BENEFITS & REMUNERATION

2026

UnitedHealthcare

Choice High Plan

Coverage for: Family | Plan Type: EP1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-833-760-7892 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,300** Individual / **$2,600** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes.	Bariatric Surgery has a separate $4,500 deductible.
What is the out-of-pocket limit for this plan?	Network: **$2,800** Individual / **$5,600** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-833-760-7892** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply.	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$50 copay per visit, deductible does not apply.	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office: No Charge Free Standing Lab: 20% coinsurance, deductible does not apply up to $100, then No Charge Outpatient Facility: 20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Office: No Charge Free Standing Lab: 20% coinsurance, deductible does not apply up to $100, then No Charge Outpatient Facility: 20% coinsurance	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $7 copay, deductible does not apply Mail-Order: $14 copay, deductible does not apply	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.
	Tier 2 – Your Mid-Range Cost Option	Retail: $30 copay, deductible does not apply Mail-Order: $60 copay, deductible does not apply	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply Mail-Order: $90 copay, deductible does not apply	Not Covered	
	Tier 4 – Specialty Medications	Retail: $75 copay, deductible does not apply Mail-Order: $150 copay, deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply.	$250 copay per visit, deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	$50 copay per visit, deductible does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 20 visits per year: No Charge After 20 visits: $25 copay per visit, deductible does not apply.	Not Covered	Network Partial hospitalization/intensive outpatient treatment: $25 copay per visit, deductible does not apply.
	Inpatient services	20% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not Covered	Limits per calendar year: Physical, Speech, Occupational: combined limit 60 visits; Cardiac and Pulmonary: Unlimited
	Habilitative services	20% coinsurance	Not Covered	Services are provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	Durable medical equipment	20% coinsurance	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam every year.
	Children's glasses	Covered	Not Covered	See Vision Discount Rider
	Children's dental check-up	Covered	Not Covered	See Dental Discount Rider

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic (Manipulative care) – 24 visits per calendar year
- Hearing aids - $1,500 per calendar year
- Routine eye care (adult) - 1 exam per 1 year

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-833-760-7892.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-760-7892.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-760-7892.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-760-7892 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-760-7892.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-760-7892.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-760-7892.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-760-7892.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,300
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,300
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,300
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$300
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,640**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact at this job?		
11. Phone number (if different from above)	12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

BROWARD COUNTY FLORIDA

Dental PPO

UnitedHealthcare

	In the Network	Out of the Network
Deductible*—Before the plan pays, you'll pay all costs up to:		
Employee/Family	$50/$150	$50/$150
Coinsurance*—Once the deductible is met, the plan pays:		
Diagnostic and preventive services (deductible waived)	100%	70%
Basic dental services:		
Restorations	80%	60%
Simple extractions	80%	60%
Emergency treatment/general services	80%	60%
Endodontics	80%	60%
Periodontics	80%	60%
Oral surgery	80%	60%
Major dental services:		
Crowns and bridges	50%	40%
Dentures	50%	40%
Annual limits—This is the most the plan will pay in the plan year.	$1,500	$1,000
Orthodontic services:		
Child(ren) to age 19	50%	50%
Lifetime ortho maximum	$1,000	$1,000

For more information, please read your plan documents. Additional information such as benefit details, plan limitations and exclusions, and the costs of coverage can be found in the Summary of Benefits

Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

☐ Enroll ☐ Address Change
☐ Cancel ☐ Name Change
☐ Change Date of Change ___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____ Dental _____ Life _____	Medical _____ Vision _____ Dental _____ Life _____	Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date _____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
☐ Dependent reached maximum age
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe) _____

Employee Type ☐ Union ☐ Non-union ☐ Salaried ☐ Hourly ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

Employer Position _____ Phone Number _____

A. Employee Information

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical Entities should be as follows: UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Dental coverage provided by UnitedHealthcare Insurance or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / MI Social Security Number	Sex	Relationship**	Birthdate	Physician* (First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change		M F	Spouse		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work
*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Pay for care and save money with an FSA

What kind of FSA is right for you?

A flexible spending account (FSA) lets you set aside money to help pay for health and/or dependent care. You keep more of your money because you don't pay taxes on the money you put into your FSA. The amount you save depends on how much you put into your FSA and your income tax rate.

There are 2 types of FSAs

1. **Health care FSA** – Use it for eligible health care expenses like medical, pharmacy, dental and vision services and supplies
2. **Dependent care FSA** – Use it for eligible dependent care expenses like child care and elder care services and programs

Remember

You'll need to re-enroll in your FSA each plan year.

How an FSA works

You decide how much money you want to put into your FSA

Not sure how much to put in your FSA? Use the FSA Savings Calculator on **welcometouhc.com/fsa**.

Money is taken from your paycheck—before taxes

When the plan year begins, money is deducted from your paycheck before federal, state or Social Security taxes are taken out. The money is placed into your FSA.

You can use money in your FSA to pay for eligible expenses

The entire amount of your health care FSA is available the first day of the plan year. You don't have to wait until the money is in the account. If you sign up for a dependent care FSA, money must be in your FSA to be able to use it.

An easier way to pay

Your FSA may come with a UnitedHealthcare Health Care Spending Card Mastercard®,[1] which can be used to pay for eligible expenses by phone, online or at anyplace that accepts Mastercard.

continued

United Healthcare

FSA eligible expenses

These lists include some of the eligible expenses that you can pay for with your FSA(s). See your FSA benefit documents or visit **irs.gov** for a full list of expenses and rules.

Health care FSA

- Acupuncture
- Blood sugar test kits
- Breast pumps and lactation supplies
- Chiropractor visits
- Doctor visits, X-rays and lab work
- Health plan deductible, coinsurance and copayments
- Hearing aids and batteries
- LASIK eye surgery
- Over-the-counter medicines
- Prescriptions (retail and mail)
- Sunscreen (SPF 30 or higher and may require a prescription)
- Surgery, excluding cosmetic surgery

Dependent care FSA

Child care expenses:

- Before and after school care and extended care programs for dependents under age 13
- Babysitter (he/she cannot be your child, under age 19 and a tax dependent)
- Child care and qualified child care centers for dependents under age 13
- Nursery school
- Preschool

Elder care expenses:

- Adult day care center for dependents age 13 or older who are not able to support themselves
- Elder care while you work (in your home or someone else's)
- Senior day care

Take charge of your FSA

With **myuhc.com®** it's easier to:

- Submit your claims
- Track account balances
- Turn on direct deposit for fast reimbursements

Learn more

Visit **welcometouhc.com/fsa**

United Healthcare

[1] May not be available to some members. Please see your FSA benefit documents.

A flexible spending account is not insurance.

How to use your flexible spending account

Here are examples of medical services, treatments and over-the-counter (OTC) medications you can purchase using your flexible spending account (FSA).*

Medical services and treatments

- Acupuncture
- Ambulance
- Artificial limbs
- Artificial teeth
- Blood sugar test kits for diabetics
- Breast pumps and lactation supplies
- Chiropractor
- Dental treatments including X-rays, cleanings, fillings, braces and tooth removals
- Diabetes test strips
- Doctor's office visits and procedures
- Drug addiction treatment
- Eyeglasses and vision exams
- Fertility treatment
- Hearing aids and batteries
- Hospital services
- Insulin
- Laboratory fees
- Laser eye surgery
- Physical therapy
- Psychiatric care
- Speech therapy
- Stop-smoking programs (including nicotine gum or patches, if prescribed)
- Surgery, excluding cosmetic surgery
- Vasectomy
- Weight-loss program, if it's a treatment for a specific disease diagnosed by a physician

OTC medications

- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Antidiarrheal medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine antifungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Pain relievers
- Sleep aids

What is an FSA?

An FSA is a benefit plan that allows you to set aside money from your paycheck—before taxes—into a special account to help pay for certain medical costs, child care or other eligible health services.

*May vary based on your particular health plan. See your plan documents for details.

continued

United Healthcare

OTC supplies that may be eligible for FSA reimbursement

- Bandages, adhesive or elastic
- Braces and supports
- Catheters
- Condoms
- Contact lens solution and supplies
- Crutches
- First-aid supplies
- Menstrual products
- Ostomy products
- Personal protective equipment (PPE)—personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of the Coronavirus Disease 2019 (COVID-19 PPE)
- Pregnancy tests
- Reading glasses
- Sunscreen SPF15 or higher
- Walkers, wheelchairs and canes

What is an eligible expense?

An eligible expense is a medical, dental or vision expense that can be paid for or reimbursed by your health plan.

Common services and expenses not eligible for FSA reimbursement

- Aromatherapy
- Baby bottles
- Baby wipes
- Cotton swabs
- Dental floss
- Deodorants
- Hair regrowth
- Moisturizer with SPF protection
- Mouthwash
- Petroleum jelly
- Shampoo and conditioner
- Skin care
- Spa salts
- Sun-tanning products

Learn more

For a complete list of eligible expenses, see your benefit plan documents or visit irs.gov

Flexible Spending Account (FSA)
Employee Enrollment Form

Please provide this form to the HR Department

CareerSource BROWARD

Employer Information

Employer Name	CareerSource Broward

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Insurance Coverage

Coverage Effective Date	Coverage Type ☐ Single ☐ Family

Annual Elections

	Contribution Per Pay Period	Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Care Flexible Spending Account ($3,400.00 Max)	$	X	=	$
Dependent Care Flexible Spending Account*	$	X	=	$
Total	$			$

Contribution Per Pay Period x Number of Pay Periods = Your Annual Election Amount

***Dependent Care Flexible Spending Account limit for 2026: $7,500 per household, $3,750 if filing separately**

Signature

Print Name	Signature	Date

Your Humana benefits guide:

2026 Vision plan

Broward County Government

Humana

BROWARD COUNTY FLORIDA

Welcome to Humana

At Humana, we want to help take care of you — with benefits that make it easy for you to get the care you need, when you need it. With plan options designed to support your overall well-being, your care is always at the core of what we do.

Scan the QR code below to learn more about your Broward County vision plan.

Vision plans are definitely worth a closer look

There's more to vision health than getting an annual eye exam. It not only makes sure you're seeing clearly, but also supports your eye and overall health. A yearly eye exam monitors your vision and eye health for things like glaucoma and cataracts, and signs of medical conditions, including diabetes and high blood pressure.

Why sign up for vision benefits?

Get an annual eye exam* for no more than $10 when you see an in-network doctor. And, they may help detect or prevent other eye or health conditions.

Easily find an eye doctor near home, work or away with independent, retail and online options.

Save an average of 80% off retail prices for glasses and contacts with our fixed copays and allowances.

Caring for you is at the heart of everything we do so we make it easy for you to get the help you need – when you need it. Our service teams are always ready to help and answer your questions.

Earn EyeRewards when you get an eye exam

Get a reward voucher to use at Sunglass Hut when you visit an in-network eye care professional for your annual eye exam.

The voucher will be available through your online Humana account at MyHumana.com.

* Eye exams not covered on Humana Vision Materials Only plans.

Humana Custom Vision

Broward County Government

Vision care services	If you use an in-network provider (Member cost)	If you use an out-of-network provider (Reimbursement)
Exam with dilation[1] as necessary	$10	Up to $50
Retinal imaging	Up to $39	Not covered
Contact lens exam options[2]		
Standard contact lens fit and follow-up	$0	Not covered
Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$230 allowance 20% off balance over $230	$80 allowance
Standard plastic lenses[4]		
Single vision	$15	Up to $50
Bifocal	$15	Up to $75
Trifocal	$15	Up to $100
Lenticular	$15	Up to $125
Covered lens options[4]		
UV coating	$15	Not covered
Tint (solid and gradient)	$13	Not covered
Standard scratch-resistance	$0	Not covered
Standard polycarbonate - adults	$0	Not covered
Standard polycarbonate - children <19	$0	Not covered
Standard anti-reflective coating	$40	Not covered
Premium anti-reflective coating		
• Tier 1	$57	Not covered
• Tier 2	$68	Not covered
• Tier 3	80% of charge	Not covered
Standard progressive (add-on to bifocal)	$0	Up to $50
Premium progressive		
• Tier 1	$0	Not covered
• Tier 2	$120	Not covered
• Tier 3	$135	Not covered
• Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
Photochromatic / plastic transitions	$50	Not covered
Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
Conventional	$130 allowance 15% off balance over $130	$115 allowance
Disposable	$130 allowance	$115 allowance
Medically necessary	$0	$210 allowance

1. *Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.*
2. *Premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.*
3. *Discounts available on all frames except when prohibited by the manufacturer.*
4. *Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.*
5. *Plan covers contact lenses or frames/lenses, but not both.*

Humana Custom Vision

Broward County Government

Vision care services	**If you use an in-network provider** (Member cost)	**If you use an out-of-network provider** (Reimbursement)
Frequency		
Examination	Once every calendar year	Once every calendar year
Lenses or contact lenses	Once every calendar year	Once every calendar year
Frame	Once every calendar year	Once every calendar year
Diabetic Eye Care: care and testing for diabetic members		
Examination • Up to (2) services per calendar year	$0	Up to $77
Retinal Imaging • Up to (2) services per calendar year	$0	Up to $50
Extended Ophthalmoscopy • Up to (2) services per calendar year	$0	Up to $15
Gonioscopy • Up to (2) services per calendar year	$0	Up to $15
Scanning Laser • Up to (2) services per calendar year	$0	Up to $33
Additional plan discounts	Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price. Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.	

See the savings with Humana Vision plans:

	Retail	Humana Vision In-network providers
Eye Exam	$119	$10
Lenses	$153	$15
Average retail frame cost	$208	$250
Average frame allowance	none	– $230
Discount on balance over frame allowance	none	– 20%
YOUR COST:	**$480**	**$41**

On average, members save 80% when visiting an in-network provider

Savings example only for illustrative purposes. Actual savings will depend on benefits and frame selection. Retail cost based on industry averages.

Humana Custom Vision

Broward County Government

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

How to find a vision doctor in the network

Visiting a vision provider in the Humana network ensures you're getting the lowest cost when using your vision benefits. To find an in-network doctor, follow these steps:

Step 1:
Scan the QR code or go to **huma.na/vision** to search for eye doctors in the **Humana Vision** plan network.

Step 2:
Search for an eye doctor using your location to find a doctor in your area, or search by a doctor's name

INDEPENDENT PROVIDER NETWORK + LensCrafters PEARLE VISION OPTICAL Walmart sam's club

In-network online providers

You may also consider one of our many in-network online options including **Oakley**, **Ray-Ban**, **Glasses.com**, **ContactsDirect.com**, **LensCrafters** and **Target Optical**.

OAKLEY Ray-Ban GLASSES.COM

contactsdirect LensCrafters OPTICAL

See the bottom line ahead of time

Try our Know Before You Go out-of-pocket cost estimator

Humana Vision members have access to an out-of-pocket cost estimator tool, which can be accessed from MyHumana online or the MyHumana mobile app.

The **Know Before You Go** cost estimator tool boosts member confidence by explaining the different types of contact and eyeglass lenses, lens materials and frame categories.

Using this tool, you can receive estimated total costs ahead of time, so there are fewer surprises when it's time to pay the provider. That's what we call human care.

Here's how to view your estimated total cost in three easy steps:

1. Sign in to MyHumana at Humana.com, select the "**Vision**" tab, then select "**Humana Vision**".
2. Select the "**Estimate Costs**" tab.
3. Complete the **Know Before You Go** out-of-pocket cost estimator.

Many members often have no out-of-pocket costs beyond their copays, but you can feel better prepared for your visit by estimating costs ahead of time.

What else comes with your Humana plan?

As a Humana member, you'll have access to other perks like our exclusive discounts on a variety of services that support your overall health and well-being.

Exclusive discounts for Humana members

Access to a variety of discounts that support your overall health and well-being

We understand the importance of your overall health and that's why we've carefully selected companies to team up with to offer special discounts Humana members can enjoy:

- **Personalized dental products** for things like teeth whitening and dental devices with tracking and personalized feedback
- **Vision care discounts** on Lasik, exams, glasses and contacts
- **Hearing aid options** in your area and online
- **Additional discounts** for things like weight loss, massage therapy, fitness devices and more

Once your Humana plan coverage begins, **access your exclusive discounts** by signing in to **MyHumana.com**.

Look for "Special Discounts" in the "Coverage" section of MyHumana.

Manage your Humana plan online

MyHumana on the go

Once you become a Humana plan member, you get the most of your plan with a MyHumana account, and take your Humana essentials wherever you go with the MyHumana mobile app.

Depending on your plan, you can use the app to:

- **Explore coverage and benefit details** the moment you need them
- **Get your member ID cards** and add them to your phone's wallet
- **Find care close to you** and get directions on your phone's map app
- **Review claims status**
- **Access your exclusive member discounts**

Once your Humana plan coverage begins, go to **MyHumana.com** to activate your account **or download and register on the MyHumana app** for iOS and Android.

App Store Google Play

Learn more at humana.com/member/manage-your-account

VISION

Additional discounts for Humana Vision plan members

Good vision health is important to overall health and that's why we're committed to providing access to value-added discounts that make it easier to care for your eyes—and help save you money.

With your Humana Vision plan, you already get 40% off a second pair of prescription glasses and 20% off non-prescription sunglasses when you use an in-network provider.

To access your discounts, go to **Humana.com** and sign in. Select Vision, then select Humana Vision, then select Special Offers.

Additionally, you can enjoy even more discounts from these retailers, including*:

- **LensCrafters:** Get a $50 bonus and 50% off additional pairs of glasses at LensCrafters® in addition to your vision insurance
- **Target:** Get up to $150 instant savings on an annual supply of contact lenses. You can also get $50 off multi-focal glasses lenses or $25 off single-vision glasses lenses with a complete pair purchase.
- **Pearle Vision:** Get $50 off a complete pair of glasses purchase (frames and lenses)
- **LasikPlus:** Save $1,000 on LASIK with the Wavelight Laser at LasikPlus®, TLC Laser Eye Center and the LASIK Vision Institute
- **Glasses.com:** Get $30 off on Blue Light lens treatment at Glasses.com
- **ContactsDirect:** Save 10% on contact lenses
- **Cooper Vision | MiSight®:** Save $200 on 1-day soft contact lenses designed for kids with nearsightedness. The discount is for MiSight brand only.
- **MyEyeDr®:** Save $50 off glasses or contacts or save 20% off your next order of contact lenses at shop.myeyedr.com
- **Hilco Vision:** Save on lens cleaners, Croakies retainers and glasses cases
- **Amplifon:** Up to 66% off hearing aids at thousands of locations nationwide

* Discounts and offers are not valid for policies issued in the State of Texas.

Vision coverage when you travel out of the country

Get emergency eyewear and eye care when traveling abroad

If you lose or break your glasses while traveling or need eye care, Humana vision members can get emergency services with trusted providers in 20 countries and territories:

- **Emergency glasses delivered within 24 hours*** – get adjustable, temporary eyewear for $0
- **24/7 call support** and free translation help in 160 languages
- **Online directory of international providers** in 20 countries
- **International eye care guide** with Q&As to help you find vision care in 20 countries and territories around the world, with advice and guidelines tailored to each country
- **All part of your vision benefits** – only pay for the eye exam or eyewear materials you purchase
- **Easy online claims submission** – simply upload receipts and get reimbursed 100% of remaining eligible out-of-network benefits

When traveling, keep this number handy:

+1.513.765.2870

to order emergency glasses, find a provider, or request translation.

Tip for calling the US from another country: Dial the plus sign +, then 1, then area code, and the number.

Access international support through MyHumana

Once your vision plan coverage begins, you can access your international vision benefits after you activate your MyHumana.com account.

Simply sign in to MyHumana and look for the "International" tab on your vision benefits home page.

* Glasses are delivered to most locations within 24 hours, however, some areas of the world may take longer.

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc. provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us as well as provides free language assistance services to people whose primary language is not English, including qualified sign language interpreters and written information in other formats.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

California members or residents: You may also call the California Department of Insurance toll-free hotline number, **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

These notices are available at **www.humana.com/legal/non-discrimination-disclosure** and **www.humana.com/legal/multi-language-support**.

Humana

your.humana.com/broward-county

BROWARD COUNTY FLORIDA

Insured by Humana Insurance Company.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

FLHMN54EN 0925

Your Humana benefits guide:

2026 Dental plan

Broward County Government

Humana

BROWARD COUNTY FLORIDA

Welcome to Humana

At Humana, we want to help take care of you — with benefits that make it easy for you to get the care you need, when you need it. With plan options designed to support your overall well-being, your care is always at the core of what we do.

Scan the QR code below to learn more about your Broward County dental plan.

Our dental plans will make you smile

At Humana we want to help take care of you. Dental health is an important part of your overall well-being and Humana's dental benefits help make it easy to make your dental care a priority. When you sign up for a Humana dental plan, you're signing up for a healthier you.

Why sign up for dental benefits?

Preventive dental care, such as checkups and cleanings, help stop issues before they start, saving you time and money in the long run. And when you use an in-network dentist, **preventive care is at no additional cost to you.**

For years, doctors have recognized the link between oral health and whole-body health. **Routine teeth cleanings can help reduce your risk for heart disease, stroke and dementia.**

Plus, **caring for you is at the heart of everything we do,** so we make it easy for you to get the help you need – when you need it. Our service teams are always ready to help and answer your questions.

Humana Dental Prepaid HS195MB Plan

The Humana Dental Prepaid plans focus on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. HS plans copayments for listed procedures are applicable at either a participating general dentist or a participating specialist dentist.

A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services: Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Visit **Humana.com** to find a participating specialist.

Summary of services

Services marked with a single asterisk (*) below also require separate payment of laboratory charges, not to exceed $200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

ADA Code	Procedure	
Appointments		**Member cost**
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit (normal hours)	$5
D9440	Office visit (after regularly scheduled hours)	$35
D9986	Missed appointment	$10
D9987	Cancelled appointment	$10
D9999	Emergency visit during regular scheduled hours, by report	$20
Diagnostic		**Member cost**
D0120	Periodic oral examination (limited to twice in any 12 calendar months)	no charge
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge
D0150	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge
D0170	Re-evaluation—problem focused (not post-operative visit)	no charge

ADA Code	Procedure	
Diagnostic (cont.)		**Member cost**
D0180	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	$10
D0210	X-ray intraoral—complete series including bitewings (once per three calendar years)	no charge
D0220	X-ray intraoral—periapical, first radiographic image	no charge
D0230	X-ray intraoral—periapical, each additional radiographic image	no charge
D0240	X-rays intraoral—occlusal radiographic image	no charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	no charge
D0270	X-ray bitewing—single radiographic image (limited to twice in any 12 calendar months)	no charge
D0272	X-ray bitewings—two radiographic images (limited to twice in any 12 calendar months)	no charge
D0273	X-ray bitewings—three radiographic images (limited to twice in any 12 calendar months)	no charge
D0274	X-ray bitewings—three radiographic images (limited to twice in any 12 calendar months)	no charge
D0277	X-ray bitewings, vertical—seven to eight radiographic images (limited to twice in any 12 calendar months)	no charge
D0330	Panoramic radiographic image (once per three calendar years)	no charge
D0350	Oral/facial photography images	no charge
D0415	Collect microorganisms culture & sensitivity	no charge
D0425	Caries susceptibility tests	no charge
D0431	Oral cancer screening using a special light source	no charge
D0460	Pulp vitality tests (not covered if a root canal is performed)	no charge
D0470	Diagnostic casts	no charge
D0472	Pathology report—gross examination of lesion	no charge
D0473	Pathology report—microscopic examination of lesion	no charge
D0474	Pathology report—microscopic examination of lesion and area	no charge
Preventive		**Member cost**
D1110	Prophylaxis—adult (limited to three in any 12 calendar months, by primary care dentist)	no charge
D1111	Additional adult prophylaxis, with and without fluoride (maximum of two additional per year)	$20
D1120	Prophylaxis—child (limited to three in any 12 calendar months, by primary care dentist)	no charge
D1121	Additional child prophylaxis, with or without fluoride (maximum of two additional per year)	$20
D1206	Topical application of fluoride varnish (for child <16) (limited to twice in any 12 calendar months)	no charge

ADA Code	Procedure	
Preventive (cont.)		**Member cost**
D1208	Topical application of fluoride—excluding varnish (limited to twice in any 12 calendar months)	no charge
D1310	Nutrition counseling for the control of dental disease	no charge
D1320	Tobacco counseling services for the control or prevention of oral disease	no charge
D1330	Oral hygiene instruction	no charge
D1351	Sealant—per tooth (permanent teeth only to age 16)	$10
D1510*	Space maintainer—fixed, unilateral (through age 14)	$45
D1515*	Space maintainer—fixed, bilateral (through age 14)	$45
D1520*	Space maintainer—removable, unilateral (through age 14)	$85
D1525*	Space maintainer—removable, bilateral (through age 14)	$85
D1550	Re-cement or re-bond space maintainer	$10
D1555	Removal of fixed space maintainer	$15
D1575	Distal shoe space maintainer – fixed – unilateral (through age 14; primary teeth only)	$55
Restorative		**Member cost**
D2140	Amalgam—one surface, primary or permanent	no charge
D2150	Amalgam—two surfaces, primary or permanent	no charge
D2160	Amalgam—three surfaces, primary or permanent	no charge
D2161	Amalgam—four or more surfaces, primary or permanent	no charge
D2940	Protective restoration	$15
Resin restorative (inlays and onlays limited to one per tooth every five years)		**Member cost**
D2330	Resin based composite—one surface, anterior	$35
D2331	Resin based composite—two surfaces, anterior	$40
D2332	Resin based composite—three surfaces, anterior	$50
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)	$70
D2390	Resin based composite crown, anterior	$70
D2391	Resin based composite—one surface, posterior	$60
D2392	Resin based composite—two surfaces, posterior	$80
D2393	Resin based composite—three surfaces, posterior	$100
D2394	Resin based composite—four or more surfaces, posterior	$120
D2510*	Inlay—metallic, one surface	$95
D2520*	Inlay—metallic, two surfaces	$105
D2530*	Inlay—metallic, three or more surfaces	$130
D2542*	Onlay—metallic, two surfaces	$230
D2543*	Onlay—metallic, three surfaces	$230

ADA Code	Procedure	
Resin restorative (inlays and onlays limited to one per tooth every five years) (cont.)		**Member cost**
D2544*	Onlay—metallic, four or more surfaces	$230
D2610*	Inlay—porcelain/ceramic, one surface	$230
D2620*	Inlay—porcelain/ceramic, two surfaces	$230
D2630*	Inlay—porcelain/ceramic, three or more surfaces	$230
D2642*	Onlay—porcelain/ceramic, two surfaces	$230
D2643*	Onlay—porcelain/ceramic, three surfaces	$230
D2644*	Onlay—porcelain/ceramic, four or more surfaces	$230
D2650*	Inlay—resin based composite, one surface	$230
D2651*	Inlay—resin based composite, two surfaces	$230
D2652*	Inlay—resin based composite, three or more surfaces	$230
D2662*	Onlay—resin based composite, two surfaces	$230
D2663*	Onlay—resin based composite, three surfaces	$230
D2664*	Onlay—resin based composite, four or more surfaces	$230
Crown and bridge (limited to one per tooth every five years)		**Member cost**
D2710*	Crown—resin based composite, indirect	$230
D2712*	Crown—3/4 resin based composite, indirect	$230
D2720*	Crown—resin with high noble metal	$230
D2721	Crown—resin with predominantly base metal	$230
D2722*	Crown—resin with noble metal	$230
D2740*	Crown—porcelain/ceramic	$280
D2750*	Crown—porcelain fused to high noble metal	$280
D2751	Crown—porcelain fused to predominantly base metal	$280
D2752*	Crown—porcelain fused to noble metal	$280
D2780*	Crown—3/4 cast high noble metal	$230
D2781	Crown—3/4 cast predominantly base metal	$230
D2782*	Crown—3/4 cast noble metal	$230
D2783*	Crown—3/4 porcelain/ceramic	$230
D2790*	Crown—full cast high noble metal	$280
D2791	Crown—full cast predominantly base metal	$280
D2792*	Crown—full cast noble metal	$280
D2794*	Crown—titanium	$230
D2799	Provisional crown	no charge
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	no charge
D2920	Re-cement or re-bond crown	$15

