

- No benefits under this contract will be payable as the result of the following:
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- Rehabilitative care and treatment (unless the Rehabilitation Unit Confinement Benefit Rider is included) or rest care
- Immunization shots and routine examinations such as: physical examinations, mammograms, pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests, and blood screenings (unless Wellness Indemnity Benefit Rider is included)
- Any pregnancy of a dependent child, including confinement rendered to her child after birth
- Routine newborn care (unless Wellness Indemnity Benefit Rider is included)
- Hospital confinement of a newborn child following the child's birth, unless the newborn child is being treated for accidental injury or sickness (unless the Newborn Child In-Hospital Indemnity Benefit Rider is included)
- An insured person's abortion, except for medically necessary abortions performed to save the mother's life
- Treatment of mental or emotional disorder (unless Inpatient Mental and Nervous Disorder Indemnity Benefit Rider is included)
- Treatment of alcoholism or drug addiction (unless Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider is included)
- Participation in a riot or insurrection
- Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred)
- Dental care or treatment, except for such care or treatment due to accidental injury to sound, natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly
- Sex change, reversal of tubal ligation, or reversal of vasectomy
- Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law
- Committing, attempting to commit, or taking part in a felony [or assault], or engaging in an illegal occupation
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip
- Any loss incurred on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no insurance is provided as a result of this e xce pti on.)

Limitations and Exclusions

- Involvement in any war or act of war, whether declared or undeclared

CONVERSION OPTION

If an employee loses eligibility for this insurance for any reason other than fraud or nonpayment of premiums or termination of the group master policy, they will have the option to convert this group insurance to an individual hospital indemnity policy by submitting an application and the first month's premium to us within 31 days after loss of eligibility. We will bill the employee directly once we receive notification to continue insurance.

If the insured employee elects to convert the policy upon losing eligibility and the insurance at the time of
conversion includes a pre-existing condition limitation or a normal pregnancy limitation, the limitation[s] will continue in the conversion policy from the insured person's original effective date under the initial insurance.

HOSPITAL ADMISSION INDEMNITY BENEFIT RIDER

Admissions in a hospital or ICU for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. In the event we pay a hospital admission benefit and the
insured is later admitted to the ICU for the same or related condition within 30 days, we will pay the difference between what was paid for the hospital admission and the higher ICU admission benefit. Successive admissions separated by more than 30 days will be treated as a new and separate admission.

TERMINATION OF INSURANCE

The insurance terminates on the earliest of:

- The insured's death
- The premium due date when we fail to receive a premium, subject to the grace period
- The date the employee requests the insurance to be canceled, or the date the request is received, whichever is later
- The date the policy terminates
- The date the insured ceases to be eligible for insurance

Dependent insurance ends on the earliest of:

- The date the insured employee's insurance terminates
- The date the dependent no longer meets the definition of a dependent
- The date of the dependent's death
- The premium due date when we fail to receive a premium, subject to the grace period
- The date the employee requests the dependent's insurance to be canceled, or the date the request is received, whichever is later
- The date the policy is modified so as to exclude dependent insurance

The insurance company has the right to terminate the insurance of any insured who submits a fraudulent claim.

Termination will not impact any claim which begins before the date of termination.

TERMINATION OF THE GROUP MASTER POLICY

This policy will end on the earliest of the following events:

- If the policyholder submits an advance written request to us to terminate this policy, this policy will terminate on the date specified in that request

Limitations and Exclusions

- If we give a 60-day advance written notice to the policyholder that we intend to terminate this policy, this policy will terminate on the date specified in that notice
- If any premium payable by the policyholder is not paid within its grace period, this policy will terminate on the day after the end of the grace period
- If the policyholder fails to comply with any terms of this policy or the policyholder application; fails to fulfill any obligations or duties under or pertaining to this insurance; or fails to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance; this policy will terminate on the 32nd day after we have given the policyholder written notice of our intent to terminate

OTHER INSURANCE WITH US

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

Group Benefits Disclosure Policy

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

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

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

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TRANSAMERICA®

Ancillary

PrePaid Legal

Identity Theft

Finanical Wellness

WHY CHOOSE IDIQ

Your Financial Wellness Solution

Enhance workforce financial wellness with up to **three services** in **one program.**

Financial Wellness

Empower employees to make smarter financial decisions that help them achieve their goals.

ID Theft & Credit Monitoring

Help minimize employees' risk of identity theft while allowing them to actively monitor their credit.

Pre-Paid Legal

Offer convenient and affordable access to legal services for every stage of life.

KEY STATISTICS

Impact of Financial Wellness on Workforces

4 out of 5

employers link financial stress to job performance issues, causing a month of lost workdays and employees twice as likely to seek a new job.

Source: Moneygeek.com

60%

of employees say they are more likely to stay with an employer that offers a program designed to help them manage their money.

Source: Financial Health Network

1 out of 3

employees say financial stress has a negative impact on their mental health.

Source: PwC's Annual Employee Financial Wellness Survey

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IDENTITY THEFT PROTECTION & CREDIT MONITORING

Benefits Plan

Group Size:	Secure Pro + BITDEFENDER® TOTAL SECURITY	Secure Plus + BITDEFENDER® TOTAL SECURITY
Voluntary Employee Only	$12 Per month	$14 Per month
Voluntary Employee + Family	$16 Per month	$18 Per month
Employer-Paid Employee Only (50% Off)	$6 Per month	$7 Per month
Employer-Paid Employee + Family (50% Off)	$8 Per month	$9 Per month

Coverage:
Employee Only: The primary member only (Employee)
Employee + Family: Primary member (Employee), a secondary member, and the option to enroll up to 3 dependents in full restoration services and up to $25,000 identity theft insurance policy.* Dependents must be under the age of 24 and live with the primary member.