ADA Code	Procedure	
Crown and bridge (limited to one per tooth every five years) (cont.)		**Member cost**
D2929	Crown-Prefabricated porcelain/ceramic crown - primary tooth	$75
D2930	Prefabricated stainless steel crown—primary tooth	$75
D2931	Prefabricated stainless steel crown—permanent tooth	$25
D2932	Prefabricated resin crown	$35
D2933	Prefabricated stainless steel crown with resin window	$35
D2950	Core buildup, including any pins	$45
D2951	Pin retention—per tooth, in addition to restoration	$15
D2952*	Cast post and core in addition to crown	$90
D2953*	Each additional cast post—same tooth	$90
D2954	Prefabricated post and core in addition to crown	$90
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post—same tooth, base metal post	$30
D2960	Labial veneer (resin laminate)—chairside	$250
D2961*	Labial veneer (resin laminate)—laboratory	$300
D2962*	Labial veneer (porcelain laminate)—laboratory	$280
D2970	Temporary crown (fractured tooth)	no charge
D2971	Additional procedure—new crown existing partial denture	$50
D2980	Crown repair, necessitated by restorative material failure	no charge
D2981	Inlay repair, necessitated by restorative material failure	no charge
D2982	Onlay repair, necessitated by restorative material failure	no charge
D2983	Veneer repair, necessitated by restorative material failure	no charge
D6940	Stress breaker	$110
D6950	Precision attachment, separate from prosthesis	$195
D6980*	Fixed partial denture repair necessitated by restorative material failure	$45
Prosthodontics (fixed-replacement limited to every five years, adjustments once per year)		**Member cost**
D6210*	Pontic—cast high noble metal	$280
D6211	Pontic—cast predominantly base metal	$280
D6212*	Pontic—cast noble metal	$280
D6240*	Pontic—porcelain fused to high noble metal	$280
D6241	Pontic—porcelain fused to predominantly base metal	$280
D6242*	Pontic—porcelain fused to noble metal	$280
D6750*	Retainer crown—porcelain fused to high noble metal	$280
D6751	Retainer crown—porcelain fused to predominantly base metal	$280
D6752*	Retainer crown—porcelain fused to noble metal	$280
D6790*	Retainer crown—full cast high noble metal	$280

ADA Code	Procedure	
Prosthodontics (fixed–replacement limited to every five years, adjustments once per year) (cont.)		**Member cost**
D6791	Retainer crown—full cast predominantly base metal	$280
D6792*	Retainer crown—full cast noble metal	$280
D6794*	Retainer crown—titanium	$245
D6930	Re-cement or re-bond fixed partial denture (per unit)	$10
Prosthodontics (replacement limited to every five years)		**Member cost**
D5110*	Complete denture—maxillary	$300
D5120*	Complete denture—mandibular	$300
D5130*	Immediate denture—maxillary	$300
D5140*	Immediate denture—mandibular	$300
D5211*	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	$300
D5212*	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	$300
D5213*	Maxillary partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$300
D5214*	Mandibular partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$300
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$210
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$210
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5225*	Maxillary partial denture—flexible (including clasps, rests and teeth)	$365
D5226*	Mandibular partial denture—flexible (including clasps, rests and teeth)	$365
D5281*	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	$300
D5410	Adjust complete denture—maxillary	$30
D5411	Adjust complete denture—mandibular	$30
D5421	Adjust partial denture—maxillary	$30
D5422	Adjust partial denture—mandibular	$30
D5660*	Add clasp to existing partial denture—per tooth	$35
Endodontics (each procedure limited to once per tooth per life)		**Member cost**
D3110	Pulp cap—direct (excluding final restoration)	$5
D3120	Pulp cap—indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration)	$35

ADA Code	Procedure	
Endodontics (each procedure limited to once per tooth per life) (cont.)		**Member cost**
D3221	Pulpal debridement, primary and permanent teeth (Not to be used when root canal is done on the same day)	$100
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	$40
D3310	Root canal therapy—anterior tooth (excluding final restoration)	$100
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$200
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$250
D3331	Treatment of root canal obstruction—non-surgical access	$85
D3332	Incomplete endodontic therapy—inoperable or fractured tooth	$96
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy—anterior	$180
D3347	Retreatment of previous root canal therapy—bicuspid	$280
D3348	Retreatment of previous root canal therapy—molar	$325
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	$70
D3353	Apexification/recalcification—final visit (includes any necessary radiographs)	$70
D3410	Apicoectomy—anterior	$125
D3421	Apicoectomy—premolar (first root)	$95
D3425	Apicoectomy—molar (first root)	$95
D3426	Apicoectomy—(each additional root)	$60
D3430	Retrograde filling—per root	$40
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	$95
D3910	Surgical procedure to isolate tooth with rubber dam	$19
D3920	Hemisection not included in root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
Periodontics (gum treatment)		**Member cost**
D4210	Gingivectomy/gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	$125
D4211	Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	$40
D4240	Gingival flap, including root planing—four or more teeth, per quadrant	$150
D4241	Gingival flap, including root planing—one to three teeth, per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening—hard tissue	$120

ADA Code	Procedure	
Periodontics (gum treatment) (cont.)		**Member cost**
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$350
D4263	Bone replacement graft—retained natural tooth—first site in quadrant	$180
D4264	Bone replacement graft—retained natural tooth—each additional site in quadrant	$95
D4265	Biological materials which can aid soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration—resorbable barrier, per site	$215
D4267	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$245
D4271	Free soft tissue graft procedure (including donor site surgery)	$245
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$225
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft site	$110
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$75
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$380
D4320	Provisional splinting—intracoronal	$95
D4321	Provisional splinting—extracoronal	$85
D4341	Periodontal scaling and root planing—four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months)	$50
D4342	Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342)	$50
D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120)	$50

ADA Code	Procedure	
Periodontics (gum treatment) (cont.)		**Member cost**
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years)	$45
D4381	Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy)	$45
D4910	Periodontal maintenance (covered only after active periodontal therapy)	$50
D4911	Additional periodontal maintenance procedures (beyond two per 12 months)	$55
Extractions/oral and maxillofacial surgery		**Member cost**
D7111	Extraction, coronal remnants - primary tooth	no charge
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	no charge
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	Removal of impacted tooth—soft tissue	$50
D7230	Removal of impacted tooth—partially bony	$70
D7240	Removal of impacted tooth—completely bony	$85
D7241	Removal of impacted tooth—completely bony, unusual complications by report	$100
D7250	Surgical removal of residual tooth roots	$35
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Exposure of an unerupted tooth (excluding wisdom teeth)	$85
D7282	Mobilization of erupted or malposed tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	no charge
D7286	Incisional biopsy of oral tissue-soft (all others)	no charge
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy—transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions—per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$35
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$70
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess—intraoral soft tissue	$25

ADA Code	Procedure	
Extractions/oral and maxillofacial surgery (cont.)		**Member cost**
D7511	Incision and drainage of abscess—intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess—extraoral soft tissue	$35
D7521	Incision and drainage of abscess—extraoral soft tissue, complicated	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy)— separate procedure	$50
D7963	Frenuloplasty	$50
D7970	Excision hyperplastic tissue—per arch	$55
D7971	Excision of pericoronaal gingiva	$40
Repairs to prosthetics		**Member cost**
D5511*	Repair broken complete denture base, mandibular	$15
D5512*	Repair broken complete denture base, maxillary	$15
D5520*	Replace missing or broken teeth—complete denture (each tooth)	$15
D5611*	Repair resin partial denture base, mandibular	$15
D5612*	Repair resin partial denture base, maxillary	$15
D5621*	Repair cast partial framework, mandibular	$30
D5622*	Repair cast partial framework, maxillary	$30
D5630*	Repair or replace broken clasp—per tooth	$15
D5640*	Replace broken teeth—per tooth	$15
D5650*	Add tooth to existing partial denture	$30
D5670*	Replace all teeth and acrylic on cast metal framework—maxillary	$165
D5671*	Replace all teeth and acrylic on cast metal framework—mandibular	$165
D5710*	Rebase complete maxillary denture	$75
D5711*	Rebase complete mandibular denture	$75
D5720*	Rebase maxillary partial denture	$75
D5721*	Rebase mandibular partial denture	$75
D5730	Reline complete maxillary denture (chairside)	$50
D5731	Reline complete mandibular denture (chairside)	$50
D5740	Reline maxillary partial denture (chairside)	$50
D5741	Reline mandibular partial denture (chairside)	$50
D5750*	Reline complete maxillary denture (laboratory)	$35
D5751*	Reline complete mandibular denture (laboratory)	$35
D5760*	Reline maxillary partial denture (laboratory)	$35
D5761*	Reline mandibular partial denture (laboratory)	$85
D5810*	Interim complete denture (maxillary)	$230

ADA Code	Procedure	
Repairs to prosthetics (cont.)		**Member cost**
D5811*	Interim complete denture (mandibular)	$230
D5820*	Interim partial denture (maxillary)	$60
D5821*	Interim partial denture (mandibular)	$60
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862*	Precision attachment, by report	$160
D6214*	Pontic titanium	$230
D6245*	Pontic—porcelain/ceramic	$230
D6250*	Pontic—resin with high noble metal	$230
D6251	Pontic—resin with predominantly base metal	$230
D6252*	Pontic—resin with noble metal	$230
D6253*	Provisional pontic	no charge
D6545*	Retainer—cast metal, resin bonded fixed prosthesis	$200
D6549	Resin retainer – for resin bonded fixed prosthesis	$200
D6600*	Retainer inlay—porcelain/ceramic, two surfaces	$230
D6601*	Retainer inlay—porcelain/ceramic, three or more surfaces	$230
D6602*	Retainer inlay—cast high noble metal, two surfaces	$230
D6603*	Retainer inlay—cast high noble metal, three or more surfaces	$230
D6604	Retainer inlay—cast predominantly base metal, two surfaces	$230
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces	$230
D6606*	Retainer inlay—cast noble metal, two surfaces	$230
D6607*	Retainer inlay—cast noble metal, three or more surfaces	$230
D6608*	Retainer onlay—porcelain/ceramic, two surfaces	$230
D6609*	Retainer onlay—porcelain/ceramic, three or more surfaces	$230
D6610*	Retainer onlay—cast high noble metal, two surfaces	$230
D6611*	Retainer onlay—cast high noble metal, three or more surfaces	$230
D6612	Retainer onlay—cast predominantly base metal, two surfaces	$230
D6613	Retainer onlay—cast predominantly base metal, three or more surfaces	$230
D6614*	Retainer onlay—cast noble metal, two surfaces	$230
D6615*	Retainer onlay—cast noble metal, three or more surfaces	$230
D6710*	Retainer crown—indirect resin based composition	$230
D6720*	Retainer crown—resin with high noble metal	$230
D6721	Retainer crown—resin with predominantly base metal	$230
D6722*	Retainer crown—resin with noble metal	$230
D6740*	Retainer crown—porcelain/ceramic	$230

ADA Code	Procedure	
Repairs to prosthetics (cont.)		**Member cost**
D6780*	Retainer crown—3/4 cast high noble metal	$230
D6781	Retainer crown—3/4 cast predominantly base metal	$230
D6782*	Retainer crown—3/4 cast noble metal	$230
D6783*	Retainer crown—3/4 porcelain/ceramic, denture	$230
Adjunctive general service		**Member cost**
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$10
D9120	Fixed partial denture sectioning	no charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	no charge
D9211	Regional block anesthesia	no charge
D9212	Trigeminal division block anesthesia	no charge
D9215	Local anesthesia in conjunction with operative or surgical procedures	no charge
D9222	Deep sedation/general anesthesia – first 15 minutes	$75
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$64
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$75
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$64
D9248	Non-intravenous conscious sedation	$15
D9450	Case presentation, detailed and extensive treatment planning	no charge
D9610	Non-intravenous conscious sedation	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment—limited	$25
D9952	Occlusal adjustment—complete	$150
Bleaching		**Member cost**
D9972	External bleaching in office—per arch	$125
D9975	External bleaching in home—per arch	$125

ADA Code	Procedure	
Orthodontics		**Member cost**
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
	Consultation	no charge
	Evaluation	$35
	Records/treatment planning	$250
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
	Consultation	no charge
	Evaluation	$35
	Records/treatment planning	$250
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,000
D8680	Orthodontic retention	$450
D8693	Re-cement or re-bond fixed retainer	no charge

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures).
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at **Disclosure.Humana.com**.

Pre-determination of your Humana Dental benefits

If you expect to pay more than $300 for dental care, your dentist may submit a proposed dental treatment plan that Humana will use to help provide you with an estimate of benefits for the planned service. This is known as a "predetermination of benefits."

The dental treatment plan may include:

- A list of services to be performed, including any supporting documentation
- A written description from the dentist of the treatment
- An itemized list of costs

Schedule of benefits

Florida: HS195MB

Implants services:

Implants and implant supported prostheses are covered with a 50% copayment, up to an annual maximum benefit of $1,500 and a $10,000 lifetime maximum benefit. The Member is responsible for payment of the copayment and any amounts in excess of the annual maximum benefit. No benefits for implants and implant supported prostheses are available after the lifetime maximum is met.

Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while covered under this plan, or for replacement of a prior prosthesis if it has been at least five years since the prior insertion, and is not, and cannot be made serviceable.

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Some Covered Dental Care Services are typically only offered by a specialist (like many oral surgery procedures).
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
- Additional exclusions and limitations are listed along with full plan information in your Certificate of Dental Benefits.
- Copayment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist. Specialist services are only available in areas where the dental plan has a Participating Specialist.

How to find a dentist in the network

Visiting a dentist in the Humana network ensures you're getting the lowest cost for dental care. To find an in-network dentist for each plan, follow these steps:

Step 1: Scan the QR code or go to **humana.com/findadentist** and select the "Dentist" tab.

Step 2: Enter your search information based on plan

For the **DHMO** plan

- Enter your **ZIP code**
- In the popup window, choose **"DHMO"** for "Coverage Type"
- Select the network: **HS195MB DHMO**
- Click the **"Select"** button
- On the next screen, click on the "**all dental providers**" link located below the "Dentist name or specialty" entry box to get a list of all providers.
- Choose a dentist from the search results, call to confirm they're accepting new patients, and then take note of their **Dental ID** number.
- After you enroll, the dentist you selected will need to be assigned as your Primary Care Dentist (PCD) before you get dental services. To do this, contact Humana using the number on the back of your ID card and provide the Dental ID number for your chosen PCD.

Is your dentist missing from our network?

We don't want you to have to choose between continuing to see your dentist and receiving the best possible value from your dental benefit plan.

You can help us get your dentist in our network. **Scan the QR code and fill out the online form to refer your dentist.**

What else comes with your Humana plan?

As a Humana member, you'll have access to other perks like our exclusive discounts on a variety of services that support your overall health and well-being.

Exclusive discounts for Humana members

Access to a variety of discounts that support your overall health and well-being

We understand the importance of your overall health and that's why we've carefully selected companies to team up with to offer special discounts Humana members can enjoy:

- **Personalized dental products** for things like teeth whitening and dental devices with tracking and personalized feedback
- **Vision care discounts** on Lasik, exams, glasses and contacts
- **Hearing aid options** in your area and online
- **Additional discounts** for things like weight loss, massage therapy, fitness devices, and more

Once your Humana plan coverage begins, **access your exclusive discounts** by signing in to MyHumana.com.

Look for "Special Discounts" in the "Coverage" section of MyHumana.

Manage your Humana plan online

MyHumana on the go

Once you become a Humana plan member, you get the most of your plan with a MyHumana account, and take your Humana essentials wherever you go with the MyHumana mobile app.

Depending on your plan, you can use the app to:

- **Explore coverage and benefit details** the moment you need them
- **Get your member ID cards** and add them to your phone's wallet
- **Find care close to you** and get directions on your phone's map app
- **Review claims status**
- **Access your exclusive member discounts**

Once your Humana plan coverage begins, go to **MyHumana.com** to activate your account **or download and register on the MyHumana app** for iOS and Android.

Download on the App Store | GET IT ON Google Play

Learn more at humana.com/member/manage-your-account

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc. provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us as well as provides free language assistance services to people whose primary language is not English, including qualified sign language interpreters and written information in other formats.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. - 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

California members or residents: You may also call the California Department of Insurance toll-free hotline number, **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis èd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

These notices are available at **www.humana.com/legal/non-discrimination-disclosure** and **www.humana.com/legal/multi-language-support**.

Humana

your.humana.com/broward-county

For customer service call

1-800-233-4013

BROWARD COUNTY FLORIDA

Insured by Humana Insurance Company.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

FLHMN53EN 1025

Group Employee Enrollment Form (all group sizes)

Humana.

Humana.com

FLORIDA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Group Employee Enrollment Form as "Humana", "We", "Us", or "Our".

Dental, Vision, Life and Disability plans insured or administered by ☐ Humana Insurance Company.

Prepaid dental plans offered and administered by ☐ CompBenefits Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name	Employer / Group city	State

Qualifying Event Instructions

☐ New business enrollment
☐ New hire/Newly eligible
☐ Dependent birth or adoption
☐ Loss of coverage
☐ Open Enrollment event
☐ Rehire/Reinstatement
☐ Marital status change
☐ Other _____

Office use only

Qualifying event date (MM/DD/YYYY)

Benefit effective date (MM/DD/YYYY)

EMPLOYEE/ INDIVIDUAL INFORMATION – Please type or print clearly in black ink

Last name:	First name:	MI:
Social Security Number:	Date of birth (MM/DD/YYYY):	Phone number:
Street address:		
Apt / Suite / PO box number:	Gender: ☐ Female ☐ Male	Language of choice: ☐ English ☐ Spanish
City:	State: / ZIP code:	County:
Email address:		
Are you actively at work? ☐ Yes ☐ No If not, reason: ☐ Retiree ☐ COBRA Other: _____	Date of full-time hire (MM/DD/YYYY):	
Do you have a disability that affects your ability to communicate or read? ☐ No ☐ Yes Are you disabled or unable to perform normal work activities? ☐ No ☐ Yes If yes, indicate reason: _____		
Annual salary: $	Hours worked per week:	
Occupation:		

DEPENDENT INFORMATION – Enter information for each covered dependent, including spouse.

1 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

2 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

3 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

4 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

Use the following alternate address for these dependents: ☐ 1 ☐ 2 ☐ 3 ☐ 4			
Street address:			
Apt / Suite / PO box number:			
City:	State:	ZIP code:	County:

DENTAL

Coverage type: ☐ Employee / Individual only ☐ Employee / Individual & spouse ☐ Employee / Individual & child(ren) ☐ Family ☐ Other	**Office use only:** Group #: Benefit #: Class/Div #:
Plan name:	
Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ☐ Yes ☐ No If yes, list all: (This section must be completed for Humana to process any dental claims)	

Current dental carrier name:	Orthodontia coverage? ☐ Yes ☐ No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply) ☐ Employee / Individual ☐ Spouse ☐ Child(ren)			
Prior dental carrier name:	Orthodontia coverage? ☐ Yes ☐ No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply)	☐ Employee / Individual only ☐ Employee / Individual and spouse ☐ Employee / Individual and child(ren) ☐ Family		

BASIC LIFE /AD&D

Do you elect basic employee / individual life coverage? ☐ Yes ☐ No If no, complete waiver section	**Office use only:** Group #: Benefit #: Class/Div #:
Class (employer / group will provide you with this information if needed):	
Do you elect basic dependent life? ☐ Yes ☐ No If no, complete waiver section	

VOLUNTARY LIFE /AD&D

Do you elect voluntary employee / individual life coverage? ☐ Yes ☐ No If no, complete waiver section If yes, amount elected (minimum of $15,000):	**Office use only:** Group #:	Benefit #:	Class/Div #:

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ☐ Yes ☐ No If no, complete waiver section

If yes, voluntary spouse life coverage (minimum of $5,000): $

Do you elect voluntary child(ren) life coverage? ☐ Yes ☐ No If no, complete waiver section

VISION

Coverage type: ☐ Employee / Individual only ☐ Employee / Individual & spouse ☐ Employee / Individual & child(ren) ☐ Family ☐ Other	**Office use only:** Group #:	Benefit #:	Class/Div #:

Plan name:

SHORT TERM DISABILITY

Do you elect short term disability coverage? ☐ Yes ☐ No If no, complete waiver section	**Office use only:** Group #:	Benefit #:	Class/Div #:

Class (employer / group will provide you with this information if needed)

LONG TERM DISABILITY

Do you elect long term disability coverage? ☐ Yes ☐ No If no, complete waiver section	**Office use only:** Group #:	Benefit #:	Class/Div #:

Class (employer / group will provide you with this information if needed)

BENEFICIARY FOR LIFE AND DISABILITY BENEFITS

Primary beneficiary Last name:	First name:	MI:
Relationship to employee / individual:		
Secondary beneficiary Last name:	First name:	MI:
Relationship to employee / individual:		

WAIVER (refusal of coverage)

I hereby waive coverage for (check all that apply):				I decline to apply for group coverage because of:
Dental for:	☐ Myself	☐ My spouse	☐ My dependent child(ren)	☐ Spousal coverage
Basic Life for:	☐ Myself	☐ My spouse	☐ My dependent child(ren)	☐ Medicare supplement
Vision for:	☐ Myself	☐ My spouse	☐ My dependent child(ren)	☐ Individual coverage
Short Term Disability for:	☐ Myself			☐ Coverage under another carrier's plan provided by my employer / group
Long Term Disability for:	☐ Myself			☐ Other:_____

AGREEMENT

True and Complete Knowledge. I understand, agree, and represent:

- I have read the Group Employee Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Group Employee Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Group Employee Enrollment Form.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee Enrollment Form by Humana.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

AUTHORIZATION

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy, pharmacy benefit manager, insurance, HMO, or reinsuring company, and the Medical Information Bureau, Inc., having information regarding myself, including information concerning advice, diagnosis, treatment and care of the physical, mental or emotional conditions, drug, substance or alcohol abuse, illness (and copies of all hospital or medical records, non-public personal health information, and any other nonmedical information), and prescription drug history to share any and all such information with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development. The signature is true and accurate and a copy of the signature is valid as the original.

I understand and agree:

- Although Humana is required to inform me that any health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules, any information obtained will not be released by Humana to any person or organization.
- A copy of this authorization is available to me or my legal representative upon written request.
- This authorization shall be valid for two years from the date shown below.

You have the right to revoke this authorization at any time by sending written notice Humana's Privacy Office. The revocation will become effective after it is received by us but will not apply to information that has already been released in response to this authorization.

The Group Employee Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

SIGNATURE – Please sign below if enrolling or waiving any group coverage

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature: _____ Date: _____

Name and relationship of legal representative _____
(if a covered dependent)

Spouse signature: _____ Date: _____
(Only if selecting Life coverage over the guarantee issue amount.)

Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Medical Group number | Benefit number | Class/Division

Current Dental Group number | Proposed Effective Date for change: ___ / ___ / _____

Company name | Company city | State

Employee Information and Changes

Please provide employee information and indicate all applicable employee changes.

Last name | First name | MI | Social Security number

❍ **Change Medical benefit/class to:** Benefit number: _____ Class/Division: _____

❍ **Change or Select Employee Primary Care Physician** (HMO and POS only):

Primary care physician: _____ Physician ID: _____

❍ **Change Dental benefit/class to:** Benefit number: _____ Class/Division: _____

❍ **Change or Select Employee Primary Care Dentist** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: _____ Facility number: _____

❍ **Change Basic Life benefit/class to:** Benefit number: _____ Class/Division: _____

❍ **Change Basic Life Beneficiary:** Group number: _____

Primary beneficiary name: Last name | First name | MI

Secondary beneficiary name: Last name | First name | MI

❍ **Change Voluntary Life Beneficiary:** Group number: _____

Primary beneficiary name: Last name | First name | MI

Secondary beneficiary name: Last name | First name | MI

❍ **Change Vision benefit/class to:** Benefit number: _____ Class/Division: _____

❍ **Cancel My Coverage** for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Short-term Income Protection ❍ Vision ❍ Health Savings Account (HSA) ❍ Health Care FSA ❍ Dependent Care FSA

Qualifying Event Information

Please indicate the qualifying event date and reason for employee or dependent changes below.

Qualifying event date: ___ / ___ / _____

Reason for change:

- ❍ Re-hire
- ❍ Employer contribution ceases
- ❍ Dependent birth / adoption
- ❍ Dependent change to full-time student
- ❍ Marriage
- ❍ Legal separation
- ❍ Divorce
- ❍ Spouse deceased
- ❍ Spouse terminates employment
- ❍ Spouse's employer terminates coverage
- ❍ Spouse changes from full-time to part-time employment
- ❍ Other: _____

Change Address Information

Address change applies to:

❍ Employee only ❍ Employee and all covered dependents

❍ Only for the following dependent (please print full name): Last name | First name | MI

New street address | Apt / Suite / PO Box number

City | State | Zip code | County

Email address | Phone number

Group Number | Social Security Number

Dependent Changes

Please complete this section for all dependent changes.

1 Last name | First name | MI | Date of birth __/__/____

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only):

Primary care physician: _____ Physician ID: _____

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: _____ Facility number: _____

2 Last name | First name | MI | Date of birth __/__/____

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only):

Primary care physician: _____ Physician ID: _____

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: _____ Facility number: _____

3 Last name | First name | MI | Date of birth __/__/____

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only):

Primary care physician: _____ Physician ID: _____

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: _____ Facility number: _____

4 Last name | First name | MI | Date of birth __/__/____

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

❍ **Add** or ❍ **Delete** dependent to/from my current plan for the following products: ❍ Medical ❍ Dental ❍ Basic Life ❍ Voluntary Life ❍ Vision

❍ **Change or Select Primary Care Physician** (HMO and POS only):

Primary care physician: _____ Physician ID: _____

❍ **Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: _____ Facility number: _____

Signature - please sign below if requesting changes

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

CareerSource BROWARD

2026 BENEFIT PLAN RATES: MONTHLY RATES

DENTAL INSURANCE (Rates remain the same as 2025)		
TIER	HUMANA/COMPBENEFITS (DHMO)	UNITEDHEALTHCARE (PPO)
Employee	$ 11.75	$ 35.66
Emp+Spouse/DP	$ 21.11	$ 70.78
Emp+Child	$ 23.48	$ 83.02
Emp+Family	$ 28.17	$ 118.14

VISION INSURANCE (Rates down 5%)	
TIER	HUMANA
Employee	$ 8.45
Emp+Spouse/DP	$ 16.99
Emp+Child	$ 16.06
Emp+Family	$ 25.26

2026 MONTHLY PREMIUMS & CONTRIBUTIONS FOR HEALTH – CDH HIGH

Tier of Coverage	2026 Premium	2026 CSBD Contribution	2026 CSBD Contribution %	2025 Employee Contribution	2026 Employee Contribution %
Employee	$ 1,424.52	$ 1,424.52	100.00%	$0	0.00%
Employee + Spouse/DP	$ 3,063.88	$ 2,836.57	92.58%	$227.31	7.42%
Employee + Children	$ 2,619.78	$ 2,524.11	96.35%	$95.67	3.65%
Employee + Children + 26	$ 2,663.11	$ 2,524.11	94.78%	$139.00	5.22%
Employee + Family	$ 4,478.37	$ 3,811.57	85.11%	$666.80	14.89%
Employee + Family +26	$ 4,521.37	$ 3,808.57	84.30%	$710.13	15.70%

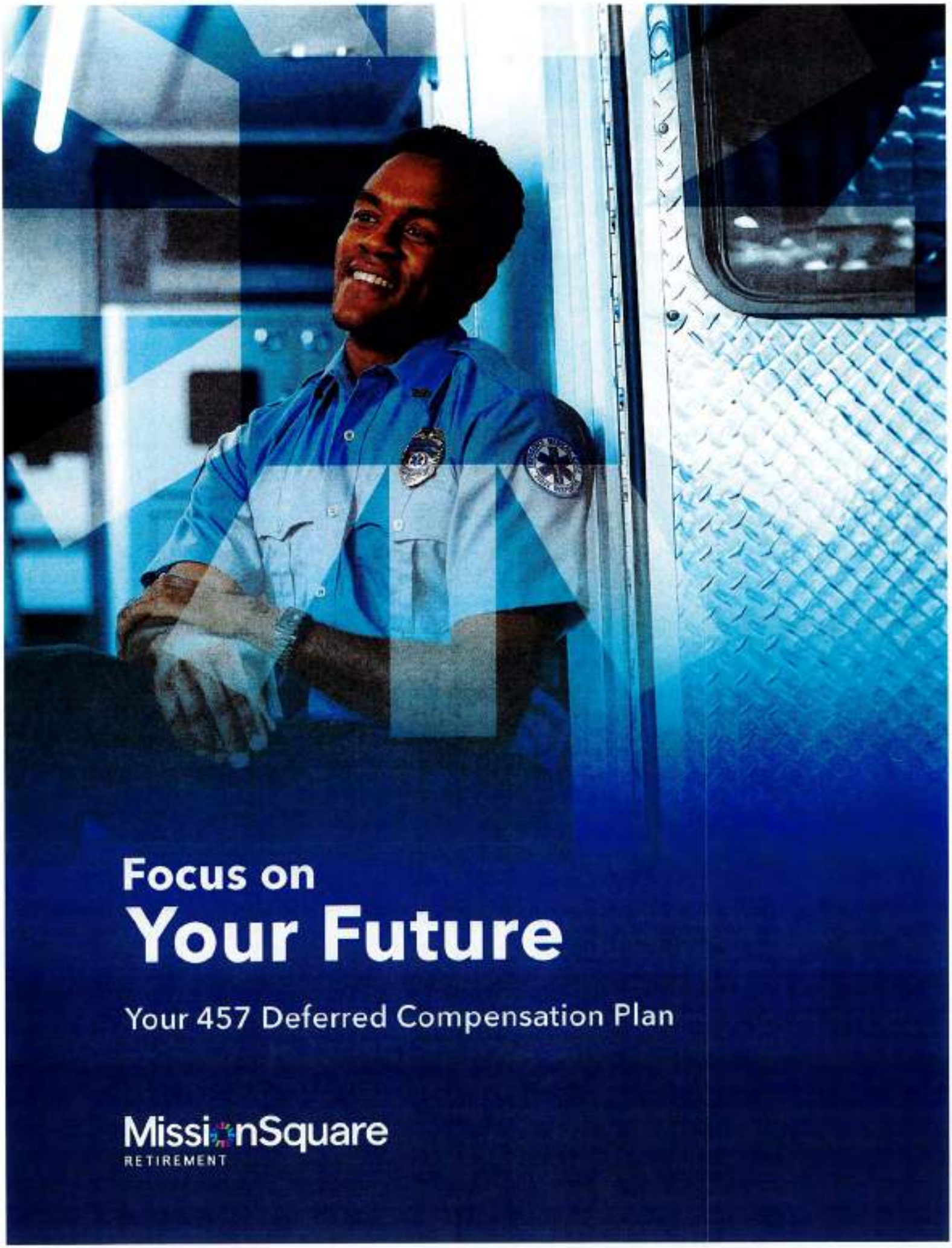
CareerSource BROWARD

2026 BENEFIT PLAN RATES: EMPLOYEE BI-WEEKLY RATES

DENTAL INSURANCE (Rates remain the same as 2025)		
TIER	HUMANA/COMPBENEFITS (DHMO)	UNITEDHEALTHCARE (PPO)
Employee	$5.42	$16.46
Emp+Spouse/DP	$9.74	$32.67
Emp+Child	$10.84	$38.32
Emp+Family	$13.00	$54.53

VISION INSURANCE (Rates down 5%)	
TIER	HUMANA
Employee	$3.90
Emp+Spouse/DP	$7.84
Emp+Child	$7.41
Emp+Family	$11.66

HEALTH INSURANCE UNITED HEALTHCARE – Biweekly Rates	
TIER OF COVERAGE	CDH HIGH OPTION
Employee	0
Emp+Spouse/DP	$104.91
Emp+Child/ren	$44.16
Employee + Child/ren + 26	$64.15
Emp+Family	$307.75
Employee + Family +26	$327.75



Focus on Your Future

Your 457 Deferred Compensation Plan

MissionSquare RETIREMENT

Maximize
Your Benefit

Retirement is one of the biggest financial decisions you'll face in your lifetime.

Your 457 Deferred Compensation Plan, a benefit offered by your employer and managed by MissionSquare Retirement, gives you control over when and how much you save, how to invest those savings, and how to withdraw funds in retirement.

While it may seem far into the future, retirement and planning for it should be balanced with everything else, including your current finances, career stage, and life situation.

Why start planning for retirement?

Planning for retirement means learning about and choosing financial strategies that can allow you to be comfortable and secure in your later years. Your 457 plan can help you:

Enjoy tax benefits and greater savings returns.

Plan for the lifestyle you want.

Support your family.

Protect your financial independence.

Prepare for future health care costs.

Enjoy retirement with peace of mind.

Why
Saving Now Matters

How Much Will You Need?

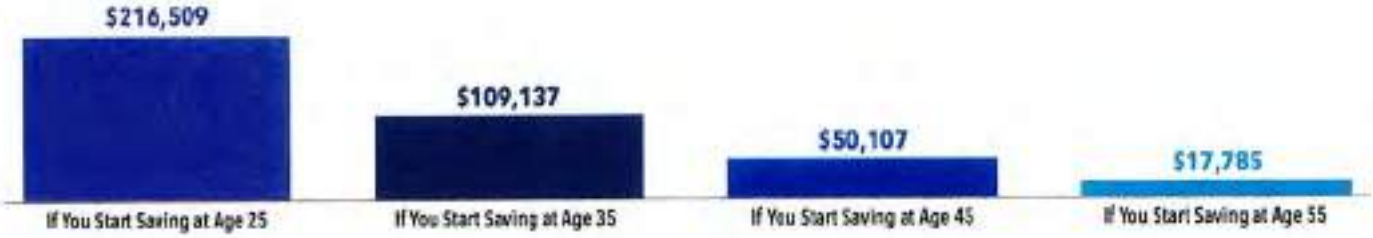
Many people think they'll rely on their pension or Social Security to cover their expenses in retirement, but both are designed to replace only a portion of your salary. Financial professionals estimate you'll need to replace about 80% of your pre-retirement income, but your needs may be higher.

Starting now, saving consistently, and investing wisely in your 457 plan can contribute significantly to your retirement security and independence. The earlier you start saving, the more time your money has to grow.

Compare Projected Annual Retirement Income and Expenses

Account Balance at Age 65

After Contributing $50 Biweekly to Your 457(b)



Small Increases Can Go a Long Way Over Time

Investing regularly and increasing your contributions annually can help magnify your savings while reducing your taxable income each year while you're working. And because your contributions are pre-tax, you won't miss as much out of your paychecks as you might think. A pre-tax contribution of $25 is only $18.75 out of your check.

Contribution to Plan	Paycheck Deduction	Accumulation 10 Years	Accumulation 20 Years	Accumulation 30 Years
$25	$18.75	$8,832	$24,649	$52,974
$50	$37.50	$17,664	$49,297	$105,948
$75	$56.25	$26,496	$73,946	$158,921
$100	$75.00	$35,328	$98,594	$211,895
$200	$150.00	$70,655	$197,189	$423,790

Use this calculator to see how saving early can help you secure your future:

https://www.missionsq.org/ret/cost-of-delay.html

For illustrative purposes only. The above tables and charts are hypothetical examples and are not intended to reflect actual performance of any investments. Actual returns may be higher or lower.

Get To Know Your

457 Deferred Compensation Plan

A smart addition to any pension or Social Security benefits you may receive, your 457 Deferred Compensation Plan offers simple and flexible ways to increase your retirement savings.

Use the plan resource site to enroll today:

https://services.msqretirement.org/plansearch

Watch a short video to learn more about your 457 plan:

https://www.missionsq.org/roc/whos-in-charge-of-your-retirement.html

Easy to Contribute

- Contributions are made through payroll deduction.
- You can change, increase, or stop your contributions at any time.

Tax Benefits While You Save

- Pretax contributions lower your taxable income while your earnings grow.
- Delay all taxes until you take money out.

Investment Control

- Create your own mix of investments from a range of options.
- Consider a diversified fund.

Simplify Your Accounts

- Roll in retirement accounts from former employers to see all your retirement savings information in one place.*
- Start your roll-in by visiting missionsq.org/simplify.

Flexible Withdrawal Options

- Only 457 plans have no early withdrawal penalty regardless of your age.**
- Determine which withdrawal strategy works best: Keep investing until a later date, withdraw when and as needed, or set up regular installment payments.

* Before moving money from one retirement account to another, consider your own circumstances. Key differences exist depending on the plan, the financial provider, and your personal situation.

** The penalty may apply to non-457 plan assets rolled into a 457 plan and subsequently withdrawn prior to age 59½.

Choose Your **Investing Approach**

You are always in control of how your assets are invested. Your plan includes a wide range of options from more conservative stable value funds to more aggressive bond and stock funds, including a self-directed brokerage option.

Keep It Simple

Select a simple, diversified, date-based fund geared toward your projected retirement date. This may be a good alternative if you're not comfortable managing your investments. Target-date funds are designed to become more conservative over time and to be withdrawn over a long retirement period, but they don't consider your risk tolerance.

Build Your Own

Build a diversified portfolio of individual funds available in your plan – a good route to take if you're an active investor who wants some control over your portfolio. This investment strategy holds a portfolio of funds, versus investing directly in individual stocks, bonds, or other investments.

Get Professional Management

Work with a MissionSquare Retirement Financial Consultant or through the intuitive, user-friendly Morningstar[1] online advice managed accounts[2] platform to help you reach your retirement goals. You'll receive recommendations on how much to save, when to retire, how to invest your assets, when to start taking Social Security benefits, and how to take withdrawals.

[1] Investment advice and analysis tools are offered to participants through MissionSquare Retirement, a federally registered investment adviser. Investment advice is the result of methodologies developed, maintained, and overseen by the Independent Financial Expert, Morningstar Investment Management LLC. Morningstar Investment Management LLC is a registered investment adviser and subsidiary of Morningstar, Inc. Morningstar, Inc. and Morningstar Investment Management LLC are not affiliated with MissionSquare Retirement. All rights reserved. The Morningstar name and logo are registered marks of Morningstar, Inc. For additional information on our Guided Pathways® Advisory Services, please refer to Form ADV Part 2A Brochure available at www.adviserinfo.sec.gov.

[2] Managed Accounts is a fee-based service and may not be offered through your employer's plan.

Digital Tools and **Personalized Services**

From one-on-one meetings to mobile capabilities, webinars, and our interactive Financial Wellness Center, we're with you at every step. Even after you retire, you'll enjoy the same personalized assistance and tools for managing your savings and supporting your financial well-being.

The Digital Connection

Plan Resource Site: Log in at any time to manage your account, schedule financial consultations, and access interactive tools and resources.

Financial Wellness Center: Learn from 100+ videos, charts, interactive calculators, articles, and tutorials on financial topics specific to you.

Am I On Track Calculator: Get a personalized retirement readiness score and retirement income gap analysis assessment as well as a proposed savings rate, retirement age, and investment mix.

Mobile Access: Use our eDelivery, Text Access, or Ask Alexa capabilities to get certain account information on your time. And manage your account from anywhere with our mobile app.

The Personal Touch

MissionSquare Retirement Plans Specialists: They can help you with establishing goals, reviewing investment options, creating savings strategies, rolling assets in from previous employers, and more.

Live Webinars: Presented by our CERTIFIED FINANCIAL PLANNER™ professionals, webinars feature topics like financial planning, investing, retirement income planning, IRA basics, and Social Security.

CERTIFIED FINANCIAL PLANNER™ Professionals: Work with a CFP® professional to discuss and develop your financial goals, create a financial plan for you and your family, and more.

MissionSquare Retirement

Focused on Your Future

Expertise.

Dedicated to the public service sector for over 50 years. Focused on government, health care, education, and not-for-profit sector employees, we have the unmatched expertise you need. Our Retirement Plans Specialists and other representatives are trained to serve your unique needs. From personalized financial strategies to investment planning for long-term goals, we can help you get there.

It's not just retirement planning, it's retirement planning for the public service sector.

Commitment.

From start to finish. Whether you're just getting started, already have a savings plan, or are close to retirement, we're committed to helping you and your family achieve financial wellness and save for the retirement you want and deserve. From helping you enroll to managing your money toward and in retirement, MissionSquare Retirement can help every step of the way.

With you to and through retirement.

Mission.

It's in our name. Unlike most of our competitors, MissionSquare Retirement is a nonprofit with no shareholders. We focus solely on our mission – helping build retirement security for public sector employees like you.

And it doesn't end there. We invest in you and the programs that benefit the communities you serve and live in. From partnering with public sector-focused organizations to supporting the surviving children of fallen public sector heroes through our MissionSquare Scholarship Fund, we're dedicated to helping those who serve their communities.

One mission – helping you and the communities you serve.

Visit your plan resource site to learn more about your plan and to get started!

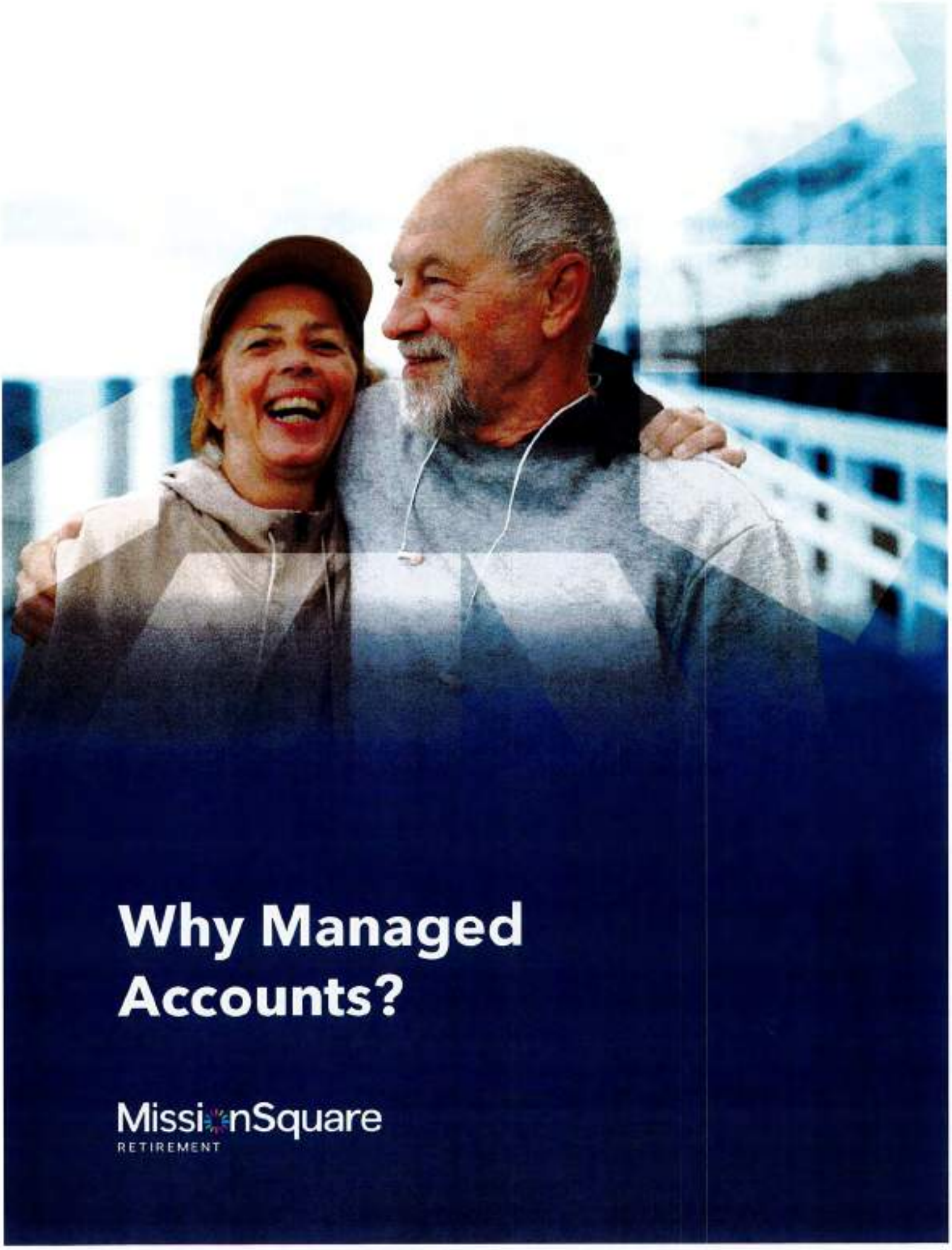
Retirement Plans Specialist:
https://services.msqretirement.org/plansearch

Founded in 1972, **MissionSquare Retirement** has helped more than 3 million people in public service retire well. MissionSquare is a mission-based, non-stock, nonprofit financial services company that focuses on delivering results-oriented retirement plans, education, investments, and advice for those working in the public sector.

For more information, visit www.missionsq.org.

MissionSquare
RETIREMENT

MissionSquare Retirement 7771 Calvin Hall Rd, Washington, DC 20002-4240
800.669.7400 **www.missionsq.org**



Why Managed Accounts?

MissionSquare
RETIREMENT

Why Managed Accounts?

Guided Pathways® Managed Accounts provides ongoing investment management for your MissionSquare Retirement accounts, personalized for you by an independent financial expert.

- How Much to Save
- How to Invest Those Savings
- When to Retire
- When to Start Receiving Social Security Benefits
- How to Turn Savings Into Income

Investments Managed for You Each Step of the Way

Schedule a Consultation With a MissionSquare Financial Consultant

Learn more about Managed Accounts, get a retirement plan and investment strategy, and determine if you're on track to reach your retirement goals.

It All Starts With Making Sure You Save Enough.

The sooner you know how much you need to save, the better. Managed Accounts provides you with a well-thought-out plan that includes a savings rate recommendation based on a detailed analysis of your complete financial situation based on the information you provide.

Know When You Can Retire.

Managed Accounts helps you prepare for one of the biggest financial decisions you'll ever make: "When can I retire?"

Learn When to Start Receiving Social Security Benefits.

Managed Accounts can help you make an informed decision on when to start receiving Social Security benefits.

Your Investments Are Managed for You.

You will benefit from ongoing professional investment management that provides a diversified portfolio with a level of risk customized for you and a disciplined investing strategy.

Turn Your Savings Into Income During Retirement.

Once you retire, then what? Managed Accounts provides recommendations for taking withdrawals from all your sources of retirement income to help ensure your money meets your needs and lasts.

Managed Accounts gives you a diversified investment portfolio, not market predictions that are usually a losing game.

Consider this chart, showing how different areas of the stock and bond markets have performed yearly since 2014. Since the markets are so unpredictable, diversification really matters! However, diversification does not ensure a profit or ensure protection against losses.

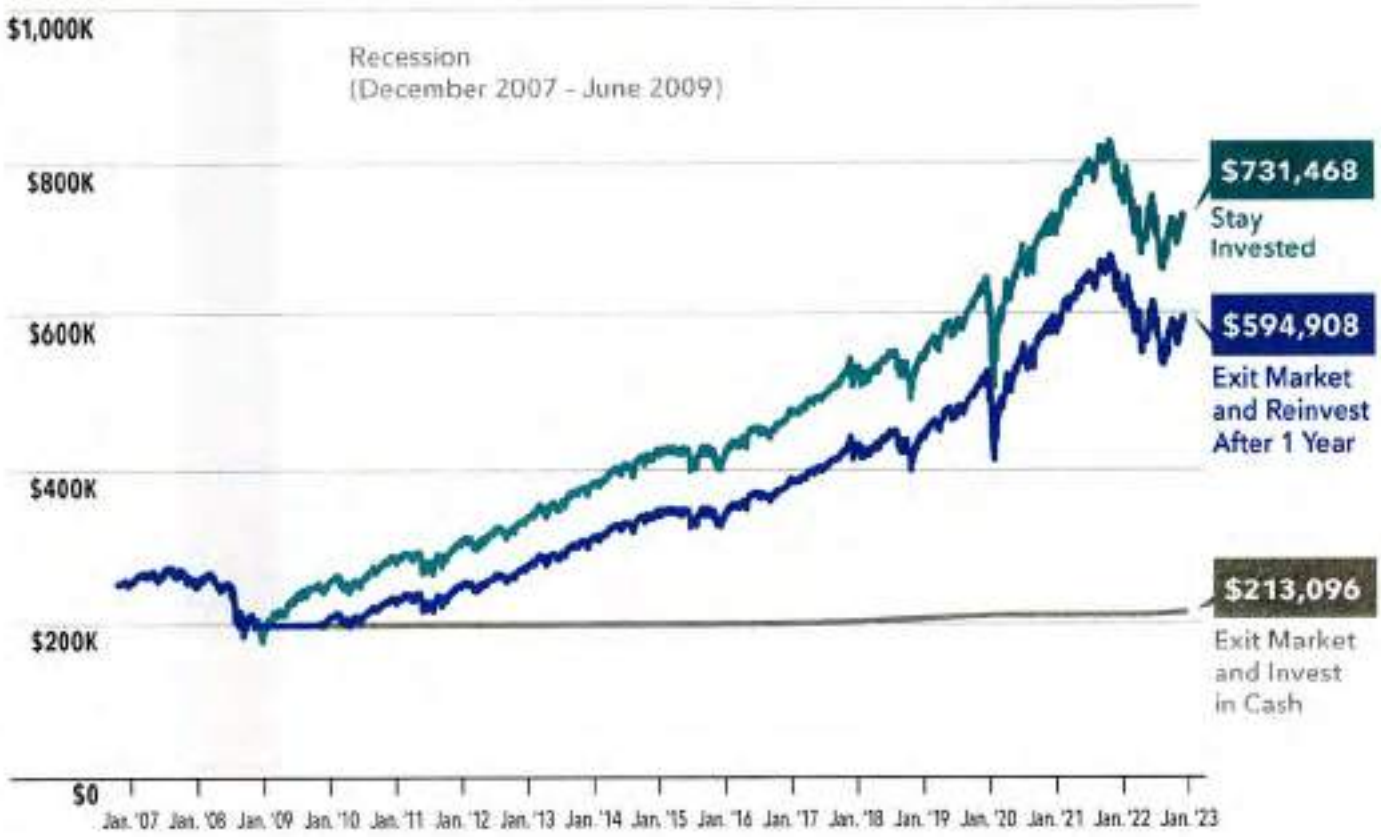
- **Large Growth** (large-cap growth U.S. stocks, represented by Russell 1000 Growth Index)
- **Large Value** (large-cap value U.S. stocks, represented by Russell 1000 Value Index)
- **Small Growth** (small-cap growth U.S. stocks, represented by Russell 2000 Growth Index)
- **Small Value** (small-cap value U.S. stocks, represented by Russell 2000 Value Index)
- **Developed International** (developed market stocks excluding U.S. and Canada, represented by MSCI EAFE Index (Net))
- **Bonds** (investment-grade U.S. fixed-income securities, represented by Bloomberg Barclays U.S. Aggregate Bond Index)
- **Balanced** (60% Russell 1000 Index and 40% Bloomberg Barclays U.S. Aggregate Bond Index)
- **Cash** (3-Month Treasury Bill)

Source: Morningstar Direct. Past performance, as shown, does not guarantee future returns. It is not possible to invest in an actual index.

Time in the market is more important than trying to time the market.

Managed Accounts gives you a disciplined investment strategy, so you stay invested when maintaining composure is most challenging. Think back to the 2008 financial crisis; those who stayed invested did much better than those who got out of the markets, including those who got back in soon after.

The Importance of Staying Invested: Ending Market Values After a Market Decline



Assumes investment in a balanced portfolio of 60% stocks (S&P 500) and 40% bonds (Bloomberg Barclays U.S. Aggregate) vs. cash as measured by 3-month Treasury bills. Past performance, as shown, is no guarantee of future results.

This illustration regarding compounding or the likelihood of various investment outcomes is hypothetical, does not reflect actual investment results, and does not guarantee future results. Results may vary with use and over time, reflecting any changed circumstances, assumptions, or variables upon which the information is based. Projections involve known and unknown risks, uncertainties, and other factors which may cause actual results to differ materially and substantially from any future results or performance expressed or implied by the projections for any reason. Projections do not guarantee that a particular result will be produced or achieved. The projections do not represent actual securities or client performance and cannot determine which securities to buy or sell or if your investment strategy is appropriate.

The advice you receive from Managed Accounts is personalized, low cost, and flexible!

Independent Financial Expert

The advice and investment management is provided by Morningstar Investment Management, LLC.,[1] an independent financial expert using a sophisticated investment methodology.

This helps ensure that:

- Your financial situation is analyzed based on hundreds of different economic and investment scenarios.
- The emotional biases that can impact investment decision-making are minimized.

What Does It Cost?

You pay an ongoing fee for your accounts to be managed and for the advice you receive. Compare our fees with similar services from others – we believe you'll find it's quite a value!

Your Account Balance	Annual Fee[2,3]
First $100,000	0.50%
Next $200,000	0.40%
Next $200,000	0.30%
Over $500,000	0.20%

What if I Want Out?

You can cancel your participation in Managed Accounts at any time – online, by phone, or through your local MissionSquare Retirement representative.

To cancel by phone, contact us at **(800) 669-7400**. You can ask questions about your enrollment via email at **GPASManagedAccounts@missionsq.org**.

[1] Investment advice and analysis tools are offered to participants through MissionSquare Retirement, a federally registered investment adviser. Investment advice is the result of methodologies developed, maintained, and overseen by the Independent Financial Expert, Morningstar Investment Management LLC. Morningstar Investment Management LLC is a registered investment adviser and subsidiary of Morningstar, Inc. Morningstar, Inc., and Morningstar Investment Management LLC are not affiliated with MissionSquare Retirement.

[2] Underlying fund expenses and plan administration fees still apply. Please consult the applicable disclosure materials for a description of these fees and expenses.

[3] Certain Managed Accounts clients will pay less than the annual fee reflected above.

Founded in 1972, **MissionSquare Retirement** is a mission-based, non-stock, nonprofit financial services company that focuses on delivering results-oriented retirement plans, education, investments, and advice for those working in the public sector.

For more information, visit **www.missionsq.org**.

MissionSquare
RETIREMENT

MissionSquare Retirement 777 N. Capitol Street, NE, Washington, DC 20002-4240
(800) 669-7400 **www.missionsq.org**

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CAREERSOURCE BROWARD Enrollment and Contribution Election Form

Use this form to establish your account and /or make contributions elections for your CAREERSOURCE BROWARD 457 Deferred Compensation Plan at MissionSquare Retirement.

I want to: ☐ Enroll / Start My Contributions ☐ Change My Contributions

PERSONAL INFORMATION

EMPLOYER PLAN NAME: CAREERSOURCE BROWARD 301196		
SOCIAL SECURITY NUMBER: FOR TAX REPORTING PURPOSES	DATE OF BIRTH: MM/DD/YYYY	GENDER: ☐ FEMALE ☐ MALE ☐ OTHER
FULL NAME: LAST, FIRST, MI		MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
MAILING ADDRESS: STREET / CITY / STATE / ZIP		
MOBILE PHONE NUMBER	EMAIL ADDRESS	DATE OF HIRE: MM/DD/YYYY

CONTRIBUTION AMOUNT

I authorize my employer to contribute the amount specified below from my pay each pay period. Your contributions will be maintained based upon the information entered in this form. Contributions will begin as soon as administratively feasible under your plan.