	Features	Secure Pro + BITDEFENDER TOTAL SECURITY	Secure Plus + BITDEFENDER TOTAL SECURITY
Credit Scores & Monitoring	Daily Credit Monitoring & Alerts	3-Bureau	1-Bureau
	3-Bureau Credit Reports & Scores	Quarterly	Annual
	ScoreCasterIQ® -Customized Report Analysis -Short-Term & Long-Term Action Recommendations -Target Score Simulations	✓	✓
	Checking Account Report	✓	✓
	Discounted Additional Reports & Scores	✓	✓
	Score Change Alerts	✓	
	Enhanced Credit Monitoring	✓	
Identity Theft Protection	Up to $1 Million in Identity Theft Insurance* -Coverage for Lawyers & Experts* -Coverage for Personal Expense Compensation* -Stolen Funds Reimbursement*	✓	✓
	100% U.S.-Based Customer Service	✓	✓
	100% U.S.-Based ID Restoration Service	✓	✓
	Lost Wallet Assistance	✓	✓
	Opt-Out IQ (Junk Mail/Do-Not-Call List)	✓	✓
	File Sharing Network Searches	✓	✓
	Dark Web & Internet Monitoring	✓	✓
	SSN Alerts	✓	✓
	Synthetic ID Theft Protection	✓	✓
	IQ Alerts with Application Monitoring	✓	✓
	IQ Center	✓	✓
	Change-of-Address Monitoring	✓	✓
	Alerts on Crimes Committed in Your Name	✓	✓
	Anti-Virus Protection	✓	
Bitdefender Device Security VPN (Up to 10 devices)	Unlimited VPN	✓	✓
	Parental Controls	✓	✓
	Ad-Blocker	✓	✓
	Web Tracker Blocking	✓	✓
	Secure Browsing	✓	✓
	Secure Wallet & Banking	✓	✓
	Security Advisor	✓	✓
	Anti-Fraud & Anti-Spam Features	✓	✓
	Hardware Optimization	✓	✓
	Software Optimization	✓	✓
	Optimization Profiles (Gaming, Movies, Work)	✓	✓
		✓	✓

IDIQ

*Underwritten by AIG.

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PRE-PAID LEGAL
Benefits Plan

Group Size:	Voluntary		Employer-Paid (50% off)	
Employee Only	$12	Per month	$6	Per month
Employee + Family	$12	Per month	$6	Per month

Coverage: The participant (employee); participant (employee) and participant's spouse or domestic partner and dependents up to the age of 26.

IDIQ®

PRE-PAID LEGAL PLAN
Benefits Plan Features

Plan Benefit Features	Pre-Paid Legal Plan
Simple Will Preparation	✓
Living Will Preparation	✓
Medical Power of Attorney Preparation	✓
Unlimited Phone Consultations per Legal Matter	✓
30-Minute In-Person Consultations per Legal Matter	✓
Access to Online Library of Custom DIY Legal Documents	✓
Legal Letters and Phone Calls on Your Behalf	✓
Advice on Small Claims Court	✓
Advice on Government Programs	✓
Advice on IRS & State Tax Relief	✓
Advice on Consumer Protection & Warranty Problems	✓
Legal Document Review (Up to 6 Pages)	✓

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FINANCIAL WELLNESS
Benefits Plan

Group Size:	Voluntary	Employer-Paid (50% off)
Employee Only	$4 Per month	$2 Per month
Employee + Family	$4 Per month	$2 Per month

Coverage: The participant (employee); participant (employee) and participant's spouse or domestic partner and dependents up to the age of 26.

IDIQ®

FINANCIAL WELLNESS
Benefits Plan Features

Plan Benefit Features	Financial Wellness
Debt & Credit Coaching	✓
Debt Resolution Solutions	✓
Credit & Personal Finance Alerts	✓
Personal Loan & Credit Card Options	✓
Personalized Budgeting Tools & Assistance	✓
Student Loan Refinancing Options	✓
Educational Resources	✓
Access to Money Sensei™ Technology	✓

IDIQ does not provide debt relief and does not promise to help you obtain a loan. A coach can guide you through a free financial evaluation, help you understand your options and connect you with a qualified partner.

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Turning 65?

Medicare Concierge Service

OSPREY
GUIDANCE YOU CAN TRUST

Medicare Concierge Services

Turning 65 becomes complicated when navigating the enrollment process and plan offerings within Medicare insurance. Luckily, Osprey Benefit Advisors are here to help guide you through this process from beginning to end. Simply schedule an appointment with one of their licensed insurance agents to learn more. No obligation to enroll and no cost to you.

The Value of Medicare Concierge Services

Discovery Call

Identify needs, priorities, health risks and lifestyle of each individual

Educate

Starting with Medicare 101 and educating each individual at their pace to ensure a complete understanding of the program

Enrollment

Once the individual is completely comfortable with the information, we assist in finalizing their enrollment

Year Round Support

Our Senior Health Plan Coverage Concierge is available all year round to answer questions and be a resource for plan and program inquiries.

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