Pre-tax contributions of _____% **OR** $_____ from my pay each pay period.

Roth contributions of _____% **OR** $_____ from my pay each pay period.

Normal Contribution Limit (2026): 100% of compensation or $24,500, whichever is less

Consider Ways to Save More:

- Age 50 catch-up contributions (up to $8,000 more than the normal limit, $32,500 maximum)
- Age 60-63 "Super Catch-Up" (**if offered by your employer** up to $11,250 more than the normal limit. $35,750 maximum)
- 457 Pre-Retirement Catch-up –**SEE PRE-RETIREMENT CONTRIBUTION CATCH-UP FORM**

SIGNATURE

By submitting this form, you understand you are authorizing your plan sponsor to enroll you and/or update your contributions in CAREERSOURCE BROWARD 457 Deferred Compensation Plan Plan at MissionSquare Retirement.

Note that upon enrollment your entire account is invested in the Plan's default investment selection until you select your investment allocations. To see information on the default fund for CAREERSOURCE BROWARD 457 Deferred Compensation Plan 301196 as well as performance and fees of available investment options go to www.missionsq.org/enroll

Employee Signature: _____ Date: _____

SUBMIT THE COMPLETED FORM TO YOUR EMPLOYER. RETAIN A COPY FOR YOUR RECORDS

MissionSquare
RETIREMENT

2026 Roth Catch-Up Contributions Rule:
What You Need To Know

Are you over age 50 and earning more than $145,000 per year? Get up to speed on what the new Roth catch-up rule may mean for you.

Starting in 2026, if you earned over $145,000 in the prior year, your age 50 or age 60 to 63 catch-up contributions to your employer-sponsored retirement plan must be Roth contributions, which are made with after-tax dollars.

What are the benefits of making Roth contributions to your employer-sponsored retirement plan?

- **Tax-Free Withdrawals:** Roth assets can be withdrawn tax-free in retirement if at least five years have passed since Jan. 1 of the year of your first Roth contribution and you are at least 59 1/2 years old.
- **Higher Contribution Limits Than Roth IRAs:** You can save more after-tax dollars than you can with Roth IRAs.
- **Eligibility at All Income Levels:** Unlike with Roth IRAs, your ability to make Roth contributions to a 457(b) or 401(k) plan does not depend on your income.
- **Tax Planning Flexibility:** Having both pre-tax and Roth assets available as sources of retirement income creates additional flexibility when managing tax liabilities during retirement.

Does everyone need to make Roth contributions?

No. The following groups of employees are eligible, but not required, to make Roth contributions to an employer-sponsored 457(b) or 401(k) plan:

- Employees under age 50.
- Employees over age 50 with annual income under the $145,000 threshold (Social Security wages shown in Box 3 on your W-2).
- Employees who do not contribute to Social Security.
- Employees who do not contribute above the normal contribution limit in effect for the – for example, $23,500 in 2025.

Did You Know?

You can start making Roth contributions to your employer-sponsored 457(b) or 401(k) plan at any time, regardless of your age or income. Log in to your account to review your retirement plan options and get started at **www.missionsq.org/login**.

MissionSquare
RETIREMENT

Did you know your employer plan allows for a higher catch-up limit if you are age 60, 61, 62, or 63?

We understand that saving for retirement is an important goal and you would like to save a bit more than you could in years past. Beginning in 2025, if you are age 60, 61, 62 or 63, you can choose to save more!

Discover the Benefit

Your plan now allows those between the ages of 60 and 63 to save more than the age-50 catch-up limit:

- The higher limit is $11,250 for 2025.
- This limit applies for each year you are 60, 61, 62, and 63.
- For the year you turn 64, the limit will revert back to the age-50 catch-up limit – which is $7,500 for 2025.

The higher catch-up limit of $11,250 is **instead** of the normal catch-up limit of $7,500, **not in addition to it**. The higher catch-up limit is indexed and may change each year.

For more information, contact MissionSquare Plan Services at (800) 669-7400.

Career Source Broward

G000C8VY

Benefit Information Prepared For

All Eligible Employees

Mutual of Omaha

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Career Source Broward, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1 times your annual salary, but in no event less than $10,000 or more than $250,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $200,000.

Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Childcare - Child Education - Seat Belt - Airbag - Common Carrier - Paralysis - Coma
Portability	Allows you to continue this insurance program should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.
AGE REDUCTIONS AND EXCLUSIONS	
Insurance benefits and guarantee issue amounts are subject to age reductions: - At age 65, amounts reduce to 65% - At age 70, amounts reduce to 40% - At age 75, amounts reduce to 25% Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling. Please contact your employer if you have questions prior to enrolling.	

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 40%
  - At age 75, amounts reduce to 25%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Mutual of Omaha

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United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Career Source Broward, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES	Minimum	Guarantee Issue	Maximum
For You	$10,000	$100,000	$400,000, in increments of $10,000
Spouse	$5,000	100% of employee's benefit, up to $10,000	100% of employee's benefit, in increments of $5,000, up to $200,000
Child(ren)	$10,000	100% of employee's benefit	100% of employee's benefit, in increments of $10,000, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent child(ren). Child(ren) include those up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principal Sum.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $320,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to increase your coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag - Coma - Common Carrier - Paralysis
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:
- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 40%
- At age 75, amounts reduce to 25%

Spouse coverage terminates when you reach age 70.
Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.
Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.
Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life and AD&D Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 34	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00
35 - 39	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
40 - 44	$1.70	$3.40	$5.10	$6.80	$8.50	$10.20	$11.90	$13.60	$15.30	$17.00
45 - 49	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$25.00
50 - 54	$3.70	$7.40	$11.10	$14.80	$18.50	$22.20	$25.90	$29.60	$33.30	$37.00
55 - 59	$5.90	$11.80	$17.70	$23.60	$29.50	$35.40	$41.30	$47.20	$53.10	$59.00
60 - 64	$9.10	$18.20	$27.30	$36.40	$45.50	$54.60	$63.70	$72.80	$81.90	$91.00
65+	$15.20	$30.40	$45.60	$60.80	$76.00	$91.20	$106.40	$121.60	$136.80	$152.00

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 34	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50
35 - 39	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
40 - 44	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
45 - 49	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00	$11.25	$12.50
50 - 54	$1.85	$3.70	$5.55	$7.40	$9.25	$11.10	$12.95	$14.80	$16.65	$18.50
55 - 59	$2.95	$5.90	$8.85	$11.80	$14.75	$17.70	$20.65	$23.60	$26.55	$29.50
60 - 64	$4.55	$9.10	$13.65	$18.20	$22.75	$27.30	$31.85	$36.40	$40.95	$45.50
65 - 69	$7.60	$15.20	$22.80	$30.40	$38.00	$45.60	$53.20	$60.80	$68.40	$76.00

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*
$10,000
$1.80

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 40%
  - At age 75, amounts reduce to 25%
- Spouse coverage terminates when you reach age 70.
- Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Short-Term Disability Insurance

How Would You Pay Your Bills if You Were Sick or Injured Temporarily?

Even a short illness or injury could seriously impact your paycheck. Sick time will get you by while it lasts, but what happens when your sick days run out? A short-term disability policy provides you with cash benefits when you need it.

We've Got You Covered

As an active employee of Career Source Broward, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A disability income insurance policy can help provide security when you need it, plus give you peace of mind so you can recover faster and get back on the job sooner.

Coverage guidelines and benefits are outlined below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by you.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources. The premium for your short-term disability coverage is waived while you are receiving benefits.
Maximum Benefit Period	Up to 9 weeks
Maximum Weekly Benefit	$1,250
Minimum Weekly Benefit	$10

Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Voluntary Vocational Rehabilitation Benefit	If you become disabled and choose to participate in the vocational rehabilitation program, you will be eligible for a weekly benefit increase of 10%.
Portability	The portability feature allows you to apply for disability insurance through a trust policy should your employment end, without having to provide evidence of insurability. You will be responsible for paying the premium for coverage.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

VOLUNTARY SHORT-TERM DISABILITY PREMIUM CALCULATION

Use the premium factor in the table provided below to calculate your premium for voluntary short-term disability coverage in the worksheet below, using the example as a guide.

MONTHLY PREMIUM CALCULATION		EXAMPLE *(42-year-old employee earning $40,000 a year)*
List your weekly earnings (Maximum is $2,083.33)	$_____	$ 769.23
Multiply by the premium factor	0.0168000	0.0168000
Your Estimated Monthly Premium**	$_____	$ 12.92

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

›Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.

Benefits are not payable for any disability or loss that:

- Results from an act of declared or undeclared war or armed aggression
- Results from participation in a riot or commission of or attempt to commit a felony
- Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
- Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
- Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, or attempted suicide
- Occurs while incarcerated or imprisoned for any period exceeding 31 days
- Is solely a result of a failed drug test
- Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you have the right to port your coverage to a group trust plan, subject to certain conditions.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability income insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number G2018MP.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of Career Source Broward, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 60 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.

Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per month during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Voluntary Vocational Rehabilitation Benefit	If you become disabled and choose to participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

› Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months per occurrence.
- Disabilities related to mental disorders are only payable for up to 24 months per occurrence.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

Benefits are not payable for any disability or loss that:

- Results from an act of declared or undeclared war or armed aggression
- Results from participation in a riot or commission of or attempt to commit a felony
- Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
- Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, or attempted suicide
- Results from alcohol and drug abuse and/or substance abuse, except as noted above
- Results from a mental disorder, except as noted above
- Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
- Occurs while incarcerated or imprisoned for any period exceeding 31 days
- Is solely a result of a failed drug test
- Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

EMPLOYEE ASSISTANCE PROGRAM

Available Services When You Need Help the Most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Sessions per year (per household) conducted by face-to-face* counseling or telehealth (text, chat, phone, or video) via a secure, HIPAA compliant portal

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers for face-to-face counseling • National network of more than 30,000 licensed clinical providers for telehealth counseling • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources — legal libraries, tools and forms — available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

MUTUAL SOLUTIONS

WILL PREPARATION SERVICES

Services provided by Epoq, Inc.

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Living Will and Trust
- Power of Attorney
- Healthcare Directive
- Pour-Over Will
- Last Will and Testament

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions from any device and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requiremens

Create your will at **www.willprepservices.com**
and use the code **MUTUALWILLS** to register

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

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MUTUAL SOLUTIONS

WORLDWIDE TRAVEL ASSISTANCE THAT TRAVELS WITH YOU

Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip

We'll Be There If You Need Us — 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations
- Translation and Interpreter Services for emergency situations while traveling internationally

Emergency Travel Support Services

- **Telephonic translation and interpreter services —** 24/7 access to telephone translation services
- **Locating legal services —** referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- **Baggage —** assistance with lost, stolen or delayed baggage while traveling on a common carrier
- **Emergency payment and cash —** assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- **Emergency messages —** assistance with recording and retrieving messages between you, your family and/or business associates at any time
- **Document replacement —** coordination of credit card, airline ticket or other documentation replacement
- **Vehicle return —** if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

Mutual of Omaha

613210 *Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100 mile travel radius

Worldwide Travel Assistance

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

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- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

Identity Theft

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

Education and Prevention

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

Recovery Information

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

Assistance

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance Plan Limitations

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Carry this card with you when you travel

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Employee Assistance Program

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We are here for you

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mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

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Continued on back.

Mutual of Omaha

Enhanced EAP Services *(continued)*

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	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members, including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Mutual Solutions

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Services provided by AXA Assistance USA.

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Mutual Solutions

Will Preparation Services

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and use the code MUTUALWILLS
to register

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Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

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Easy, Free and Secure

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- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Group Name: Career Source Broward
Group ID: NEW1 *Temporary Until Group ID Is Issued*

› We Make Evidence of Insurability Easy

Evidence of Insurability is simply a statement that proves a person is healthy enough to insure. This application process allows you to provide information about you and/or your dependents' health history in order to be considered for coverage.

EVIDENCE OF INSURABILITY (EOI) IS REQUIRED WHEN:

- You request a coverage amount greater than the guaranteed issue (an amount that is guaranteed to be issued to applicants regardless of their health status)
- Coverage is requested outside of your initial benefit enrollment period

To aid us in making a decision of whether to cover the person and/or their dependents, the EOI review may include:

- Questions or details about health conditions provided on the application
- Statement from your physician
- Medical examination

Our medical exams, which include a blood draw and urine sample, must be conducted by our highly reputable mobile medical contractor, American Para Professional Systems (APPS), and can be done in the comfort of your own home or business and are scheduled at your convenience.

All medical information is private and confidential, and is used for underwriting purposes only.

HOW TO SUBMIT AN ELECTRONIC APPLICATION (eApp)

Simply visit mutualofomaha.com/eoi to fill out an eApp. The eApp is a short questionnaire that collects the applicant's medical history. The following information will be needed:

- Group ID Number
- Hire Date
- Current Salary
- Current Coverage Amounts
- Guaranteed Issue Amounts

Once your application is submitted, you will receive an email regarding next steps.

Employer Access

Guide to Submitting Member Enrollment Requests

Managing employee benefits can be time consuming. But Mutual of Omaha offers quick, convenient options that simplify plan administration.

Secure Online Plan Administration

Spend less time on paperwork and expedite transactions with our secure online portal. Through Employer Access, you can quickly and easily enroll, update or terminate employee coverage from a single screen.

Once you log in to the secure portal:

- Click on the "Members" tab and search for the member's name
- Access functions such as updating eligible employee roster, sending Evidence of Insurability (EOI), and editing or terminating employees
- Click the green "New Enrollment" button to add new employees

Employees who were terminated and rehired need to be added to the roster via a request to our service team.

Questions or Need Assistance?

Contact your Dedicated Service Team.

Not registered to use our portal?

If you are not a registered user of Employer Access, go to **mutualofomaha.com.**

1) Click on **Sign In**

2) Select **Plan Administrator**

3) Click the **Sign Up Button** *(bottom of the screen)*

See the next page for more convenient enrollment options!

Mutual of Omaha

Options When Using Paper Enrollment

Enrollment Form

If you prefer using the paper enrollment process, each employee must complete and sign an enrollment form.

Enrollment forms must be filled out completely to avoid delays in processing; required fields are marked with an asterisk (*). Return completed forms to your Dedicated Service Team.

Note: A new hire enrollment form was included in your welcome email.

Excel Spreadsheet

If you prefer to capture new employee information in a spreadsheet format, Mutual of Omaha will accept an Excel file. To expedite your request, please include the information listed here.

Type of Change Requested (Hires, Qualifying Life Event, etc.)

Effective Date of Change

- Member's First and Last Name
- Date of Birth (Employee and Spouse)
- Date of Hire or Rehire
- Signature Date (Contributory/Voluntary)
- SSN (optional but strongly preferred for Dental/Vison)
- Salary: Annual or Hourly
- Hours Worked per Week
- Coverage Elections by Product
- Tobacco Status, if Applicable
- Class (if more than one class)
- Bill Group (if receiving separate bills)
- Location Code (if receiving one bill and employees are itemized by location/department)
- Termination Date (last date worked)

Dental & Vision Benefits Require:

- Address
- Dependents: First and Last Name, Date of Birth & Gender

Important | *We must receive all required information before completing the enrollment process.*

Mutual of Omaha

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Career Source Broward		Effective Date:	Group ID: G000C8VY
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:		MI:
* SSN/ID Number:	* Birth Date (MM/DD/YYYY):	* Gender:	*Marital Status:
*Street Address:		E-mail Address:	
*City:	*State:	*Zip Code:	Telephone: ( ) -

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Monthly Premium Amount (12/Year)
Voluntary Life and AD&D - Employee	☐ $20,000 ☐ $50,000 ☐ $70,000 ☐ $100,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Spouse	☐ $5,000 ☐ $10,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child) ☐ Other $_____ ☐ Decline	$1.80 (all children) $_____

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $10,000. In no event shall your amount of insurance exceed 5 times your salary.

- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Voluntary Short-Term Disability	☐	☐	_____ per Week	$_____

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)

Long-Term Disability	☒	☐	_____ per Month	Paid by Employer

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

Florida Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

A Guide for Successfully Completing the Group Insurance Evidence of Insurability Form

United of Omaha Life Insurance Company (United of Omaha) appreciates the opportunity to provide you with valuable insurance protection for yourself and/or your loved ones. So that we can effectively determine if you qualify for group insurance (whether you are seeking new coverage or additional coverage), we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

Please Note: The evidence of insurability form should only be completed if these coverages are provided by your employer through United of Omaha.

Submission Options

- An electronic version can be completed online at *www.mutualofomaha.com/eoi*
- Complete the attached form and mail it to United of Omaha Life Insurance Company.

Important Tips for Paper Copy Submission

- All sections of the form are to be completed by the employee. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting to United of Omaha.

Guidelines for Section 1: Policyholder/Employer Information

The Group ID Number for your employer will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.

Guidelines for Section 2: Employee/Member Contact & Employment Information

Employment information is for your current employer (identified in Section 1) and your current job.

Guidelines for Section 3: Applicant (Proposed Insured) Information

In this section, you only provide information for those applying for coverage, whether yourself (the employee), your eligible dependents, or a combination thereof. (For example, if you are only applying for insurance for yourself and your spouse, you would not provide information for any children.)

Be sure to provide weight in pounds, and height in feet and inches, for all applicants.

Guidelines for Section 4: Requested Insurance

Indicate the type(s) of insurance you are applying for, whether life, short-term disability or long-term disability.

The evidence of insurability form should only be completed if the coverages are provided by your employer through United of Omaha.

Guidelines for Section 5: Requested Life Insurance Benefit Amount

Helpful Hints for (1) Current Amount of Insurance

- If you recently enrolled for life insurance and are applying for coverage in excess of the Guarantee Issue amount, the Guarantee Issue amount is the current amount you should provide.
- If you have had life insurance for some time, and are applying to increase the amount of coverage you have, provide the current amount of coverage you have. Please contact your employer/benefits administrator to confirm current amount(s) if you are uncertain.
- If you (or a dependent) do not currently have coverage, enter 0 (zero).

Helpful Hints for (2) Additional Requested Amount

- This amount is the difference between any current amount you have and the total amount of insurance you would like to have.
- The total amount of insurance available is subject to plan maximums. Consult your employer for additional plan specific information, if needed.

For (3) Total Amount of Insurance Requested, indicate the total amount of life insurance you would like to have.

Guidelines for Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance

- The health information provided in this section is used to underwrite your application for insurance.
- Be sure to answer all questions as honestly and accurately as possible, and provide additional information where indicated.
- For Degree of Recovery, indicate the percent of function you have recovered. (100% indicates full recovery. Any lesser percentage would be a judgment of partial recovery.)
- If you are only applying for coverage for yourself, then answer these questions for yourself only. If you are applying for coverage for any dependents, then answer these questions for anyone included on the form.

Guidelines for Section 8: Authorization to Disclose Personal Information & Application for Insurance

Please read this section in its entirety. By signing, you are applying for insurance coverage with United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of underwriting your application.

For any applicant, if the name associated with any medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.

To be complete, the form must be signed by you, and must also be signed by your spouse if your spouse is applying for coverage.

United of Omaha Life Insurance Company

Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175

Mutual of Omaha

Group Insurance Evidence of Insurability Form

Please print clearly in blue or black ink. All required information should be completed to avoid any delays in the processing of this application. No amount of insurance for which evidence of insurability is required will be effective until approved by the underwriting company. When complete, to help ensure efficient processing and protect your information, mail the completed application to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
P.O. Box 2476
Omaha, NE 68103-2476
Fax: (402)351-2537

Section 1: Policyholder/Employer Information (Required fields are marked with an asterisk (*).)

Policyholder/Employer Name*	Group ID Number*	Subgroup Number (IF APPLICABLE)
CAREER SOURCE BROWARD	G000 C_8_V_Y	

Street Address*	City*	State*	Zip Code

Section 2: Employee/Member Contact & Employment Information (Required fields are marked with an asterisk (*).)

Last Name*	First Name*	MI

Street Address*	E-mail Address

City*	State*	Zip Code*	Telephone* (000)XXX-XXXX

Full-Time Employment Date (MM/DD/YYYY)*	Annual Salary*	Job Title/Description*	Avg. Hours Worked/Week

Section 3: Applicant (Proposed Insured) Information (Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee/Member is Applying for Insurance

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	SSN/ID Number
		☐F ☐M	Lbs.	Ft. In.	

Part B – Complete if Applying for Spouse Insurance (for Life Insurance only)

Last Name*	First Name*	MI

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	SSN/ID Number
		☐F ☐M	Lbs.	Ft. In.	

Note: Use of the term "spouse" on this application refers to the person to whom you are legally married; or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live.

Part C– Complete if Applying for Child(ren) Insurance (for Life Insurance only)

Last Name*	First Name*	Gender*	Birth Date (MM/DD/YYYY)*	Weight	Height
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.
		☐F ☐M		Lbs.	Ft. In.

Note: If you apply for one child, you must apply for all eligible children. Attach a list of additional children with the above information if necessary.

Section 4: Requested Insurance

Select each insurance product for which you are applying:

☐ Life ☐ Short-Term Disability (STD) ☐ Long-Term Disability (LTD)

Section 5: Requested Life Insurance Benefit Amount (Required fields are marked with an asterisk (*).)

	Employee/Member (IF APPLICABLE)	Spouse (IF APPLICABLE)	Child(ren) (IF APPLICABLE)
(1) Current Amount of Insurance (IFANY)			
(2) Additional Requested Amount			
(3) Total Amount of Insurance Requested* (1+2)			

Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance (A response is required for each question for each applicant.)

Part A

1 – To the best of the applicant's knowledge, during the past 5 years, has any person proposed for insurance ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following (Check all that apply):

Condition	Member	Spouse	Condition	Member	Spouse
Urinary tract or kidney?	☐	☐	Lung or respiratory disorder?	☐	☐
Liver or hepatitis?	☐	☐	Chronic fatigue syndrome?	☐	☐
Anemia or blood (except HIV)?	☐	☐	Arthritis or joints (incl. replacements)?	☐	☐
Skin or connective tissue?	☐	☐	Epilepsy or any nervous, mental or emotional disorder?	☐	☐
Chronic Epstein-Barr?	☐	☐	Breasts or reproductive organs (incl. implants, infertility, irregular cycles, pregnancy complications)?	☐	☐
Cancer or tumor?	☐	☐	Neurological condition (incl. Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)?	☐	☐
Alcohol or drug abuse?	☐	☐	Any disease of the immune system (except HIV)?	☐	☐
Spine, neck or back?	☐	☐	Stroke or cerebral vascular condition?	☐	☐
Fibromyalgia or myalgia?	☐	☐	Diabetes or glandular condition?	☐	☐
High blood pressure, arteries or veins?	☐	☐	Stomach, upper or lower digestive tract?	☐	☐
Coronary arteries of the heart?	☐	☐			

	Member	Spouse
2 – To the best of the applicant's knowledge, during the past 5 years, has any person proposed for insurance ever been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition, derived from such infection? **Notice for Residents of CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. **Notice for Residents of MN:** The applicant(s) do not have to disclose an HIV (AIDS Virus) test or test to determine a blood-borne pathogen which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility; or (3) to emergency medical service personnel who were tested as a result of performing emergency medical services.	☐ Yes ☐ No	☐ Yes ☐ No
3 – To the best of the applicant's knowledge, during the past 5 years, **other than for questions 1 and 2**, has any person proposed for insurance: • Been diagnosed or treated by a medical professional? • Had surgery or been hospitalized? • Had a medical or diagnostic examination or evaluation? • Had or been advised to seek treatment for any illness, injury or disorder (except HIV)? • Received medical care?	☐ Yes ☐ No	☐ Yes ☐ No
4 – To the best of the applicant's knowledge, has any person proposed for insurance been absent from work for more than 5 consecutive working days because of illness or injury during the past five years?	☐ Yes ☐ No	☐ Yes ☐ No
5 – To the best of the applicant's knowledge, within the past 6 months, has any person proposed for insurance been prescribed medication by a medical professional or taken any medication requiring a prescription?	☐ Yes ☐ No	☐ Yes ☐ No
6 – To the best of the applicant's knowledge, during the past 5 years, has any person proposed for insurance regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	☐ Yes ☐ No	☐ Yes ☐ No
7 – If female, have you been diagnosed or treated by a medical professional for pregnancy? If Yes, please provide anticipated delivery date (MM/DD/YYYY): _____	☐ Yes ☐ No	NA

Part B – For any questions (except question 5) in Part A, **except for questions about HIV/AIDS/ARC**, answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format. Attach a separate signed and dated sheet containing additional information if necessary.

Ques. #	Name of Applicant	Date of Occurrence	Date of Recovery	Current Status/ Degree of Recovery	Diagnosis/Condition/Treatment/ Medication/Exam Results	Attending Physician's Name, Address & Phone

Part C – If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable. Attach a separate signed and dated sheet containing additional information if necessary.

Name of Applicant	Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

Section 7: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. If you are a resident of one of these states, please refer to the attached list for the specific fraud warning for your place of residence.)

Section 8: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 8

- **Medical Persons and Entities** means all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of health care services.
- **MIB Group, Inc. (MIB)** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means all health information such as medical history, prescription drug records, mental and physical condition, and drug and alcohol use, and other information such as finances, occupation, general reputation, insurance claims, motor vehicle reports and criminal activity. Personal information does not include psychotherapy notes.
- **Specified Companies** means the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become a part of this group of companies (and their successors), and other persons and/or entities which act on behalf of these companies to provide services to them.

Part B – Authorization to Disclose Information

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to United of Omaha Life Insurance Company. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim. For residents of California and Vermont, this authorization excludes the release of any information relating to any previous tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by any person or entity that may possess such information.

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of federal privacy regulations. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by underwriting company.

Name(s) used for medical records for any proposed insured (if different than the name(s) provided on this form):

_____

Part C – Authorization to Receive and Disclose Information to the MIB

I authorize the MIB to disclose Personal Information for me (the undersigned) to the Specified Companies. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize the Specified Companies to disclose Personal Information for me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom any person proposed for insurance applies for life or health insurance or to whom any proposed insured may submit a claim for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by United of Omaha Life Insurance Company.

Part D – Application for Insurance

I apply for insurance for the proposed insured(s) identified in Section 3 of this application who is/are eligible for insurance. Information in this form is given to obtain the insurance requested and is true and complete, and no important circumstance or information has been withheld or omitted, to the best of my knowledge and belief. I understand that all statements contained in this application for insurance are deemed representations and not warranties.

I understand that insurance for new or additional amounts of insurance in excess of any guarantee issue amount for any proposed insured does not begin until United of Omaha Life Insurance Company approves such person for such amounts, the proposed insured(s) is/are eligible for the insurance under the terms of the policy, and the appropriate premium is paid. If applicable, I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance for any proposed insured.

I understand that this application is only valid for 90 days from my signature date below. I acknowledge that incomplete information on this application may delay processing. If the Specified Companies request additional medical information to complete processing of this application, I understand that any delay in my response may make it necessary for me to submit a new application. I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued to any proposed insured.

I will retain a copy of this application with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that: (a) I understand and agree to the terms of this application; (b) this form has been completed in accordance with the instructions provided; and (c) for residents of all states except California, I have read the applicable fraud warning for my state of residence.

SIGNATURE OF EMPLOYEE/MEMBER (REQUIRED) _____ **DATE** ____/____/_____

SIGNATURE OF SPOUSE (IF APPLYING FOR INSURANCE) _____ **DATE** _____

FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Fraud Warnings

United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

Mutual of Omaha Plaza • Omaha, NE 68175-0001
www.mutualofomaha.com/customer-service

Please review the specific fraud warning for your place of residence prior to signing the attached form or application.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Maine/Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts/Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

North Carolina/Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, Mutual of Omaha and its affiliated companies ("we") will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO – ATTN: GROUP UNDERWRITING INDIVIDUAL SELECTION; MUTUAL OF OMAHA; MUTUAL OF OMAHA PLAZA; OMAHA, NE 68175.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha and its affiliated companies, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Mutual of Omaha and its affiliated companies, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

Mutual of Omaha and its affiliated companies, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address – Attn: Group Underwriting Individual Selection; Mutual of Omaha; Mutual of Omaha Plaza; Omaha, NE 68175.

INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha and its affiliated companies ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation.

You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it.

We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

EMPLOYEE/MEMBER NAME* _____

Section 6 Addendum: Health Information for Life and/or Disability (STD or LTD) Insurance

Part B – For any questions in Part A answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format.

Ques. #	Name of Applicant	Date of Diagnosis	Date of Recovery	Current Status/ Condition	Diagnosis/Condition/Treatment/ Medication/Exam Results/Relationship	Attending Physician's Name, Address & Phone

Part C If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable.

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Career Source Broward Group ID: G000C8VY

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name: *First Name: MI:

*Social Security Number: *Birth Date (MM/DD/YYYY): *Gender: *Marital Status:

*Street Address: Email Address:

*City: *State: *ZIP Code: Telephone: ( )

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)

Percentage Total: 100%

Secondary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)

Percentage Total: 100%

Primary Beneficiary Designation-Voluntary Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation-Voluntary Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

Signature of Employee/Member _____ Date _____

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Services for All Life's Highs and Lows

All employees experience milestones where legal and financial guidance would be a huge relief, both in good times and bad.

U.S. LEGAL SERVICES

Family Defender®

3 New Coverages starting 1/1/2025

Civil Law
- Plaintiff or Defendant
- Small Claims
- Name Change
- Landlord/Tenant as Tenant

Consumer-Seller Protection
- Consumer Protection
- Personal Property Protection

Contingency Matters**
- Personal Injury
- Medical Malpractice

Criminal Law
- Misdemeanor Defense
- Felony Defense (Policyholder only)+
- Juvenile Defense
- Habeas Corpus

Document Preparation & Review
- Demand Letters
- Quit Claim Deeds
- Personal Affidavit
- Promissory Note
- Bill of Sale
- Personal Contract
- Lessee Agreement

Estate Planning
- Wills & Testamentary Trusts for Minors
- Codicils
- Powers of Attorney
- Living Will
- Revocable or Irrevocable Living Trust
- Estate Administration

Family Law (Contested*/Uncontested)
- Divorce/Annulments
- Spousal Support
- Paternity Action
- Child Support/Custody
- Post-Decree Enforcement
- Post-Decree Modification
- Equitable Distribution of Marital Assets

Family Law (Other)
- Pre/Postnuptial Agreements
- Domestic Adoption
- Domestic Violence

Financial Matters
- Debt Collection
- Garnishment Defense
- IRS Audit Protection
- IRS Collection Defense+
- Foreclosure
- Ch. 7 & 13 Bankruptcy

Immigration Matters
- Visa Extension
- Naturalization
- Deportation (Removal)

Real Estate Transactions
- Purchase/Sale of Primary and Secondary+ Residence including review/preparation of Purchase Agreement, Mortgage and Deed, & attorney attendance at closing
- Refinancing of Residence

Traffic Violations
- Moving Traffic Violations
- First Offense DUI
- License Revocation & Suspension

Other Legal Matters
- Guardianship or Conservatorship
- Elder Law for Parents
- Insurance Law
- Social Security, Veteran's Affairs & Medicare/Medicaid
- Standard Business Incorporation

33.3% Discounted Rate
- Pre-existing & Non-covered (except Excluded Matters)

**Contested: subject to 20-hour limitation.* ***First $2,000 exempt from fee.* *+New Coverage starting 1/1/2025*

Member Rates

Family Defender $16.75 per month

Coverage extends to the employee, employee's spouse/domestic partner, and unmarried eligible dependent children through the end of the calendar year [December 31st] in which they turn age 26.

For more information, call 800-356-LAWS or visit *www.uslegalservices.net/companies/broward-county*

Total Wellness Suite

U.S. LEGAL SERVICES

The comprehensive Wellness Suite integrates these services without extra charges to amplify the legal benefits offered by the Family Defender plan. Collectively, these services support members in attaining overall legal and financial well-being.

Legal Document Library & DIY Legal Forms — For All Employees

Continuous online access to an extensive, state-specific legal document resource library offering over 10,000 articles and documents across various legal subjects. These resources assist individuals and their families in preparing DIY legal documents, such as wills, powers of attorney, bills of sale, and more. Available to all employees, no enrollment required.

Financial Wellness Suite powered by Best Money Moves

Continuous access to a comprehensive financial wellness platform that provides customized solutions and insights into your specific financial circumstances. State-of-the-art algorithms track your financial well-being score over time and review personalized content, resources, and tools based on your unique interactions within the dashboard. Financial Education includes 1,000+ pieces of written/video content and webinars, interactive journeys, tools and calculators, and a budgeting module that helps you set savings goals.

Tax Coaching & Preparation powered by PATHWISE GROUP

As part of our financial wellness initiative, members can utilize telephone consultations to address tax-related concerns. Additionally, they can opt to have their personal income tax returns prepared by a Tax Professional at a reduced rate of $195, which includes acomplimentary review of the previous year's return.

Perks Program powered by BenefitHub

Enjoy perks, rewards, and discounts on 1,000s of brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health & Wellness
- Beauty & Spa
- Tickets
- Home Office

Identity Theft Restoration Program powered by IdentityForce

To assist our members in combating the financial and emotional toll of identity theft, we provide confidential, full-service restoration services conducted by Certified Fraud Examiners. These restoration services encompass:

- Creditor/Bureau Notification
- Preparation of All Legal Documents
- Fraud Alerts to Credit Bureaus
- Case File Maintenance
- Review of Credit Files
- Assistance by Certified Specialists

For more information, call 800-356-LAWS or visit

www.uslegalservices.net/companies/broward-county

Application

U.S. LEGAL SERVICES

Full Name _____ Date of Birth _____
Last First Middle

Spouse Name _____ Date of Birth _____
Last First Middle

Address _____
Street Address Apartment/Unit #

_____
City State Zip Code

Phone _____ Email _____
(*Required as this will be where policy and ID are delivered)

Social Security Number or Employee ID _____

Company Affiliation CareerSource Broward

I want to enroll:

☐ **Family Defender** $16.75 per month

☐ **Identity Defender** $9.95 per month

Disclaimer and Signature

I declare, under penalty of perjury, that the information provided in this application is true and correct to the best of my knowledge. I understand that legal services will be provided as outlined in the contract and that I will be responsible for any filing fees, court costs, etc. associated with any action. By submitting this application, I authorize for a monthly payment to be collected as indicated in this application or by any other method I change to in the future. I understand that the attorney-client relationship is confidential and such relationship is with my assigned attorney and not with U.S. Legal Services. By submitting this application, I understand that U.S. Legal Services will deliver electronically, via email, both the Plan Policy and Member ID Card. I understand that the Plan Policy will be made available at **www.uslegalservices.net.** I understand that I have the option to receive a hard copy of the Plan Policy and can do so by contacting U.S. Legal Services at **fulfillment@uslegalservices.net.** Electronic delivery may be limited in some states; in those circumstances, U.S. Legal Services will deliver the Plan Policy via U.S. Mail. Not sponsored or approved by the United States Government or any Department or Agency thereof.

Signature _____ Date _____

We Florida FINANCIAL

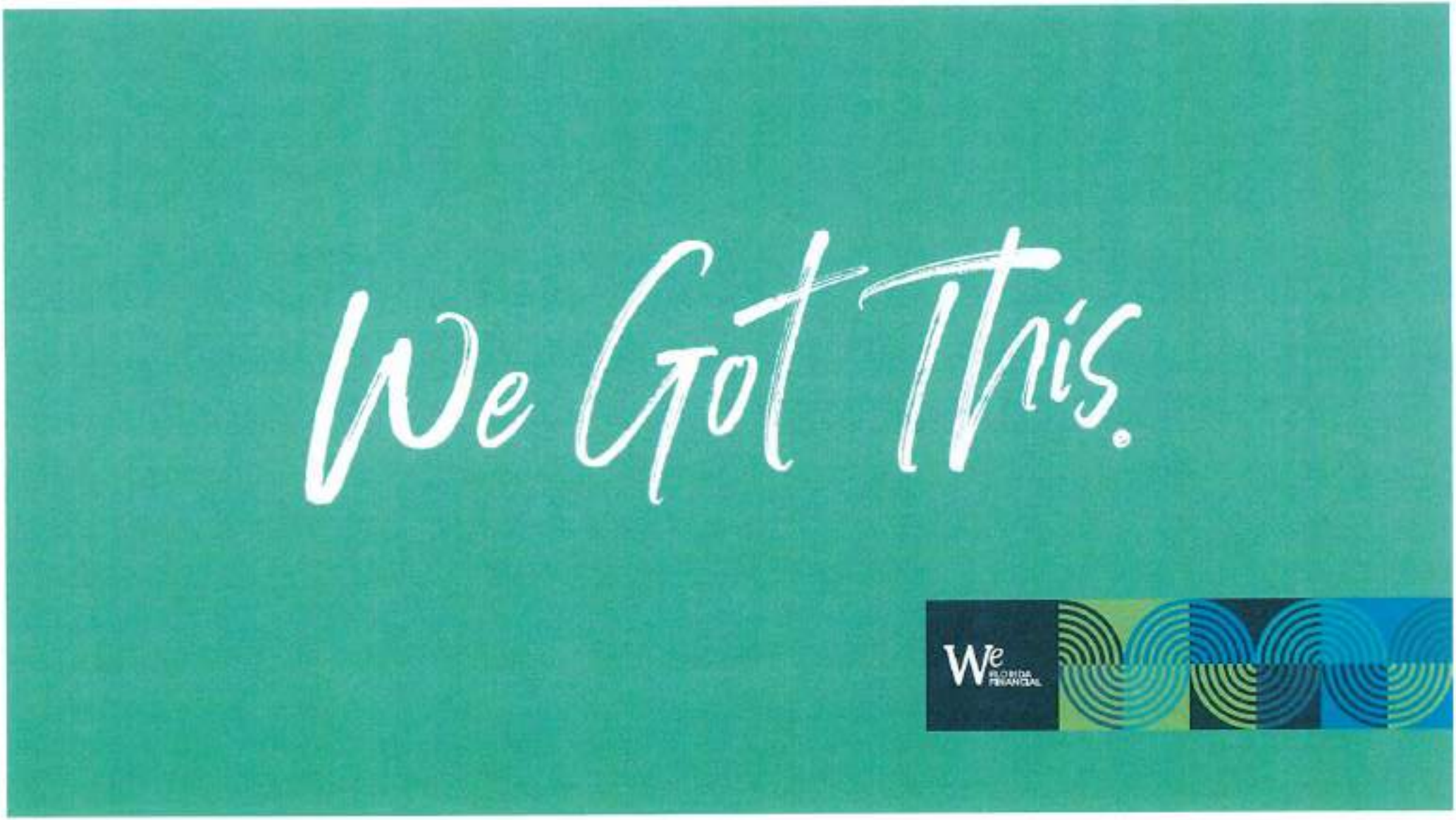
WE FLORIDA FINANCIAL

WELCOME TO YOUR CREDIT UNION

We Florida Financial is a full-service credit union that has been providing outstanding customer service since 1952. We are not-for-profit, so every member is a shareholder of We Florida Financial. When you deposit money into our credit union account, you become both a customer & an owner. We offer low fees & high savings rates. We also offer a range of loans including auto, home, aviation loans & more, which have low interest rates.

HISTORY OF WE

- We Florida Financial is a cooperatively owned, not-for-profit credit union
- 60,000 members & over $600 million in assets
- Founded in 1952
- Serves individuals & small businesses in 46 Florida counties from Jacksonville to Key West
- Offers a full range of affordable deposit & loan products to meet the needs of our diverse communities


We Got This.
We
FLORIDA
FINANCIAL

WE
FLORIDA
FINANCIAL

EMPOWERING
YOUR DREAMS

BENEFITS & PERKS

We Florida Financial has many benefits & perks, including but not limited to:

- Special member discounts (Sprint, Dell, AAA, BJ's Wholesale Club, DirecTV & more)
- Free educational seminars
- Free Publix "Presto" transactions
- Personalized customer service
- Free real estate services for buying or selling a home
- Low fees & big savings
- Community involvement
- Mobile app
- Zogo financial literacy app

TYPES OF ACCOUNTS WE OFFER

We offer both personal & business account options, including:

- Checking
- Savings
- Investment
- Encore
- Retirement
- Youth/College

We also offer various types of credit card options, which are:

- Visa Signature
- Visa Platinum
- Visa Secured
- "Dream More" Visa Rewards Card

AWESOME LOANS

We Florida Financial offers a range of loans with low interest rates, including:

- Auto
- Home
- Home equity
- Aviation
- "Live your Life"/Personal
- Boat & RV
- Motorcycle
- Mortage

"We rise by lifting others"
-Robert Ingersoll

COMMUNITY

ANSWERING THE CALL TO HELP

We Florida Financial not only offers financial services, but we are dedicated to giving back to the community as well. We continuously are involved with volunteering events, sponsorships, teaching financial literacy, & making sure all of our members feel a sense of community.

WE HAVE OPTIONS

With We Florida Financial, you can bank from anywhere...

- Digital banking
- In person
- Share-branching
- Mobile app - view your account activity, transfer funds, pay bills, deposit checks, send money to friends & family instantly, view your progress toward your savings goals & budget
- Coming soon: Zelle!

WE ARE MEANT FOR EVERYONE

We Florida Financial offers services that fit a diverse community...

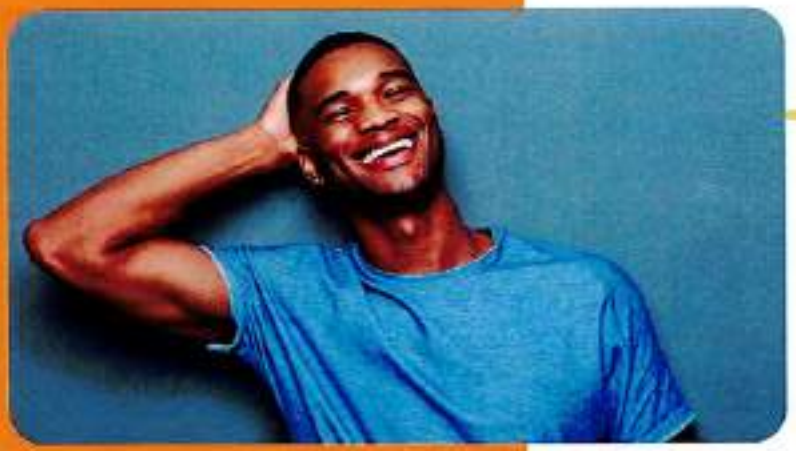
- Youth
- Students
- Business owners
- People who need a second chance
- Seniors

WE HAVE FUN FINANCIAL TIPS

- We Florida Financial has partnered with Zogo to provide you with a gamified financial literacy app that teaches everything from opening a bank account to saving for retirement
- Win rewards for completing bite-sized financial literacy lessons on intelligently saving, spending, & managing your money
- If you're looking ways to further education, Zogo is a free app that teaches you about finance & teaches you to learn
- Download Zogo in the app store & use code WEFLORIDA

"It's an educational experience! Most of these topics aren't taught in school, so it's really great I can learn them here."
- Meghan F.

App store:
ZOGO
Use Code:
WEFLORIDA



HOW TO JOIN WE

- How much does it cost to join? There is no fee! Simply open your savings account with a minimum $5 deposit. This represents your share of credit union ownership
- As long as your $5 stays on deposit, you're eligible to benefit from any credit union service, including applying for loans, mortgages & more
- Have to live or work in one of our 46 Florida counties, including Broward, Miami-Dade & West Palm Beach
- Family members of existing members

WE CONNECT

Wefloridafinancial

@Weflfinancial

Wefloridafinancial

Wefloridafinancial

@Wefloridafinancial

@Wefloridafinancial

We Florida FINANCIAL

Your Credit Union

We Got This.

Personal Checking

Together,
We Got This.

We FLORIDA FINANCIAL

PERSONAL CHECKING ACCOUNTS TO MAXIMIZE YOUR LIFESTYLE.

ULTRA Earn the Most

- Earns incredible interest on your money
- FREE WeProtect Identity Theft and Fraud Protection
- FREE initial order of standard checks
- Active CD required
- Minimum $1,500 balance

PRIME Excellent Benefits

- Earns high interest
- FREE WeProtect Identity Theft and Fraud Protection
- FREE initial order of standard checks
- Minimum $1,500 balance

FABULOUS 50+ Celebrate

- Earns interest
- FREE WeProtect Identity Theft and Fraud Protection
- FREE initial order of standard checks
- No minimum balance

emPOWER Steady Earning

- Earns interest
- All the perks of Essential
- Direct Deposit required
- Minimum $500 balance

ESSENTIAL Easy Access

- Online Banking & Bill Pay
- Visa Debit Card
- eStatements
- No minimum balance

We're in your neighborhood.

PUBLIX PRESTO! ATM NETWORK

1,250 PUBLIX PRESTO! ATMS Across Southeast U.S.

NATIONWIDE

5,000+ CO-OP SHARED BRANCHES
We Florida Financial members can use 5,000+ participating credit union branch offices in 50 states to conduct routine transactions such as deposits, withdrawals and loan payments.

BROWARD & MIAMI-DADE COUNTIES

FOR A FULL LIST OF LOCATIONS & HOURS:
WeFloridaFinancial.com/Locations

Live Chat with us at:
WeFloridaFinancial.com
Text or Call: 954-745-2400

We are here for all of your financial needs, helping empower you to explore your dreams.

- Personal Checking
- Personal Savings
- Certificates of Deposit
- Credit Cards
- Money Market Accounts
- IRAs
- Personal Loans
- Mortgage Loans
- Home Equity Line of Credit
- Auto Loans
- Aircraft and Boat Loans
- Business Accounts and Services

We FLORIDA FINANCIAL

Save time and money with these great products and services:

Savings Plans

Your membership is created with a Savings Account/Share Account. Build your savings with a monthly transfer from your Checking Account to your Savings Account.

- 5,000+ Co-Op Shared Branches
- FREE Debit Card
- FREE Online Banking
- FREE Mobile Banking with Mobile Deposit
- FREE e-Statements
- Convenient Direct Deposits
- Online Wire Transfers
- Online Bill Payments
- Credit Cards
- Personal/Home Loans
- Certificates of Deposit (CDs)
- Business Checking
- Zelle

Federally insured by NCUA

Other fees such as non-sufficient funds, overdraft, etc. may apply. See fee schedule for details. Minimum opening deposit is only $50. Ask us for details. We Florida Financial rules and regulations apply.

Membership required and open to individuals who live/work in select Florida counties. Members must maintain a savings account with a minimum of $5.00.

Aflac

Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses health insurance doesn't cover, so you can focus more on everything else.

Or, visit your benefits page at: www.aflacenrollment.com/CAREERSOURCEBROWARD/M8906212849 2

Aflac
Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac.

THE POLICY 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.

B70275RFL IC(3/23)

AFLAC CANCER PROTECTION ASSURANCE

CANCER INDEMNITY INSURANCE – OPTION 2

Policy Series B70000

We're there when you need us most

The unfortunate reality is cancer touches almost everyone at some point in their lives, whether it's yourself or a loved one. But each person has a unique story, especially when it comes to cancer treatment. We believe if faced with a cancer diagnosis, you need real solutions that help you face the financial, physical and emotional challenges often experienced by cancer patients and their families – before, during, and after treatment.

Since 1958, Aflac has been a pioneer in cancer insurance. As cancer treatment protocols have changed, our coverage has evolved to help cover the costs of those innovative treatments and provide solutions that empower you to seek treatment, while easing the financial concerns that often accompany it.

Benefits paid directly to you

Aflac Cancer Protection Assurance pays cash benefits directly to you, unless assigned, when you need them most. If you're ever diagnosed with a covered cancer, these benefits are more important than ever. Why? Because cancer treatment can be expensive.

Health insurance was never intended to cover the cost of things like deductibles, co-pays, lost work time, or even travel. Aflac Cancer Protection Assurance can help with cancer-associated costs like these.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you can have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose.

Aflac Cancer Protection Assurance stays with you for life*

We're with you, even when you're well. We pay a benefit for early detection and preventive care, like mammograms, PSA blood tests, and many other kinds of cancer screenings.

We'll see you all the way through treatment. If you're diagnosed with cancer, we offer benefits that you can count on. You'll receive a benefit upon initial diagnosis of a covered cancer and our support doesn't end there.

We give you the freedom to choose the best care for you. You and your doctor decide on a treatment plan together; we help provide you with financial support for every month that you're undergoing that treatment. Want a second opinion? We provide a benefit for that, too.

How it works

The above example is based on a scenario for Aflac Cancer Protection Assurance – Option 2 with three units of the Initial Diagnosis Building Benefit Rider (purchased three years prior to claim) and includes the following benefit conditions: Initial Diagnosis Benefit of $5,000, Initial Diagnosis Building Benefit Rider (three units for three years) of $900, Bone Marrow Biopsy (Cancer Screening Benefit) of $75, IV Chemotherapy (or 3 months (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) of $4,800, Immunotherapy (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) for 6 months of $9,600, Antinausea Benefit (9 months) of $900, Stem Cell Transplant Benefit of $7,000, Hospital Confinement Benefit (4 days) of $800, Annual Care Benefit (paid on the first anniversary of diagnosis) of $500.

*Coverage remains in force as long as premiums are paid.

Benefits and/or premiums may vary based on state and benefit option selected. Riders are available for an additional cost. The policy/riders have limitations, exclusions, and pre-existing condition limitations that may affect benefits payable. The policy and certain riders contain a 30-day waiting period. This brochure is for illustrative purposes only. Refer to the policy/riders for complete benefit details, definitions, limitations and exclusions.

For more information, ask your insurance agent/producer, call 1.800.992.3522, or visit aflac.com.

Benefits overview Choose the Policy and Riders that Fit Your Needs

BENEFIT:	DESCRIPTION:
INITIAL DIAGNOSIS	Named Insured or Spouse: $5,000 Dependent Child: $10,000 Payable once per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: $375 per calendar month Physician Administered: $1,600 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month
ANNUAL CARE	$500 on the anniversary date of diagnosis; lifetime maximum of five annual $500 payments per covered person
CANCER SCREENING	One $75 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	$250 per covered person, per lifetime
ADDITIONAL OPINION	$300 per covered person, per lifetime
HORMONAL THERAPY	$25 once per calendar month
TOPICAL CHEMOTHERAPY	$150 once per calendar month
ANTINAUSEA	$100 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	$7,000; lifetime maximum of $7,000 per covered person Donor Benefit: $100 for stem cell donation, or $750 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $175 per day, per covered person
SURGICAL/ANESTHESIA	$100-$3,400 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $4,250; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: $35 Excision of lesion of skin without flap or graft: $170 Flap or graft without excision: $250 Excision of lesion of skin with flap or graft: $400 Maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	$250 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: $200 Dependent Child: $250
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: $400 Dependent Child: $500

OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	$200 per day, per covered person
EXTENDED-CARE FACILITY	$100 per day; limited to 30 days in each calendar year, per covered person
HOME HEALTH CARE	$100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
HOSPICE CARE	$1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person
NURSING SERVICES	$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable
SURGICAL PROSTHESIS	$2,000; lifetime maximum of $4,000 per covered person
NONSURGICAL PROSTHESIS	$175 per occurrence, per covered person; lifetime maximum of $350 per covered person
BREAST RECONSTRUCTION	Breast Tissue/Muscle Reconstruction Rap Procedures: $2,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $500 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $220 Permanent Areola Repigmentation (on the diseased breast): $100 Maximum daily benefit will not exceed $2,000
OTHER RECONSTRUCTIVE SURGERY	Facial Reconstruction: $500 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed $500
EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION	$1,000 for a covered person to have oocytes extracted and harvested $200 for the storage of a covered person's oocyte(s) or sperm $200 for embryo transfer Lifetime maximum of $1,400 per covered person
AMBULANCE	$250 ground $2,000 air ambulance
TRANSPORTATION	$.40 cents per mile for transportation; payable up to a combined maximum of $1,200, per round trip
LODGING	$65 per day; limited to 90 days per calendar year
WAIVER OF PREMIUM	Yes
OPTIONAL RIDERS:	**DESCRIPTION:**
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

Initial diagnosis	Hospitalization	
$2,000	30 days or less; $400 per day	31 days or more; $800 per day

DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

AFLAC CANCER PROTECTION ASSURANCE COVERAGE

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For inquiries, obtaining information about coverage, and assistance in resolving complaints, call 1.800.99.AFLAC (1.800.992.3522)
For claim forms, visit our Web site at aflac.com

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, SPECIFIED DISEASE INSURANCE
Outline of Coverage for Policy Form Series B70200
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" furnished by Aflac.

(1) **Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Cancer Insurance Coverage** is designed to supplement a Covered Person's existing accident and sickness coverage only when certain losses occur as a result of the disease of Cancer or an Associated Cancerous Condition. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) **Benefits:** Aflac will pay the following benefits, as applicable, while coverage is in force, subject to all other limitations and exclusions, conditions, and provisions of the policy, unless indicated otherwise. All treatments listed below must be National Cancer Institute (NCI) or Food and Drug Administration (FDA) approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

CANCER SCREENING BENEFIT: Aflac will pay $75 per Calendar Year when a Covered Person receives one of the following:

mammogram • breast ultrasound • breast MRI • thermography • CA15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer) • Pap smear/ThinPrep • PSA (blood test for prostate cancer • CEA (blood test for colon cancer) • P32 uptake serum protein electrophoresis (blood test for multiple myeloma) • testicular ultrasound • transrectal ultrasound • abdominal ultrasound • flexible sigmoidoscopy • colonoscopy • virtual colonoscopy • cystoscopy • colposcopy • bronchoscopy • mediastinoscopy • esophagoscopy • sigmoidoscopy • proctosigmoidoscopy • gastroscopy • laryngoscopy • chest X-ray • computerized tomography (CT or CAT scan) • magnetic resonance imaging (MRI) • bone scan • thyroid scan • multiple gated acquisition (MUGA) scan • positron emission tomography (PET) scan • biopsy • hemoccult stool specimen (lab confirmed) • Genetic Testing • bone marrow donor screening • cancer vaccine

This benefit is limited to one $75 payment per Calendar Year, per Covered Person, with no Positive Medical Diagnosis. If a Covered Person receives a Positive Medical Diagnosis for Internal Cancer or an Associated Cancerous Condition, this benefit will pay up to a total of three $75 payments per Calendar Year for screenings performed on such Covered Person. Screenings must be administered by licensed medical personnel. Except for Genetic Testing, bone marrow donor screening, and cancer vaccine, the screening must be performed for the purpose of determining whether Cancer or an Associated Cancerous Condition exists in a Covered Person. No lifetime maximum.

PROPHYLACTIC SURGERY BENEFIT (DUE TO A POSITIVE GENETIC TEST RESULT): Aflac will pay $250 when a Covered Person has surgery due to a positive test result received for a genetic alteration or mutation associated with a hereditary Cancer syndrome and such surgery is recommended by a Physician. The Genetic Testing must be performed while coverage is in force.

This benefit is payable once per Covered Person, per lifetime.

CANCER DIAGNOSIS BENEFITS:

INITIAL DIAGNOSIS BENEFIT: Aflac will pay the amount listed below when a Covered Person is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the policy is in force, subject to the Limitations and Exclusions.

Named Insured or Spouse	$5,000
Dependent Child	$10,000

This benefit is payable once per Covered Person, per lifetime. In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

ADDITIONAL OPINION BENEFIT: Aflac will pay $300 when a charge is incurred for an additional surgical opinion from a Physician or an evaluation or consultation with a Physician for the purpose of determining the appropriate course of treatment for a covered Internal Cancer or Associated Cancerous Condition. **This benefit is payable once per Covered Person, per lifetime.**

CANCER TREATMENT BENEFITS:

NONSURGICAL TREATMENT BENEFITS:

RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY, OR EXPERIMENTAL CHEMOTHERAPY BENEFIT:

SELF-ADMINISTERED: Aflac will pay $375 once per Calendar Month for which a Covered Person receives and incurs a charge for self-administered Physician-prescribed Chemotherapy, Immunotherapy, or Experimental Chemotherapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

PHYSICIAN-ADMINISTERED: Aflac will pay $1,600 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy administered by a member of the medical profession in a Medical Facility as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

This benefit is limited to one self-administered treatment and one physician-administered treatment per Calendar Month. After this benefit has been paid for 12 Calendar Months, Aflac will require annual documentation from the attending Physician certifying that the Cancer or Associated Cancerous Condition is still detectable and active in the body and is not in remission in order for this benefit to continue to be payable.

HORMONAL THERAPY BENEFIT: Aflac will pay $25 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Therapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

TOPICAL CHEMOTHERAPY BENEFIT: Aflac will pay $150 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for a Topical Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

See the Payment of Nonsurgical Treatment Benefits section for additional information.

INDIRECT/ADDITIONAL THERAPY BENEFITS:

ANTINAUSEA BENEFIT: Aflac will pay $100 once per Calendar Month for which a Covered Person receives and incurs a charge for antinausea drugs that are prescribed in conjunction with Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy. This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which a person receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy, the Calendar Month prior to such treatment, and the Calendar Month following such treatment. No lifetime maximum.

STEM CELL AND BONE MARROW TRANSPLANTATION BENEFIT: Aflac will pay $7,000 when a Covered Person receives and incurs a charge for a peripheral Stem Cell Transplantation or a Bone Marrow Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Lifetime maximum of $7,000 per Covered Person. In addition, Aflac will pay the Covered Person's donor an indemnity amount for his or her expenses as a result of the donation procedure as follows: $100 for stem cell donation, or $750 for bone marrow donation. This benefit is payable one time per Covered Person.

BLOOD AND PLASMA BENEFIT: Aflac will pay $50 times the number of days paid under the Hospital Confinement Benefit when a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition during a covered Hospital confinement. Aflac will pay $175 for each day a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. This benefit does not pay for immunoglobulins, Immunotherapy, antihemophilia factors, or colony-stimulating factors. No lifetime maximum.

SURGICAL TREATMENT BENEFITS:

SURGERY/ANESTHESIA BENEFIT: Aflac will pay according to the benefits in the Schedule of Operations in the policy when a Covered Person has a surgical procedure performed for the direct treatment of a covered Internal Cancer or Associated Cancerous Condition and a charge is incurred for such surgical procedure. If any surgical procedure for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the surgical procedure most nearly similar in severity and gravity.

EXCEPTIONS: Prophylactic Surgery and procedures payable under the Cancer Screening Benefit, Skin Cancer Surgery Benefit, or Reconstructive Surgery Benefit will not be payable under the Surgery/Anesthesia Benefit.

The Surgery/Anesthesia Benefit is only payable one time per 24-hour period, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid.

Aflac will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation.

The maximum daily benefit will not exceed $4,250. No lifetime maximum on the number of operations.

SKIN CANCER SURGERY BENEFIT: When a surgical operation is performed on a Covered Person for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer, Aflac will pay the amount listed below when a charge is incurred for the specific procedure. The amount listed below includes anesthesia services. The maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations.

Laser or Cryosurgery	$ 35

Surgeries OTHER THAN Laser or Cryosurgery:

Excision of lesion of skin without flap or graft	170
Flap or graft without excision	250
Excision of lesion of skin with flap or graft	400

PROPHYLACTIC SURGERY BENEFIT (WITH CORRELATING INTERNAL CANCER DIAGNOSIS): Aflac will pay $250 when, as recommended by a Physician due to a covered diagnosis of Internal Cancer or an Associated Cancerous Condition, one of the Prophylactic Surgeries shown below is performed on a Covered Person:

1. mastectomy due to a covered diagnosis of Internal Cancer other than breast Cancer;
2. oophorectomy due to a covered diagnosis of Internal Cancer other than ovarian Cancer; or
3. orchiectomy due to a covered diagnosis of Internal Cancer other than testicular Cancer.

This benefit is payable once per Covered Person, per lifetime.

HOSPITALIZATION BENEFITS:

HOSPITAL CONFINEMENT BENEFITS:

HOSPITALIZATION FOR 30 DAYS OR LESS: When a Covered Person is confined to a Hospital for treatment of Cancer or an Associated Cancerous Condition for 30 days or less, Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse	$200
Dependent Child	$250

HOSPITALIZATION FOR 31 DAYS OR MORE: During any continuous period of Hospital confinement of a Covered Person for treatment of Cancer or an Associated Cancerous Condition for 31 days or more, Aflac will pay benefits as described above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse	$400
Dependent Child	$500

OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE BENEFIT: When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, and a surgical room charge is incurred, Aflac will pay $200. For this benefit to be paid, surgeries must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day the Hospital Confinement Benefit is payable. This benefit is payable in addition to the Surgery/Anesthesia Benefit. The maximum daily benefit will not exceed $200. No lifetime maximum on number of operations.

This benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. It is not payable for the procedures listed in the Cancer Screening Benefit or any surgery performed in a Physician's office.

CONTINUING CARE BENEFITS:

EXTENDED-CARE FACILITY BENEFIT: When a Covered Person is hospitalized and receives Hospital Confinement Benefits and is later confined, within 30 days of the covered Hospital confinement, to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such, (collectively referred to as "Extended-Care Facility"), Aflac will pay $100 per day when a charge is incurred for such continued confinement. For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. Benefits are limited to 30 days in each Calendar Year per Covered Person.

If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement.

HOME HEALTH CARE BENEFIT: When a Covered Person is hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided on his or her behalf, Aflac will pay $100 per day when a charge is incurred for each such visit, subject to the following conditions:

1. The home health care or health supportive services must begin within seven days of release from the

Hospital.

2. This benefit is limited to ten days per hospitalization for each Covered Person.
3. This benefit is limited to 30 days in any Calendar Year for each Covered Person.
4. This benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.
5. Home health care and health supportive services must be performed by a person, other than a member of your Immediate Family, who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

This benefit is not payable the same day the Hospice Care Benefit is payable.

HOSPICE CARE BENEFIT: When a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the Covered Person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of Internal Cancer or an Associated Cancerous Condition (hereinafter referred to as "Terminally Ill"), Aflac will pay a one-time benefit of $1,000 for the first day the Covered Person receives Hospice care and $50 per day thereafter for Hospice care. For this benefit to be payable, Aflac must be furnished: (1) a written statement from the attending Physician that the Covered Person is Terminally Ill, and (2) a written statement from the Hospice certifying the days services were provided. Lifetime maximum for each Covered Person is $12,000.

This benefit is not payable the same day the Home Health Care Benefit is payable.

NURSING SERVICES BENEFIT: While confined in a Hospital for the treatment of Cancer or an Associated Cancerous Condition, if a Covered Person requires and is charged for private nurses and their services other than those regularly furnished by the Hospital, Aflac will pay $100 per day for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses, or licensed vocational nurses). These services must be required and authorized by the attending Physician. This benefit is not payable for private nurses who are members of your Immediate Family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. No lifetime maximum.

SURGICAL PROSTHESIS BENEFIT: Aflac will pay $2,000 when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Internal Cancer or an Associated Cancerous Condition treatment. Lifetime maximum of $4,000 per Covered Person.

The Surgical Prosthesis Benefit does not include coverage for tissue expanders or a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap.

NONSURGICAL PROSTHESIS BENEFIT: Aflac will pay $175 per occurrence, per Covered Person when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of treatment for Internal Cancer or an Associated Cancerous Condition. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces, and removable breast prostheses. Lifetime maximum of $350 per Covered Person.

RECONSTRUCTIVE SURGERY BENEFIT:

BREAST RECONSTRUCTION: Aflac will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed $2,000.

Breast Tissue/Muscle Reconstruction Flap Procedures	$2,000
Breast Reconstruction (occurring within five years of breast Cancer diagnosis)	500
Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction)	220
Permanent Areola Repigmentation	100

OTHER RECONSTRUCTIVE SURGERY: Aflac will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed $500.

Facial Reconstruction	$ 500

Aflac will pay an indemnity benefit equal to 25% of the amount shown above for the administration of anesthesia during a covered reconstructive surgical operation.

If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown above for the operation most nearly similar in severity and gravity. No lifetime maximum on number of operations.

EGG HARVESTING, STORAGE (CRYOPRESERVATION), AND IMPLANTATION BENEFIT: Aflac will pay $1,000 for a Covered Person to have oocytes extracted and harvested due to a positive diagnosis of Internal Cancer or an Associated Cancerous Condition. In addition, Aflac will pay, one time per Covered Person, $200 for the storage of a Covered Person's

oocyte(s) or sperm when a charge is incurred to store with a licensed reproductive tissue bank or similarly licensed facility. Any such extraction, harvesting, or storage must occur prior to Chemotherapy or radiation treatment that has been prescribed for the Covered Person's treatment of Cancer or an Associated Cancerous Condition. Aflac will also pay $200 for embryo transfer resulting from such stored oocyte(s) or sperm of a Covered Person. Lifetime maximum of $1,400 per Covered Person.

ANNUAL CARE BENEFIT: Aflac will pay $500 on the anniversary date of a Covered Person's diagnosis of a covered Internal Cancer or Associated Cancerous Condition for care other than the direct treatment of Cancer or an Associated Cancerous Condition to meet the Covered Person's physical, emotional, spiritual, or social needs. Lifetime maximum of five annual $500 payments per Covered Person.

AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:

AMBULANCE BENEFIT: Aflac will pay $250 when a charge is incurred for ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. Aflac will pay $2,000 when a charge is incurred for air ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional ambulance company. No lifetime maximum.

TRANSPORTATION BENEFIT: Aflac will pay 40 cents per mile for transportation, up to a combined maximum of $1,200, if a Covered Person requires treatment that has been prescribed by the attending Physician for Cancer or an Associated Cancerous Condition.

This benefit includes:

1. Personal vehicle transportation of the Covered Person limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.
2. Commercial transportation (in a vehicle licensed to carry passengers for a fee) of the Covered Person and no more than one additional adult to travel with the Covered Person. If the treatment is for a covered Dependent Child and commercial transportation is necessary, Aflac will pay for up to two adults to travel with the covered Dependent Child. This benefit is limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.

This benefit is payable up to a maximum of $1,200 per round trip for all travelers and modes of transportation combined. No lifetime maximum.

THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL/FACILITY LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON OR FOR TRANSPORTATION BY AMBULANCE TO OR FROM ANY HOSPITAL.

LODGING BENEFIT: Aflac will pay $65 per day when a charge is incurred for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment for Cancer or an Associated Cancerous Condition at a Hospital or Medical Facility more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per Calendar Year.

PREMIUM WAIVER BENEFIT:

WAIVER OF PREMIUM BENEFIT: If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform two or more Activities of Daily Living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your Spouse becomes the new Named Insured, premiums will resume and be payable on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

Aflac may ask for and use an independent consultant to determine whether you can perform an ADL when this benefit is in force.

Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

(4) Optional Benefits:

INITIAL DIAGNOSIS BUILDING BENEFIT RIDER: (SERIES B70050) Applied for ☐ Yes ☐ No

INITIAL DIAGNOSIS BUILDING BENEFIT: This benefit can be purchased in units of $100 each, up to a maximum of five units or $500. **If more than one unit has been purchased, the number of units purchased must be multiplied by**

$100. The number of units you purchased is shown in both the Policy Schedule and the attached application.

The **INITIAL DIAGNOSIS BUILDING BENEFIT** will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased for each Covered Person on the anniversary date of their coverage, while coverage remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the Initial Diagnosis Benefit in the policy to which the rider is attached. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person's 65th birthday or at the time Internal Cancer or an Associated Cancerous Condition is diagnosed for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of coverage, this benefit will accrue for a period of at least five years, unless Internal Cancer or an Associated Cancerous Condition is diagnosed prior to the fifth year of coverage.

Exceptions, Reductions, and Limitations of Rider Series B70050:

The rider contains a 30-day waiting period. If a Covered Person has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Initial Diagnosis Building Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of coverage under the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Building Benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

DEPENDENT CHILD RIDER: (SERIES B70051)
Applied for ❑ Yes ❑ No

DEPENDENT CHILD BENEFIT: Aflac will pay $10,000 when a covered Dependent Child is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the rider is in force.

This benefit is payable under the rider only once for each covered Dependent Child. In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

Exceptions, Reductions, and Limitations of Rider Series B70051:

The rider contains a 30-day waiting period. If a covered Dependent Child has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Dependent Child Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Dependent Child who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for any benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

SPECIFIED-DISEASE BENEFIT RIDER: (SERIES B70052)
Applied for ❑ Yes ❑ No

SPECIFIED-DISEASE INITIAL BENEFIT: While coverage is in force, if a Covered Person is first diagnosed, after the Effective Date of coverage under the rider, with any of the covered Specified Diseases, Aflac will pay a benefit of $2,000. This benefit is payable only once per Specified Disease per Covered Person. **NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THE RIDER.**

HOSPITAL CONFINEMENT BENEFITS:

HOSPITALIZATION FOR 30 DAYS OR LESS: When a Covered Person is confined to a Hospital for a covered Specified Disease for 30 days or less, Aflac will pay $400 for each day the Covered Person is charged for a room as an inpatient.

HOSPITALIZATION FOR 31 DAYS OR MORE: During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay benefits as described above for the first 30 days, and beginning with the 31st day of such continuous Hospital confinement, Aflac will pay $800 for each day the Covered Person is charged for a room as an inpatient.

Exceptions, Reductions, and Limitations of Rider Series B70052:

Specified diseases must be first diagnosed by a Physician 30 days following the Effective Date of coverage under the rider for benefits to be paid. The diagnosis must be made by and

upon a tissue specimen, culture(s), and/or titer(s). If a Covered Person has a Specified Disease diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Specified Disease will apply only to treatment occurring after 120 days from the Effective Date of such person's coverage. At your option, you may elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

(5) Payment of Nonsurgical Treatment Benefits:

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of thirty days or less, then the payment under the applicable Nonsurgical Treatment Benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge.

If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of thirty days or less is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional Calendar Month for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during that additional Calendar Month. Otherwise, if the prescription is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has not been previously paid, then the benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Month.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of more than thirty days is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for up to three additional, consecutive Calendar Months for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during the three additional, consecutive Calendar Months. Otherwise, if the prescription is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has not been previously paid, then, so long as the Covered Person incurred a charge during the first Calendar Month of the prescription, for refills instructing a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Month, and for refills instructing a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

For injected treatment, the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit is payable one time per prescribed injection, but not more than one time per Calendar Month. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will not be paid for each month of continuous infusion of medications dispensed by a pump, implant, or patch.

If only Experimental Chemotherapy is payable during any Calendar Month, the benefit amount will be reduced 50% for Experimental Chemotherapy for which no charge is incurred. If a Covered Person received the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit at the reduced 50% amount and, later in the same Calendar Month, receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy where a charge is incurred, we will pay the difference between the 50% previously received and the Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Therapy Benefit.

(6) Exceptions, Reductions, and Limitations of the Policy (policy is not a daily hospital expense plan):

Except as specifically provided in the Benefits section of the policy, Aflac will pay only for treatment of Cancer or Associated Cancerous Conditions, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity.

The policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition, or any recurrence, extension, or metastatic spread of that same Cancer or Associated Cancerous Condition will apply only to treatment occurring after 120 days from the Effective Date of such person's coverage. At your option, you may elect to void the coverage and receive a full refund of premium.

The Initial Diagnosis Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the policy and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or an Associated Cancerous Condition diagnosed during the policy's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Benefit under the policy for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

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

Aflac will not pay benefits for any loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.

Aflac may void the policy and will not pay benefits whenever: (1) material facts or circumstances have been concealed or misrepresented in making a claim under the policy; or (2) fraud is committed or attempted in connection with any matter relating to the policy. If you have received benefits that were not contractually due under the policy, then Aflac reserves the right to offset any benefits payable under the policy up to the amount of benefits you received that were not contractually due.

PRE-EXISTING CONDITION LIMITATIONS

A "Pre-existing Condition" is an illness, disease, infection, or disorder for which, within the 24-month period before the Effective Date of coverage, medication prescribed by a medical professional was taken or medical testing, medical advice, consultation, or treatment was recommended by or received from a medical professional, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment from a medical professional. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the onset date is more than 24 months after the Effective Date of coverage.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the Pre-existing Conditions Limitations, exclusive of any applicable waiting periods under the new coverage.

(7) Renewability: The policy is guaranteed renewable for your lifetime as long as you pay the premiums when they are due or within the grace period. We may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. We may change the premium we charge, but not specific to any one person. Any premium change will be made for all policies of the same form number and premium classification in the state in which the policy was sold that are then in force.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

ACTIVITIES OF DAILY LIVING (ADLs): Activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing you personal independence in everyday living. The ADLs are BATHING: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower; MAINTAINING CONTINENCE: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters; TRANSFERRING: moving between a bed and a chair, or a bed and a wheelchair; DRESSING: putting on and taking off all necessary items of clothing; TOILETING: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; EATING: performing all major tasks of getting food into your body.

ASSOCIATED CANCEROUS CONDITION: Myelodysplastic blood disorder, myeloproliferative blood disorder, or internal carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An associated cancerous condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered associated cancerous conditions.**

CANCER: Disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also includes but is not limited to leukemia, Hodgkin's disease and melanoma. Cancer must receive a positive medical diagnosis.

1. **INTERNAL CANCER:** all cancers other than nonmelanoma skin cancer (see definition of nonmelanoma skin cancer).
2. **NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the outer part of the skin (epidermis).

Associated cancerous conditions, premalignant conditions or conditions with malignant potential will not be considered cancer.

COVERED PERSON: Any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured for 30 days from the moment of birth. If you desire coverage for a newborn child to continue beyond the first 30 days and individual or named insured/spouse only coverage is in force, you must notify Aflac in writing within 31 days of the newborn child's birth that you want to change your coverage type to one-parent family or two-parent family coverage. Upon your notice, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of any additional premium due, if any. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability and who became so disabled prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, legally adopted children, foster children, or children in your custodial care pursuant to a court order who are under age 26. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

EFFECTIVE DATE: The date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date is not the date you signed the application for coverage.

ADDITIONAL INFORMATION

An ambulatory surgical center does not include a physician's or dentist's office, a clinic or other such location.

Experimental chemotherapy does not include laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these experimental treatments.

The term hospital does not include any institution or part thereof used as an emergency room; an observation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational or rehabilitory care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include you or a member of your immediate family.

A stem cell transplantation does not include the bone marrow transplantation.

The diagnosis date is not the date the diagnosis is communicated to the covered person.

If nonmelanoma skin cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the covered person actually received treatment for nonmelanoma skin cancer.

If treatment for cancer or an associated cancerous condition is received in a U.S. government hospital, Aflac will not require a covered person to be charged for such services for benefits to be payable.

Aflac.

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Rate sheet prepared by Web User on 7/25/2023 5:08:24 PM.
Florida Payroll Premium rates are Biweekly for industry Class B.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CANCER PROTECTION ASSURANCE PLAN LEVEL 2 - Series B70200

		Premium	DCR*	Total
18-75	INDIVIDUAL	$17.58	$0.00	$17.58
18-75	INSURED/SPOUSE	$30.40	$0.00	$30.40
18-75	ONE-PARENT FAMILY	$17.58	$0.42	$18.00
18-75	TWO-PARENT FAMILY	$30.40	$0.42	$30.82

DCR = Optional Dependent Child Rider (Series B70061) premium 1 unit*

AFLAC PLUS RIDER

		Aflac Plus Rider
18-29	INDIVIDUAL	$1.44
30-39		$2.04
40-49		$3.48
50-70		$5.94
18-29	INSURED/SPOUSE	$2.70
30-39		$4.02
40-49		$6.60
50-70		$11.34
18-29	ONE-PARENT FAMILY	$2.88
30-39		$3.12
40-49		$4.20
50-70		$6.12
18-29	TWO-PARENT FAMILY	$3.48
30-39		$4.50
40-49		$6.78
50-70		$11.40

Aflac
Accident Insurance

ACCIDENT-ONLY INSURANCE – OPTION 3

We've been dedicated to helping provide
peace of mind and financial security
for nearly 70 years.

Aflac.

THE POLICY 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.

A36375FL IC(12/24)

AFLAC ACCIDENT INSURANCE

ACCIDENT-ONLY INSURANCE – OPTION 3

Policy Series AB8000

AC3

Accidents can happen at any moment. Let Aflac help ease the financial pain

Accidents can happen at any time and treating them can be costly. Even with health insurance there may be out-of-pocket costs — causing everyday expenses to suddenly seem overwhelming. Aflac Accident Insurance helps provide financial protection if a covered accidental injury occurs.

Health care costs continue to rise, and health insurance wasn't designed to cover everything. From out-of-pocket medical costs to time away from work, the financial impact can be surprising. Aflac can help cover those costs. Best of all, you get paid directly (unless otherwise assigned) — not the doctor or hospital.

Aflac has been there for our policyholders for nearly 70 years — in some of their most challenging moments. Aflac Accident Insurance can help give you peace of mind if you experience an accidental injury so you can focus on recovery rather than worrying about finances.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits for covered accidental injuries directly to you, unless assigned. Your own peace of mind, and the assurance that your family will have help financially, are powerful reasons to consider Aflac.

What does the Aflac Accident Insurance policy include?

- A preventive care benefit payable for routine medical exams.
- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries and surgical procedures.
- Benefits payable for initial treatment as well as follow-up care, including therapy and mental health treatment.
- A hospital confinement benefit that increases every year you have the policy, for a five-year period.
- An intensive care unit benefit that increases every year you have the policy, for a five-year period.
- An accidental death benefit.

Why Aflac Accident Insurance may be the right choice for you:

- We pay you, not the doctor or hospital.
- No underwriting questions to answer.
- No coordination of benefits—we pay regardless of any other insurance you may have.
- No network restrictions—you choose your own health care provider.
- Portable—take the plan with you if you change jobs or retire.*
- 24-hour accident insurance.

*Coverage remains in force as long as premiums are paid.

How it works

AFLAC ACCIDENT INSURANCE

AFLAC ACCIDENT INSURANCE – OPTION 3 COVERAGE IS SELECTED

WHILE PLAYING ON HIS TRAVEL BASEBALL TEAM, YOUR SON WAS INJURED SLIDING INTO HOME PLATE AND WAS TAKEN TO THE ER BY AMBULANCE.

HIS ANKLE IS BROKEN AND SURGERY IS PERFORMED.

AFLAC ACCIDENT INSURANCE – OPTION 3 COVERAGE PROVIDES THE FOLLOWING:

$5,345

TOTAL BENEFITS

The above example is based on a scenario for the Aflac Accident Insurance – Option 3 that includes the following benefit conditions: Ambulance Benefit of $400 (ground ambulance transportation); Initial Accident Treatment Benefit of $250; Named Injury Benefit (Dislocation and Fracture, Category 2, Surgically Repaired) of $7,000; Initial Hospitalization Admission Benefit of $1,500 (Year 1); Hospital Confinement Benefit (Year 1) of $300 (hospitalized for 1 day); Post-Accident Care Benefit of $630 (9 physical therapy treatments); Post-Accident Care Benefit of $140 (2 follow-up visits with surgeon); and Organized Sporting Activity Benefit of $125.

Benefits and/or premium may vary based on state and benefit option selected. The policy/rider has limitations and exclusions that may affect benefits payable. Rider is available for an additional cost. This brochure is for illustrative purposes only. Refer to the policy/rider for benefit details, definitions, limitations and exclusions.

For more information contact your insurance agent/producer, call 1.800.992.3522, or visit aflac.com.

AFLAC ACCIDENT INSURANCE – OPTION 3 BENEFIT OVERVIEW

BENEFIT NAME	BENEFIT DETAILS
	INITIAL TREATMENT BENEFITS
INITIAL ACCIDENT TREATMENT BENEFIT	$250 once per covered accident, per covered person. Limited to the maximum number of visits listed below per policy, per calendar year based on the type of coverage. **Type of Coverage** — **Number of Visits** Individual — 10 Named Insured/Spouse Only — 15 One-Parent Family — 20 Two-Parent Family — 25
AMBULANCE BENEFIT	• Ground: $400 • Air or Water: $2,500 Limited to two trips per covered accident, per covered person.
	CONFINEMENT BENEFITS
INITIAL HOSPITALIZATION ADMISSION WITH BUILDING BENEFIT	Pays the benefit amount as shown in the Building Benefit Table for a covered person's hospital admission or intensive care unit (ICU) admission as the result of injuries. **Year 1** — **Year 2** — **Year 3** — **Year 4** — **Year 5+** **Hospital Admission** — $1,500 — $2,000 — $2,500 — $3,000 — $3,500 **ICU Admission** — $3,000 — $4,000 — $5,000 — $6,000 — $7,000 Only one initial hospitalization admission benefit, the highest amount, is payable per covered accident, per covered person. If a covered person is confined to a hospital bed and is later confined to the ICU, the difference between the two benefits will be paid.
HOSPITAL CONFINEMENT WITH BUILDING BENEFIT	Pays the benefit amount shown in the Building Benefit Table for each day a covered person is confined to a hospital as the result of injuries. **Year 1** — **Year 2** — **Year 3** — **Year 4** — **Year 5+** $300 — $350 — $400 — $450 — $500 Payable up to 365 days per covered accident, per covered person.
INTENSIVE CARE UNIT CONFINEMENT WITH BUILDING BENEFIT	Pays the benefit amount shown in the Building Benefit Table for each day a covered person is confined to an intensive care unit (ICU) as the result of injuries. **Year 1** — **Year 2** — **Year 3** — **Year 4** — **Year 5+** $600 — $700 — $800 — $900 — $1,000 Payable up to 15 days per covered accident, per covered person.
REHABILITATION CONFINEMENT BENEFIT	Pays $250 for each day a covered person is confined to a rehabilitation facility for at least 18 hours as the result of injuries. Payable up to 30 days per covered accident, per covered person.
	NAMED INJURY BENEFITS
DISLOCATION AND FRACTURE BENEFIT	The benefit amount payable will be based on the body part (joint) dislocated or body part (bone) fractured regardless of the number of dislocations and/or fractures incurred on the same body part. **Category 1** — **Category 2** — **Category 3** **Surgical** — $400 — $2,000 — $4,000 **Non-Surgical** — $150 — $1,000 — $2,000 **Chip Fracture** — $40 — $250 — $500 If a covered person suffers multiple dislocations and/or fractures of different body parts as the result of one covered accident, we will pay the applicable amount for each injury per accident, per covered person.

BENEFIT NAME	BENEFIT DETAILS
DISMEMBERMENT BENEFIT	**Dismemberment Type** — **Benefit** Double Dismemberment — $50,000 Single Dismemberment — $15,000 Finger/Toe Dismemberment — $2,000 Partial Dismemberment — $500 Loss of Hearing (in one ear) — $7,500 Loss of Sight (in one eye) — $7,500 The dismemberment must occur within 90 days after the covered accident. Only one dismemberment benefit amount, the highest amount, is payable per covered accident, per covered person.
EMERGENCY DENTAL TREATMENT BENEFIT	**Type** — **Benefit** Loss or Extraction of a tooth — $200 Repair/Replacement of a tooth — $500 No more than one loss or extraction of a tooth and one repair or replacement of a tooth per covered accident, per covered person.
EMERGENCY VISION TREATMENT BENEFIT	**Type** — **Benefit** Foreign Object Removal — $100 Eye Surgery — $500 No more than one foreign object removal or eye surgery per covered accident, per covered person.
LACERATION BENEFIT	**Type** — **Benefit** Laceration with suture — $100 Laceration without suture — $50 Only one laceration benefit amount, the highest amount, is payable per covered accident, per covered person.
ROAD RASH WITH SKIN GRAFT BENEFIT	Pays when a covered person suffers a road rash and requires a skin graft to repair. **Road Rash Percentage** — **Benefit** < 10% of total body surface — $175 10% - 19% of total body surface — $550 20% - 29% of total body surface — $1,500 30% or greater of total body surface — $3,000 Only one road rash with skin graft benefit amount, the highest amount, is payable per covered accident, per covered person.
SECOND-DEGREE BURN BENEFIT	**Second-Degree Burn Percentage** — **Benefit** < 10% of total body surface — $175 10% - 19% of total body surface — $550 20% - 29% of total body surface — $1,500 30% or greater of total body surface — $3,000 Only one second-degree burn benefit amount, the highest amount, is payable per covered accident, per covered person.
THIRD-DEGREE BURN BENEFIT	**Third-Degree Burn Percentage** — **Benefit** < 2.5% of total body surface — $275 2.5% - 10% of total body surface — $1,350 10% - 19% of total body surface — $4,000 20% - 29% of total body surface — $15,000 30% or greater of total body surface — $25,000 Only one third-degree burn benefit amount, the highest amount, is payable per covered accident, per covered person.

BENEFIT NAME	BENEFIT DETAILS
SURGERY BENEFIT	Pays the benefit amount listed below when a covered person undergoes surgery performed in a medical facility. **Surgery Type** — **Benefit** Category 1 — Repair of Hernia, Arthroscopy, Surgery (Other) — $400 Category 2 — Ruptured Disc, Tendons/Ligaments, Torn Knee Cartilage, Torn Rotator Cuff — $1,500 Category 3 — Cranial Surgery, Open Abdominal Surgery, Open Thoracic Surgery (excluding chest tube insertions) — $3,000
ACQUIRED BRAIN INJURY BENEFIT	Pays the benefit amount listed below when a covered person is diagnosed with an acquired brain injury. **Severity** — **Benefit** Severe (Glasgow Scale 8 or less or coma diagnosis) — $20,000 Moderate (Glasgow Scale 9-12) — $1,000 Mild (Glasgow Scale 13-15 or concussion diagnosis) — $250 Payable once per covered accident, per covered person.
PARALYSIS BENEFIT	Pays the benefit amount listed below when a covered person is diagnosed by a medical professional with permanent paralysis. **Paralysis Type** — **Benefit** One or two limbs — $15,000 Three or four limbs — $50,000 Only one paralysis benefit amount, the highest amount, is payable per covered accident, per covered person.
FOLLOW-UP CARE AND SERVICES BENEFITS	
POST-ACCIDENT CARE BENEFIT	$70 per visit Payable up to 30 visits per covered accident, per covered person.
TRANSPORTATION BENEFIT	$1,000 per round trip to any medical facility or rehabilitation facility located more than 50 miles from the site of the covered accident or residence of the covered person when a covered person requires confinement for injuries sustained in a covered accident. Payable for up to 3 round trips per calendar year, per covered person.
PROSTHESIS BENEFIT	$1,000; payable once per covered accident, per covered person.
PROSTHESIS REPAIR/ REPLACE BENEFIT	$1,000; replacement must occur 12 months or more after any previously paid prosthesis benefit.
LOSS OF LIFE BENEFIT	
ACCIDENTAL DEATH BENEFIT	**Common-Carrier Accident** — **Other Accident** **Named Insured/Spouse** — $200,000 — $80,000 **Child** — $50,000 — $25,000 Payable once per covered person.
SPECIALTY BENEFITS	
AUTOMOBILE AND/OR HOME MODIFICATION BENEFIT	$5,000; payable once per covered accident, per covered person.
PREVENTIVE CARE BENEFIT	$100; payable once per policy, per calendar year.
ORGANIZED SPORTING ACTIVITY BENEFIT	$125; payable once per covered accident, per covered person.
WAIVER OF PREMIUM	Yes

REFER TO THE FOLLOWING OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

ACCIDENT-ONLY COVERAGE

American Family Life Assurance Company of Columbus
(referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road Columbus, Georgia 31999
1.800.99.AFLAC (1.800.992.3522)
Visit our website at aflac.com

ACCIDENT-ONLY COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Aflac.

(1) Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Accident-Only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered Accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) Aflac will pay the following benefits as applicable if a Covered Person's Accidental Death or Injury is caused by a covered Accident. Accidental-Death or Injury must be independent of Sickness or the medical or surgical treatment of Sickness, or of any cause other than a covered Accident. A covered Injury must also occur while coverage is in force and is subject to the Limitations and Exclusions. A charge is not required for benefits to be payable.

INITIAL TREATMENT BENEFITS

Initial Accident Treatment
Pays $250 when a Covered Person receives initial Treatment by a Medical Professional as the result of an Injury.

This benefit is payable once per covered Accident, per Covered Person. This benefit will not be paid for routine health examinations, immunizations, care received by a chiropractor, or other post-Accident care.

This benefit is limited to the maximum number of visits listed below per policy, per Calendar Year based on the Type of Coverage.

Type of Coverage	Number of Visits
Individual	10
Named Insured/Spouse Only	15
One-Parent Family	20
Two-Parent Family	25

Ambulance
Pays the benefit amount listed below when a Covered Person is transported by a licensed professional ambulance company via air, water or ground as the result of an Injury. The benefit amount payable will be based on the type of ambulance.

Ambulance Type	Benefit Amount
Air or Water	$2,500
Ground	$400

This benefit is limited to two trips per covered Accident, per Covered Person.

CONFINEMENT BENEFITS

Each applicable Confinement Benefit is payable once per day, even if Treatment is received for more than one Injury. The Building Benefit Amount payable will be based on the accrued Building Benefit Year for the policy while coverage remains in force. A Building Benefit Year is a 12-month time period, beginning on the policy Effective Date and ending one year later. Upon completion of each full Building Benefit Year, the Building Benefit Amount will increase until the maximum Building Benefit Amount is reached. Once the maximum is reached, the Building Benefit Amount will no longer increase.

Initial Hospitalization Admission
Pays the benefit amount listed below for a Covered Person's Hospital Admission or Intensive Care Unit (ICU) Admission as the result of Injuries.

Only one Initial Hospitalization Admission benefit, the highest amount, is payable per covered Accident, per Covered Person. If the Hospital confinement follows a previously covered Hospital confinement, it will be deemed a continuation of the first Hospital confinement unless (1) the later Hospital confinement is the result of an entirely unrelated Injury and (2) the Hospital confinements are separated by 14 days or more. If a Covered Person is confined to a Hospital bed and is transferred to the ICU, the difference between the two benefits will be paid.

	Building Benefit Year				
	1	2	3	4	5+
Hospital Admission	$1,500	$2,000	$2,500	$3,000	$3,500
ICU Admission	$3,000	$4,000	$5,000	$6,000	$7,000

Hospital Confinement
Aflac will pay the benefit amount listed below for each day a Covered Person is confined to a Hospital as the result of Injuries.

This benefit is payable for up to 365 days per covered Accident, per Covered Person.

	Building Benefit Year				
	1	2	3	4	5+
Hospital Confinement	$300	$350	$400	$450	$500

The Hospital Confinement benefit is not payable for the same day(s) that the Rehabilitation Confinement and ICU Confinement benefits are payable. The highest eligible benefit will be paid.

ICU Confinement
Aflac will pay the benefit amount listed below for each day a Covered Person is confined to an Intensive Care Unit (ICU) as the result of Injuries.

This benefit is payable for up to 15 days per covered Accident, per Covered Person.

	Building Benefit Year				
	1	2	3	4	5+
ICU Confinement	$600	$700	$800	$900	$1,000

The ICU Confinement benefit is not payable for the same day(s) that the Rehabilitation Confinement and Hospital Confinement benefits are payable. The highest eligible benefit will be paid.

Rehabilitation Confinement
Pays $250 for each day a Covered Person is Confined to a Rehabilitation Facility for at least 18 hours as the result of Injuries.

This benefit is payable for up to 30 days per covered Accident, per Covered Person.

The Rehabilitation Confinement benefit is not payable for the same day(s) that the Hospital Confinement and ICU Confinement benefits are payable. The highest eligible benefit will be paid.

NAMED INJURY BENEFITS

The diagnosis, Treatment, and/or procedure(s) must be performed by a Medical Professional.

Dislocation and Fracture

Pays the benefit amount as listed below when a Covered Person's joint is Dislocated, or a bone is Fractured, based on if the Injury requires surgical repair or non-surgical repair. We will pay the Chip Fracture benefit amount if a Covered Person has a Chip Fracture but surgical repair is not required.

The applicable amount payable for this benefit will be based solely on the body part (joint) Dislocated or body part (bone) Fractured regardless of the number of Dislocations and/or Fractures incurred on the same body part. If a Covered Person suffers multiple Dislocations and/or Fractures of the same body part as the result of one covered Accident, we will only pay the applicable Dislocation or Fracture benefit once per body part. If a Covered Person suffers multiple Dislocations and/or Fractures of different body parts as the result of one covered Accident, we will pay the applicable amount for each Dislocation and/or Fracture per Accident, per Covered Person.

Injury Type & Location		Surgically Repaired	Non-surgically Repaired	Chip Fracture
Category 1				
Fractures Finger Toe Coccyx	Dislocation Finger Toe Shoulder	$400	$150	$40
Category 2				
Fractures Foot Ankle Heel Lower leg Wrist Forearm Elbow Upper arm Face Nose Hand Kneecap Lower jaw Upper jaw Rib Cage Shoulder blade Collarbone	Dislocation Collarbone Lower jaw Wrist Knee Elbow	$2,000	$1,000	$250
Category 3				
Fractures Hip Pelvis Upper leg Skull Sternum Vertebrae Vertebral processes	Dislocation Hip Ankle/Foot	$4,000	$2,000	$500

Dismemberment
Pays the benefit amount as listed below when a Covered Person sustains a Dismemberment.

The Dismemberment must occur within 90 days after the covered Accident.

Dismemberment Type	Benefit Amount
Double Dismemberment	$50,000
Single Dismemberment	$15,000
Finger / Toe Dismemberment	$2,000
Partial Dismemberment	$500
Loss of Hearing (in one ear)	$7,500
Loss of Sight (in one eye)	$7,500

Only one Dismemberment benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

Emergency Dental Treatment
Pays the benefit amount as listed below when a Covered Person requires the following dental Treatment:

Emergency Dental Treatment Type	Benefit Amount
Loss or Extraction of a tooth	$200
Repair/Replacement of a tooth	$500

Aflac will pay for no more than one loss or extraction of a tooth and one repair or replacement of a tooth per covered Accident, per Covered Person.

Emergency Vision Treatment
Pays the benefit amount as listed below when a Covered Person requires the following vision Treatment:

Emergency Vision Treatment Type	Benefit Amount
Foreign Object Removal	$100
Eye Surgery	$500

Aflac will pay for no more than one foreign object removal or eye surgery per covered Accident, per Covered Person.

Laceration
Pays the benefit amount as listed below when a Covered Person suffers a Laceration.

Wound Type	Benefit Amount
Laceration with suture	$100
Laceration without suture	$50

A Laceration resulting from an open Fracture will not be payable under this benefit. Please refer to Fractures for benefit payable.

Only one Laceration benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

Road Rash with Skin Graft
Pays the benefit amount as listed below when a Covered Person suffers a Road Rash and requires a skin graft to repair. The benefit amount payable will be based on the percentage of the total body surface affected.

Road Rash Percentage	Benefit Amount
< 10% of total body surface	$175
10% - 19% of total body surface	$550
20% - 29% of total body surface	$1,500
30% or greater of total body surface	$3,000

Only one Road Rash with Skin Graft benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

Second-Degree Burn
Pays the benefit amount as listed below when a Covered Person suffers second-degree burn(s). The benefit amount payable will be based on the percentage of the total body surface burned.

Second-Degree Burn Percentage	Benefit Amount
< 10% of total body surface	$175
10% - 19% of total body surface	$550
20% - 29% of total body surface	$1,500
30% or greater of total body surface	$3,000

Only one Second-Degree Burn benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

Third-Degree Burn
Pays the benefit amount as listed below when a Covered Person suffers third-degree burn(s). The benefit amount payable will be based on the percentage of total body surface area burned.

Third-Degree Burn Percentage	Benefit Amount
< 2.5% of total body surface	$275
2.5% - 10% of total body surface	$1,350
11% - 19% of total body surface	$4,000
20% - 29% of total body surface	$15,000
30% or greater of total body surface	$25,000

Only one Third-Degree Burn benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

Surgery
Pays the benefit amount as listed below when a Covered Person undergoes Surgery performed in a Medical Facility.

This benefit is payable only for procedures not specified elsewhere in the Named Injury Benefits section of the policy.

Surgery Type	Benefit Amount
Category 1	
Repair of a Hernia Arthroscopy Surgery (Other)	$400
Category 2	
Ruptured Disc Tendons and/or Ligaments Torn Knee Cartilage Torn Rotator Cuff	$1,500
Category 3	
Cranial Surgery Open Abdominal Surgery Open Thoracic Surgery (excluding chest tube insertions)	$3,000

Acquired Brain Injury
Pays the benefit amount as listed below when a Covered Person is diagnosed with an Acquired Brain Injury.

Severity	Benefit Amount
Severe (Glasgow Scale 8 or less or coma diagnosis)	$20,000
Moderate (Glasgow Scale 9-12)	$1,000
Mild (Glasgow Scale 13-15 or concussion diagnosis)	$250

This benefit is payable once per covered Accident, per Covered Person.

Paralysis
Pays the benefit amount as listed below when a Covered Person is diagnosed by a Medical Professional with Permanent Paralysis.

Paralysis Type	Benefit Amount
Quadriplegia (Four Limbs) or Triplegia (Three Limbs)	$50,000
Diplegia or hemiplegia (Two Limbs) or Monoplegia (One Limb)	$15,000

Only one Paralysis benefit amount, the highest amount, is payable per covered Accident, per Covered Person.

The duration of the Permanent Paralysis must be a minimum of 7 days.

FOLLOW UP CARE AND SERVICES

The care and service(s) must be performed by a Medical Professional or Therapy Professional.

Post-Accident Care
Pays $70 per visit when a Covered Person receives follow-up Treatment, including mental health Treatment, for Injuries sustained in a covered Accident for which an Initial Accident Treatment benefit is payable.

This benefit is payable up to 30 visits per covered Accident, per Covered Person. This benefit will not be paid for care received while Confined, routine health examinations or immunizations.

Transportation
Pays $1,000 per round trip when a Covered Person requires Confinement for Injuries sustained in a covered Accident.

This benefit is not payable for transportation to any Medical Facility or Rehabilitation Facility located within a 50 mile radius of the site of the covered Accident or residence of the Covered Person. The local attending Medical Professional must prescribe the Treatment, and the Treatment must not be available locally.

This benefit is payable for up to 3 round trips per Calendar Year, per Covered Person. This benefit is not payable for transportation by ambulance or air or water ambulance.

Prosthesis
Pays $1,000 when a Covered Person requires a Prosthetic Device as a result of Injuries due to a covered Accident. This benefit is not payable for hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per covered Accident, per Covered Person.

Prosthesis Repair/Replace
Pays $1,000 if:

- a Covered Person requires replacement of an existing Prosthetic Device for which benefits were previously paid under the Prosthesis Benefit. The replacement must occur 12 months or more after any previously paid Prosthesis Benefit, or
- a Covered Person sustains damages as a result of Injuries sustained in a covered Accident, which require repair or replacement of an existing Prosthetic Device.

This benefit is not payable for repair or replacement of hearing aids, wigs, or dental aids to include false teeth.

LOSS OF LIFE BENEFIT

Accidental Death
Pays the benefit amount as listed below for a Covered Person's Accidental Death. The Accidental Death must occur within 90 days after the covered Accident.

Accident Type	Benefit Amount
Common-Carrier Accident	
Named Insured or Spouse	$200,000
Child	$50,000

Other Accident	
Named Insured or Spouse	$80,000
Child	$25,000

This benefit is payable once per Covered Person.

SPECIALTY BENEFITS

Automobile and/or Home Modification
Pays $5,000 when a Covered Person suffers a Single Dismemberment, Double Dismemberment, or Permanent Paralysis due to a covered Accident.

This benefit is payable once per covered Accident, per Covered Person.

Preventive Care Benefit
Pays $100 when a Covered Person undergoes routine examinations or other preventive testing during the Calendar Year. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, DEXA Scan, prostate-specific antigen tests (PSAs), and blood screenings. This benefit is payable only once per policy, per Calendar Year. Service must be under the supervision of or recommended by a Medical Professional and received while your policy is in force.

Organized Sporting Activity
Pays $125 when a Covered Person sustains an Injury while participating in an Organized Sporting Activity for which an Initial Accident Treatment benefit is payable.

This benefit is not payable for Injuries that are caused by or occur as a result of a Covered Person's participating in any professional or semi-professional sport or sporting activity; or racing any type of vehicle in an organized event. This benefit is payable once per covered Accident, per Covered Person.

Waiver Of Premium
If you are employed and you, due to Injuries sustained in a covered Accident, are completely unable to do all of the usual and customary duties of your occupation, or if you are not employed: are completely unable to perform two or more of the Activities of Daily Living (ADLs) without Direct Personal Assistance, for more than 90 consecutive days while the policy is in force, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Medical Professional's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Medical Professional's statement that total inability continues.

If you die and your Spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Waiver of Premium Benefits.

(4) OPTIONAL BENEFIT

Line of Duty Benefit Rider:
(Form A38050FL) Applied For: ☐Yes ☐ No

Pays $10,000 when the Named Insured suffers a gunshot wound requiring surgical repair or sustains an Injury for which a Severe Acquired Brain Injury, Dismemberment, Permanent Paralysis, Third-Degree Burn (20% or greater of total body surface), or Accidental Death benefit is payable while in the Line of Duty. This benefit is payable once per covered Accident.

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(5) Exceptions, Reductions and Limitations of the Policy:

Aflac will not pay benefits for services rendered by you.

For any benefit to be payable, the applicable Injury, Treatment, or loss must occur on or after the Effective Date of coverage and while coverage is in force.

Aflac will not pay benefits for treatment or loss due to Sickness including (1) any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness.

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

Aflac may void the policy and will not pay benefits whenever: (1) material facts or circumstances have been concealed or misrepresented in making a claim under the policy; or (2) fraud is committed or attempted in connection with any matter relating to the policy. If you have received benefits that were not contractually due under the policy, then Aflac reserves the right to offset any benefits payable under the policy up to the amount of benefits you received that were not contractually due.

Aflac will not pay benefits for an Injury, treatment, or loss that is caused by or occurs as a result of a Covered Person's:

- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve. When you notify us that you have joined an armed service, at your option, we will suspend your coverage and return any unearned premium on a pro-rata basis.;
- Being intoxicated or under the influence of alcohol, drugs, or any narcotic, unless administered on the advice of a Medical Professional and taken according to the Medical Professional's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the cause of the loss occurred);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Medical Professional and taken according to the Medical Professional's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any detention facility or penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary; or
- Having dental treatment except as a result of Injury.

(6) **Renewability.** The policy is guaranteed renewable for your lifetime as long as you pay the premiums when they are due or within the grace period. We may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. We may change the premium we charge, but not specific to any one person. Any premium change will be made for all policies of the same form number and premium classification in the state where the policy was issued that are then in force.

RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

ACCIDENT: A sudden, unforeseen event or series of events that results in bodily injury.

ACCIDENTAL DEATH: A covered person's death caused by an injury.

ACTIVITIES OF DAILY LIVING (ADLs): Activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing your personal independence in everyday living.

The ADLs are:

- Bathing: Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
- Maintaining continence: Controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- Dressing: Putting on and taking off all necessary items of clothing;
- Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- Eating: Performing all major tasks of getting food into your body.

ACQUIRED BRAIN INJURY: An injury to the brain that is not hereditary, congenital, degenerative, or induced by birth trauma, and that results in a neurological deficit. Acquired brain injury benefit is payable based on the following Glasgow Coma Scale rating:

- Severe: GCS 8 or less or coma diagnosis
- Moderate: GCS 9-12
- Mild: GCS 13-15 or concussion diagnosis

COMMON-CARRIER ACCIDENT: An accident directly involving a common-carrier vehicle in which a covered person is a passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A passenger is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction.

CONFINED/CONFINEMENT: Assignment to a bed in a hospital, intensive care unit, or rehabilitation facility.

COVERED PERSON: Any person insured under the coverage type you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children of the named insured or spouse are automatically covered under the terms of the policy for 60 days from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the newborn child's birth that you want to change your coverage type to one-parent family or two-parent family coverage. If timely notice is given, (1) Aflac may not charge an additional premium for coverage of the newborn child during the first 30 days from the moment of birth and (2) Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage provided under any one-parent family or two-parent family policy will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your children, stepchildren, legally adopted children, children placed with you for adoption, foster children, children in your custodial care pursuant to a court order, or children for whom you are appointed as the legal guardian and who are under age 26. Your grandchildren or your spouse's grandchildren are not covered under the policy unless you or your spouse are their legal guardian. A dependent child (including persons incapable of self-sustaining employment by reason of intellectual or physical disability) must be under age 26 at the time of application to be eligible for coverage.

EFFECTIVE DATE: The date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date may not be the date you requested or the date you signed the application for coverage.

HOSPITAL ADMISSION: Assignment to a bed in any covered unit of a hospital for at least 18 hours; or admission to a hospital as an inpatient.

INJURY: Unexpected and unintended physical damage to a covered person that is a direct result of an accident independent of sickness.

MEDICAL PROFESSIONAL: A person appropriately licensed by the state to provide diagnostic and/or medical care and treatment, including:

- doctor of medicine (MD/DO);
- doctor of dental medicine (DMD) or doctor of dental surgery (DDS);
- nurse practitioners (NP/APRN); or
- physician assistants (PA).

The medical professional must be acting within the scope of their license, relevant board certifications, and qualifications to treat the type of condition for which a claim is made. If required by law, the medical professional must be under the supervision of a licensed doctor of medicine.

ORGANIZED SPORTING ACTIVITY: A competition or supervised organized practice for a competition. The competition must be governed by a set of written rules, be 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.

OTHER ACCIDENT: An accident that is not classified as a common-carrier accident and that is not specifically excluded in the Limitations and Exclusions section.

PERMANENT PARALYSIS: Damage to the brain or spinal cord that results in a diagnosis of permanent monoplegia, diplegia, hemiplegia, triplegia, or quadriplegia.

Types of permanent paralysis include:

- **MONOPLEGIA:** the complete and irreversible total loss of use of a single arm or leg.
- **DIPLEGIA:** the complete and irreversible total loss of use of a combination of two arms or legs.
- **HEMIPLEGIA:** the complete and irreversible total loss of use of one arm and one leg.
- **TRIPLEGIA:** the complete and irreversible total loss of use of a combination of three arms or legs.
- **QUADRIPLEGIA:** the complete and irreversible total loss of use of both arms and both legs.

SICKNESS: An illness, disease, bodily infirmity, bacterial, fungal, parasitic or viral infection, disorder, or condition not caused by an injury.

ADDITIONAL INFORMATION

The term hospital does not include any institution or part thereof used: as a nursing home, rest home, convalescent home, home for the aged, or an assisted living facility; as a transitional care unit; primarily to provide hospice care; as a skilled nursing facility or extended-care facility; primarily to provide custodial, educational, transitional, or rehabilitative care; or primarily to provide for the care and treatment of persons with substance abuse issues/disorders and/or mental or nervous disorder(s).

The term hospital admission does not include assignment to a bed in the emergency room; or confinement in the emergency room; admissions for same day surgical procedures, or admissions for observation.

The term intensive care unit does not include a private monitored room or observation unit.

The term rehabilitation facility does not include a nursing home, rest home, convalescent home, home for the aged, or an assisted living facility; a facility which primarily provides hospice care; or facilities or a wing/ward of a hospital primarily for the care or treatment of persons with substance abuse issues/disorders or mental or nervous disorder(s).

Confinement does not include a bed in an emergency room.

A medical professional does not include a registered nurse (RN) or you.

Acquired brain injuries do not include a medically induced coma for the purpose of surgery or other medical procedure; or a coma which results directly from alcohol or drug use.

Burns will be payable based on the percentage of total body surface burned.

Dislocations and fractures will be payable based on the dislocation and fracture benefit amount shown in the policy. They can be corrected surgically or non-surgically.

Lacerations will be payable based on the laceration benefit amount shown in the policy. A laceration resulting from an open fracture will not be payable under the laceration benefit.

The organized sporting activity benefit is not payable for injuries that are caused by or occur as a result of a covered person's participating in any professional or semi-professional sport or sporting activity; or racing any type of vehicle in an organized event.

Paralysis must be confirmed by a medical professional. The duration of the paralysis must be a minimum of seven days.

Surgical procedures must be performed in a medical facility. The surgery benefit is payable only for procedures not specified elsewhere in the named injury benefits section shown in the policy.

Aflac.

Aflac.

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Aflac. | Rate Sheet

Aflac Accident Insurance | 24-Hour Accident-Only Insurance | Option 3

Biweekly rates

Age Range	Individual	Named Insured / Spouse Only	One Parent Family	Two Parent Family
18 to 75	$14.50	$20.53	$24.62	$31.09

Aflac
Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 3

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac.

THE POLICY 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.

A74375FL RC(3/22)

AFLAC CRITICAL CARE PROTECTION

SPECIFIED HEALTH EVENT INSURANCE – OPTION 3

Policy Series A74000

CCP^3

Critical care for you. Added financial protection for your family.

Aflac's Critical Care Protection policy helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event with additional benefits to be paid for things such as a hospital confinement, intensive care unit confinement, ambulance, transportation, lodging, and therapy. Benefits are also paid for specific heart surgeries, such as heart valve surgery, coronary angioplasty, coronary stent implantation, and pacemaker placement.

All benefits are paid directly to you, unless otherwise assigned, and can be used for any out-of-pocket expenses you have such as car payments, mortgage or rent payments, or utility bills. Aflac Critical Care Protection allows you to help protect the things you love the most from the things you expect the least.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned. Aflac Critical Care Protection is designed to provide you with cash benefits if you experience a specified health event, such as sudden cardiac arrest or end-stage renal failure. This means that you will have added financial resources to help with expenses incurred due to a serious health event, to help with ongoing living expenses, or to help with any purpose you choose.

Aflac Critical Care Protection offers more types of benefits compared to other critical illness coverage on the market:

- Pays $7,500 upon diagnosis of having had a specified health event, which increases to $10,000 for dependent children
- Pays benefits for specified heart surgeries, such as heart valve surgery, coronary angioplasty, coronary stent implantation, pacemaker placement, and many more
- Pays $300 per day for covered hospital stays
- Daily benefits payable for covered hospital intensive care unit and step-down intensive care unit confinements
- Pays benefits for physical therapy, speech therapy, rehabilitation therapy, home health care, and many more
- Transportation and lodging benefits payable for travel to receive treatment
- Guaranteed-renewable for your lifetime with some benefits reduced at age 70–as long as premiums are paid, the policy cannot be canceled

Specified health events covered by the Critical Care Protection policy include:

- Heart Attack
- Stroke
- Coronary Artery Bypass Graft Surgery (CABG)
- Sudden Cardiac Arrest
- Third-Degree Burns
- Coma
- Paralysis
- Major Human Organ Transplant
- End-Stage Renal Failure
- Persistent Vegetative State

Specified Heart Surgery Benefits covered by the Critical Care Protection policy include:

Tier One:

- Heart Valve Surgery
- Surgical Treatment of Abdominal Aortic Aneurysm

Tier Two:

- Coronary Angioplasty
- Transmyocardial Revascularization (TMR)
- Atherectomy
- Coronary Stent Implantation
- Cardiac Catheterization
- Automatic Implantable Cardioverter Defibrillator (AICD) Placement
- Pacemaker Placement

How it works

The above example is based on a scenario for Aflac Critical Care Protection – Option 3 that includes the following benefit conditions: First-Occurrence Benefit (heart attack) of $7,500; Ambulance Benefit (ground ambulance transportation) of $250; Specified Heart Surgery Benefit – Tier Two (Coronary Stent Implantation) of $2,000; Hospital Intensive Care Unit Benefit (4 days) of $3,200; Hospital Confinement Benefit (8 days) of $2,400; Specified Heart Surgery Benefit – Tier One (heart valve surgery) of $4,000; and Continuing Care Benefit (30 days) of $3,750.

Benefits and/or premiums may vary based on state and option level selected. The policy has limitations, exclusions and pre-existing conditions limitations that may affect benefits payable. Riders are available for an additional cost. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy for complete benefit details, definitions, limitations and exclusions.

Aflac Critical Care Protection – Option 3 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
HOSPITAL INTENSIVE CARE UNIT BENEFIT	Days 1–7: $800 per day; Days 8–15: $1,300 per day Limited to 15 days per period of confinement; no lifetime maximum
STEP-DOWN INTENSIVE CARE UNIT BENEFIT	$500 per day; limited to 15 days per period of confinement; no lifetime maximum
PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT	An indemnity of $2 will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date
FIRST-OCCURRENCE BENEFIT: • NAMED INSURED/SPOUSE • DEPENDENT CHILDREN	 $7,500; lifetime maximum $7,500 per covered person $10,000; lifetime maximum $10,000 per covered person
SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT	$3,500; subsequent occurrence limitations apply; no lifetime maximum
SPECIFIED HEART SURGERY BENEFITS	**Tier One:** $4,000 when a covered person undergoes one of the following: • Heart Valve Surgery • Surgical Treatment of Abdominal Aortic Aneurysm **Tier Two:** $2,000 when a covered person undergoes one of the following: • Coronary Angioplasty • Transmyocardial Revascularization (TMR) • Atherectomy • Coronary Stent Implantation • Cardiac Catheterization • Automatic Implantable Cardioverter Defibrillator (AICD) Placement • Pacemaker Placement
	Tier One and Tier Two benefits are payable only once per covered person, per lifetime. Subsequent occurrence limitations apply
SUBSEQUENT TIER ONE SPECIFIED HEART SURGERY BENEFIT	$1,000; subsequent occurrence limitations apply; no lifetime maximum
HOSPITAL CONFINEMENT BENEFIT	$300 per day; no lifetime maximum
CONTINUING CARE BENEFIT	$125 each day when a covered person is charged for any of the following treatments: • Rehabilitation Therapy • Physical Therapy • Speech Therapy • Occupational Therapy • Respiratory Therapy • Dietary Therapy/Consultation • Home Health Care • Dialysis • Hospice Care • Extended Care • Physician Visits • Nursing Home Care Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered specified health event or specified heart surgery. No lifetime maximum
AMBULANCE BENEFIT	$250 ground or $2,000 air; no lifetime maximum
TRANSPORTATION BENEFIT	$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss. Limited to $1,500 per occurrence; no lifetime maximum
LODGING BENEFIT	Up to $75 per day, for covered lodging charges. Limited to 15 days per occurrence; no lifetime maximum
WAIVER OF PREMIUM BENEFIT	Premium waived, from month to month, during total inability (after 180 continuous days)

REFER TO THE OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

LIMITED BENEFIT

AFLAC CRITICAL CARE PROTECTION

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)
Visit our website at aflac.com

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

SPECIFIED HEALTH EVENT INSURANCE
Supplemental Health Insurance Coverage
Outline of Coverage for Policy Form A74300FL

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company.

(1) **Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Specified Health Event Insurance Coverage** is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Specified Health Events or other conditions as specified. Specified Health Events are: Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest. Coverage is provided for the benefits outlined in **(3) Benefits.** The benefits described in **(3) Benefits** may be limited by **(5) Exceptions, Reductions, and Limitations of the Policy.**

(3) **Benefits:**

IMPORTANT: BENEFITS FOR INTENSIVE CARE UNIT CONFINEMENTS REDUCE BY ONE-HALF FOR LOSSES INCURRED ON OR AFTER THE POLICY ANNIVERSARY DATE FOLLOWING THE 70TH BIRTHDAY OF A COVERED PERSON.

While coverage is in force, Aflac will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

BENEFITS FOR INTENSIVE CARE UNIT CONFINEMENTS:

A. **HOSPITAL INTENSIVE CARE UNIT BENEFIT:** Aflac will pay the following benefits when a Covered Person incurs a charge for confinement in a Hospital Intensive Care Unit for a covered Sickness or Injury:

Days 1 – 7:	Days 8 – 15:
Sickness/Injury	Sickness/Injury
$600 per day	$1,300 per day

This benefit is limited to 15 days per Period of Confinement.

The Hospital Intensive Care Unit Benefit is not payable on the same day as the Step-Down Intensive Care Unit Benefit. If a Covered Person is charged for both on the same day, only the highest eligible benefit will be paid. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.

B. **STEP-DOWN INTENSIVE CARE UNIT BENEFIT:** Aflac will pay $500 per day when a Covered Person incurs a charge for confinement in a Step-Down Intensive Care Unit for a covered Sickness or Injury.

This benefit is limited to 15 days per Period of Confinement and is also payable for confinement in a Hospital Intensive Care Unit after exhaustion of benefits payable under the Hospital Intensive Care Unit Benefit.

The Step-Down Intensive Care Unit Benefit is not payable on the same day as the Hospital Intensive Care Unit Benefit. If a Covered Person is charged for both on the same day, only the highest eligible benefit will be paid. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.

C. **PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT:** An indemnity of two dollars will accumulate for the Named Insured and the covered Spouse for each calendar month coverage remains in force after the Effective Date. This accumulated indemnity, if

any, will be paid in addition to the Hospital Intensive Care Unit Benefit and Step-Down Intensive Care Unit Benefit for each day of a Period of Confinement for which benefits are payable. This Progressive Benefit will continue to build, regardless of claims paid, until the policy anniversary date following the 65th birthday of a Covered Person. Any amount accrued at the time this benefit ceases to build for a Covered Person will continue to be added to the benefit amount for all Hospital Intensive Care Unit/Step-Down Hospital Intensive Care Unit confinements commencing prior to the policy anniversary date following the 70th birthday of the Covered Person. **THIS ACCUMULATED BENEFIT REDUCES AT AGE 70.** This accumulated benefit will be reduced by one-half for Hospital Intensive Care Unit/Step-Down Intensive Care Unit confinements commencing on or after the policy anniversary date following the 70th birthday of a Covered Person. **This benefit is not applicable and will not accrue to any Covered Person who has attained age 65 prior to the Effective Date of coverage.** The Named Insured and covered Spouse, if any, are the only persons eligible for this benefit if One-Parent Family or Two-Parent Family coverage is in force. Dependent Children do not qualify for this benefit. When a Spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such Spouse, provided the Spouse has not yet attained age 65.

BENEFITS FOR SPECIFIED HEALTH EVENTS AND/OR SPECIFIED HEART SURGERIES:

D. **FIRST-OCCURRENCE BENEFIT:** Aflac will pay the following benefit amount for each Covered Person when he or she is first diagnosed as having had a Specified Health Event:

Named Insured/Spouse
$7,500 (Lifetime maximum $7,500 per Covered Person)

Dependent Children
$10,000 (Lifetime maximum $10,000 per Covered Person)

This benefit is payable only once per Covered Person, per lifetime.

E. **SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT:** If benefits have been paid to a Covered Person under the First-Occurrence Benefit above, Aflac will pay $3,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event.

For the Subsequent Specified Health Event Benefit to be payable, the subsequent Specified Health Event must occur 180 days or more after the occurrence of any previously paid Specified Health Event for such Covered Person. No lifetime maximum.

F. **SPECIFIED HEART SURGERY BENEFITS:** Aflac will pay the amount shown below when a Covered Person undergoes one of the following:

1. **TIER ONE $4,000:**
   a. Heart Valve Surgery
   b. Surgical Treatment of Abdominal Aortic Aneurysm

   The Tier One benefit is payable only once per Covered Person, per lifetime.

2. **TIER TWO $2,000:**
   a. Coronary Angioplasty
   b. Transmyocardial Revascularization (TMR)
   c. Atherectomy
   d. Coronary Stent Implantation
   e. Cardiac Catheterization
   f. Automatic Implantable Cardioverter Defibrillator (AICD) Placement
   g. Pacemaker Placement

   The Tier Two benefit is payable only once per Covered Person, per lifetime.

For Specified Heart Surgery Benefits to be payable for both a Tier One and a Tier Two Specified Heart Surgery, the subsequent surgery must occur 180 days or more after the occurrence of the previously paid Specified Heart Surgery for such Covered Person. If a Tier One and a Tier Two Specified Heart Surgery are performed at the same time, only the highest eligible benefit will be paid.

G. **SUBSEQUENT TIER ONE SPECIFIED HEART SURGERY BENEFIT:** If benefits have been paid for a Tier One Specified Heart Surgery, Aflac will pay $1,000 if such Covered Person has a subsequent Tier One Specified Heart Surgery.

For the Subsequent Tier One Specified Heart Surgery Benefit to be payable, the subsequent Tier One Specified Heart Surgery must occur 180 days or more after the occurrence of any previously paid Tier One or Tier Two Specified Heart Surgery for such Covered Person. No lifetime maximum.

H. **HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a Covered Person requires Hospital Confinement for the treatment of a covered Specified Health Event or Specified Heart Surgery, Aflac will pay $300 per day for each day a Covered Person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Specified Health Event or Specified Heart Surgery that occur within 500 days following the occurrence of the**

most recent covered Specified Health Event or Specified Heart Surgery. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Specified Health Event or Specified Heart Surgery at a time per Covered Person. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

This benefit is not payable on the same day as the Continuing Care Benefit. The highest eligible benefit will be paid.

I. **CONTINUING CARE BENEFIT:** If, as the result of a covered Specified Health Event or Specified Heart Surgery, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay $125 each day a Covered Person is charged:

1. rehabilitation therapy
2. physical therapy
3. speech therapy
4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
7. home health care
8. dialysis
9. hospice care
10. extended care
11. Physician visits
12. nursing home care

This benefit is payable for only one covered Specified Health Event or Specified Heart Surgery at a time per Covered Person and is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Specified Health Event or Specified Heart Surgery. Daily maximum for this benefit is $125 regardless of the number of treatments received.

This benefit is not payable on the same day as the Hospital Confinement Benefit. The highest eligible benefit will be paid. No lifetime maximum.

OTHER BENEFITS:

J. **AMBULANCE BENEFIT:** If, due to a covered Loss, a Covered Person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250. If air ambulance transportation is required due to a covered Loss, we will pay $2,000. A licensed professional ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Loss.

This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.

The Transportation and Lodging Benefits will be paid for care received within 180 days following the occurrence of a covered Loss. Benefits are payable for only one covered Loss at a time per Covered Person. If a Covered Person is eligible to receive benefits for more than one covered Loss, we will pay benefits only for care received within the 180 days following the occurrence of the most recent covered Loss.

K. **TRANSPORTATION BENEFIT:** If a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Loss, Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a Covered Person for the round-trip distance between the Hospital or medical facility and the residence of the Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Loss. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Loss. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.**

L. **LODGING BENEFIT:** Aflac will pay the charges incurred up to $75 per day for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives special medical treatment for a covered Loss at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Loss.

This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.

M. **WAIVER OF PREMIUM BENEFIT:**

Employed: If you, due to a covered Specified Health Event, are completely unable to do all of the usual and customary duties of your occupation for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

Not Employed: If you, due to a covered Specified Health Event, are completely unable to perform three or more of

the Activities of Daily Living (ADLs) without Direct Personal Assistance for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your Spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

(4) Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Form A74050FL) Applied for ❑ Yes ❑ No

The First-Occurrence Benefit, as defined in the policy, will be increased by $500 on each rider anniversary date while the rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person's 65th birthday or at the time of a Specified Health Event, subject to the Limitations and Exclusions of the policy, for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of the rider, this benefit will accrue for a period of at least five years unless a Specified Health Event is diagnosed prior to the fifth year of coverage. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of benefits.)

SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Form A74051FL) Applied for ❑ Yes ❑ No

SPECIFIED HEALTH EVENT RECOVERY: A Covered Person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Specified Health Event OR he or she is unable to engage in the duties of his or her regular occupation due to a covered Specified Health Event. "Specified Health Event" includes Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage under the rider. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of lifetime maximum benefits.)

SPECIFIED HEALTH EVENT RECOVERY BENEFIT: Aflac will pay $500 per month while a Covered Person remains in Specified Health Event Recovery upon receipt of written proof of Loss from that person's Physician.

Lifetime maximum of six months per Covered Person.

(5) Exceptions, Reductions, and Limitations of the Policy (not a daily hospital expense plan):

A. The Benefits for Intensive Care Unit Confinements will be reduced by one-half for confinements that begin on or after the policy anniversary date following the 70th birthday of a Covered Person.

B. The Benefits for Intensive Care Unit Confinements are not payable for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, private monitored rooms, observation units located in emergency room or outpatient surgery units, or other facilities that do not meet the standards for a Hospital Intensive Care Unit or Step-Down Intensive Care Unit. The Hospital Intensive Care Unit Benefit is not payable for confinement in progressive care units or intermediate care units.

C. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.

D. Aflac will not pay benefits for any Loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.

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

F. For any benefit to be payable, the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Specified Health Event per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

G. **The policy does not cover Losses or confinements caused by or resulting from:**

1. Being intoxicated or under the influence of alcohol, drugs, or any narcotic, unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the cause of the Loss occurred);

2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted ("felony" is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any detention facility or penal institution;
4. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event;
5. Intentionally self-inflicting a bodily Injury or committing or attempting suicide, while sane or insane;
6. Having elective surgery within the first 12 months of the Effective Date of coverage; or
7. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

PRE-EXISTING CONDITION LIMITATIONS: A "Pre-existing Condition" is an illness, disease, infection, disorder, or Injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits will not be payable for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the Pre-existing Conditions Limitations, exclusive of any applicable waiting periods under the new coverage.

(6) **Renewability:** The policy is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term, with some benefits reduced beginning at age 70, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of material fact relating in any way to the policy, including claims for benefits under the policy. Premium rates may change only if changed on all policies of the same form number and class in force in your state (in which the policy was sold).

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
2. Maintaining continence: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
3. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
4. Dressing: putting on and taking off all necessary items of clothing;
5. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
6. Eating: performing all major tasks of getting food into your body.

ATHERECTOMY: the opening of blocked coronary arteries or vein grafts by use of a device on the end of a catheter to cut or shave away atherosclerotic plaque.

AUTOMATIC IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (AICD) PLACEMENT: the initial surgical implantation of the AICD. An AICD is a small battery-powered device that is placed under the skin to detect abnormal heart rhythm and restore a normal heartbeat by delivering a brief low-energy or high-energy electrical shock to the heart.

CARDIAC CATHETERIZATION: the insertion of a thin flexible tube through a major blood vessel and threaded to the heart for diagnostic or interventional purposes.

COMA: a continuous state of profound unconsciousness lasting for a period of seven or more consecutive days and characterized by the absence of: (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term coma does not include any medically induced coma. The coma must begin on or after the effective date of coverage and while coverage is in force for benefits to be payable.

CORONARY ANGIOPLASTY: a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart (coronary arteries). This procedure may be performed with or without stents.

CORONARY ARTERY BYPASS GRAFT SURGERY (CABG): open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

CORONARY STENT IMPLANTATION: the permanent placement of a small wire mesh tube or coil implanted in a narrowed part of a coronary artery to act as a scaffold to keep the artery open and decrease the chance of it narrowing again.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. If notice is given, Aflac may not charge an additional premium for the coverage of the child for the notice period. If the timely notice is not given, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. If notice is given within 60 days of the birth, Aflac will not deny coverage for a child due to your failure to timely notify us of the birth. One-parent family or two-parent family coverage will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, legally adopted children, foster children, or children in your custodial care who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date **is not** the date you signed the application for coverage.

END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature.

HEART ATTACK: a myocardial infarction. The attack must be positively diagnosed (includes post-mortem diagnosis by autopsy) by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system. The heart attack must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable. Sudden cardiac arrest is not a heart attack.

HEART VALVE SURGERY: a cardiac surgical procedure in which a patient's mitral or aortic heart valve is repaired or replaced by a different valve, including human, nonhuman, or mechanical valves.

HOSPITAL: an institution licensed as a hospital and operated pursuant to the law, which is accredited by the Joint Commission on the Accreditation of Hospitals or American Osteopathic Association, that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term hospital also includes ambulatory surgical centers. The term hospital does not include any institution or part thereof used as an emergency room; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a hospital for a period of 23 hours or more for which a room charge is made. The hospital confinement must be on the advice of a physician. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

HOSPITAL INTENSIVE CARE UNIT: specifically designated facility of the hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The hospital intensive care unit must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the hospital intensive care unit on a full-time basis. These units must be listed as hospital intensive care units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Hospital intensive care unit, (2) Cardiac intensive care unit, and (3) Infant (neonatal) intensive care unit. **Hospital intensive care unit does not include tissue, cell or fluid transplants, or units such as:** telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

LOSS: a specified health event, specified heart surgery, or confinement in a hospital intensive care unit or step-down intensive care unit occurring or beginning on or after the effective date of coverage and while coverage is in force.

MAJOR HUMAN ORGAN TRANSPLANT: a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. **This does not include transplants involving mechanical or nonhuman organs.**

PACEMAKER PLACEMENT: the initial surgical implantation of a pacemaker. A pacemaker is a small battery-powered device placed under the skin that sends low-energy electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart.

PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord injury. The paralysis must be confirmed by the attending physician. The spinal cord injury causing the paralysis must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable.

PERIOD OF CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital intensive care unit or a step-down intensive care unit. Confinements must begin on or after the effective date of coverage and while coverage is in force. **Covered confinements not separated by 30 days or more from a previously covered confinement are considered a continuation of the previous period of confinement.**

PERSISTENT VEGETATIVE STATE: a state of severe mental impairment in which only involuntary bodily functions are present for a continuous period of at least 30 days and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, shall certify in writing, based upon conditions found during the course of their examination, that:

1. The covered person's cognitive function has been substantially impaired; and
2. There exists no reasonable expectation that the covered person will regain significant cognitive function.

PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your immediate family, who is licensed as a physician by the state where treatment is received to treat the type of condition for which a claim is made.

SPECIFIED HEALTH EVENT: heart attack, stroke, end-stage renal failure, major human organ transplant, third-degree burns, persistent vegetative state, coma, paralysis, coronary artery bypass graft surgery (CABG), or sudden cardiac arrest.

SPECIFIED HEART SURGERY: any of the following procedures:

- **TIER ONE:** heart valve surgery or surgical treatment of abdominal aortic aneurysm.
- **TIER TWO:** coronary angioplasty, atherectomy, coronary stent implantation, cardiac catheterization, Automatic Implantable Cardioverter Defibrillator (AICD) Placement, pacemaker placement, or Transmyocardial Revascularization (TMR).

STEP-DOWN INTENSIVE CARE UNIT: specifically designated facility of the hospital that provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility must also be separate and apart from other hospital areas, permanently equipped with telemetry equipment, and under constant and continual observation by specially trained nursing staff assigned exclusively to that area. **A step-down intensive care unit does not include:** telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate room with or without telemetry monitoring equipment; emergency rooms; or labor or delivery rooms.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed (includes post-mortem diagnosis by autopsy) by a physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), cerebrovascular insufficiency, or lacunar infarction (LACI).

SUDDEN CARDIAC ARREST: sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the sole cause of death shown on the death certificate is cardiovascular collapse, sudden cardiac arrest, cardiac arrest, or sudden cardiac death shall be deemed to be sudden cardiac arrest for purposes of the policy. Sudden cardiac arrest is not a heart attack.

SURGICAL TREATMENT OF ABDOMINAL AORTIC ANEURYSM: a surgical procedure to prevent aneurysm rupture consisting of opening the abdomen, finding the aorta, and removing (excising) the aneurysm.

TRANSMYOCARDIAL REVASCULARIZATION (TMR): a surgical procedure in which a laser is used to create small channels in the heart muscle, improving blood flow in the heart.

THIRD-DEGREE BURNS: an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals. This does not include skin abrasions caused by falling on and scraping skin on asphalt, concrete, or any other surface.

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Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Aflac.

Rate sheet prepared by Web User on 7/25/2023 5:10:59 PM.
Florida Payroll Premium rates are Biweekly for industry Class B.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CRITICAL CARE PROTECTION POLICY - Series A74300

Individual

Age	Premium	Total
18-35	$7.80	$7.80
36-45	$11.04	$11.04
46-55	$16.32	$16.32
56-70	$22.56	$22.56

One Parent Family

Age	Premium	Total
18-35	$13.26	$13.26
36-45	$15.66	$15.66
46-55	$20.16	$20.16
56-70	$28.44	$28.44

Insured/Spouse

Age	Premium	Total
18-35	$15.00	$15.00
36-45	$19.86	$19.86
46-55	$30.54	$30.54
56-70	$43.56	$43.56

Two Parent Family

Age	Premium	Total
18-35	$16.98	$16.98
36-45	$21.60	$21.60
46-55	$32.40	$32.40
56-70	$46.62	$46.62

Aflac
Choice

HOSPITAL CONFINEMENT INDEMNITY INSURANCE – OPTION 1

We've been dedicated to helping provide
peace of mind and financial security
for more than 60 years.

Aflac.

THE POLICY 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.

B40175RFL IC(1/23)

AFLAC CHOICE

HOSPITAL CONFINEMENT INDEMNITY INSURANCE – OPTION 1

Policy Series B40000

HC

Your benefits. Your way.

Like most Americans, you may feel that financial well-being isn't much of a reality these days. With inflation and health care costs on the rise, consumers of all incomes may be struggling to make ends meet. And since health insurance was never really designed to cover all the costs of medical care, an unplanned visit to the hospital could leave you with unexpected medical bills, only adding to financial struggles.

Aflac Choice offers a wide variety of options so you can customize hospital benefits based on your unique needs and budget - to help with out-of-pocket expenses associated with doctor visits, hospitalizations, and mental health treatment, including counseling and urgent care.[1]

Here's how Aflac can help

Aflac pays you cash to help with the expenses not covered by health insurance, so you can worry less about making ends meet when you're left with unexpected medical bills.

Why Aflac Choice may be right for you

- It's customizable. You choose the plan that's right for you based on your specific needs.
- Guaranteed-issue options available—that means there is no medical questionnaire required.[2]
- We pay cash directly to you (unless otherwise assigned)—not the doctor or hospital.

[1] The Extended Benefits Rider pays a benefit for visits (including telemedicine) to a physician, psychologist or urgent care center.
[2] Subject to certain conditions.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned, for covered hospital expenses. We provide you with financial resources to help you overcome some of the unexpected expenses associated with a visit to the hospital, giving you less to worry about so you can focus your energy on getting better.

How it works

The above example is based on four scenarios. **Choice 1 Scenario:** Policyholder has the Aflac Choice policy only; includes a Hospital Confinement Benefit of $1,500 and a Hospital Emergency Room Benefit of $100. **Choice 2 Scenario:** Policyholder has the Aflac Choice policy plus the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus an Initial Assistance Benefit of $100, a Surgery Benefit (appendectomy) of $200, and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days). **Choice 3 Scenario:** Policyholder has the Aflac Choice policy plus the Extended Benefits Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, and an Ambulance Benefit of $200 (ground). **Choice 4 Scenario:** Policyholder has the Aflac Choice policy plus both the Extended Benefits Rider and the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, an Ambulance Benefit of $200 (ground), an Initial Assistance Benefit of $100, a Surgery Benefit (appendectomy) of $200, and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days).

Benefits and/or premiums may vary based on state and benefit option selected. The policy has limitations, exclusions, and pre-existing condition limitations that may affect benefits payable. Riders are available for an additional cost. The policy may contain a waiting period. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations and exclusions.

For more information, ask your insurance agent/producer, call 1.800.992.3522, or visit aflac.com.

Benefits overview Choose the Policy and Riders that Fit Your Needs

BENEFIT:	DESCRIPTION:
HOSPITAL CONFINEMENT	Pays $500; $1,000; $1,500; or $2,000. You choose the benefit amount at the time of application. Payable once per calendar year, per covered person.
MENTAL ILLNESS FACILITY CONFINEMENT	Pays $500; $1,000; $1,500; or $2,000. Payable once per period of mental illness facility confinement, per calendar year, per covered person. The hospital confinement benefit and the mental illness facility confinement benefit are not payable in the same calendar year.
REHABILITATION FACILITY	Pays $100 per day; limited to 15 days per confinement. Limited to 30 days per calendar year, per covered person.
HOSPITAL EMERGENCY ROOM	Pays $100 for treatment in a hospital emergency room. Limited to 2 payments per calendar year, per covered person.
HOSPITAL SHORT-STAY	Pays $100 for hospital stays of less than 18 hours. Limited to 2 payments per calendar year, per policy.
WAIVER OF PREMIUM	Yes
OPTIONAL RIDERS:	**DESCRIPTION:**
EXTENDED BENEFITS RIDER	**Physician Visit Benefit:** Pays $25 for visits (including telemedicine) to a physician, psychologist or urgent care center.
	Individual Coverage: Limited to 3 visits per calendar year, per policy. / **Insured/Spouse & Family Coverage:** Limited to 6 visits per calendar year, per policy.
	Laboratory Test and X-Ray Benefit: Pays $35; limited to 2 payments per covered person, per calendar year. **Medical Diagnostic and Imaging Exams Benefit:** Pays $150 for a covered exam; limited to 2 exams per covered person, per calendar year. Benefits payable for a variety of medical diagnostic and imaging exams, including sleep studies. **Ambulance Benefit:** Pays $200 (ground) or $2,000 (air) for transportation to or from a hospital. The benefit is limited to two trips, per calendar year, per covered person.
HOSPITAL STAY AND SURGICAL CARE RIDER	**Initial Assistance Benefit:** Pays $100 once per calendar year, per rider, when a covered person requires a hospital admission. **Surgery Benefit:** Pays $50-$1,000 for a covered surgery. Limited to one payment per 24-hour period, per covered person. **Invasive Diagnostic Exams Benefit:** Pays $100 for one covered exam, per covered person, per 24-hour period. **Hospital Intensive Care Unit Confinement Benefit:** Pays $500 per day, per covered person, for up to 30 days. **Daily Hospital Confinement Benefit:** Pays $100 per day, per covered person, for up to 365 days. **Daily Mental Illness Facility Confinement Benefit:** Pays $100 per day. Limited to 30 days per period of confinement, per calendar year, per covered person. **Second Surgical Opinion Benefit:** Pays $50 once per covered person, per calendar year.

Refer to the outline of coverage and policy for complete benefit details, definitions, limitations and exclusions.

AFLAC CHOICE COVERAGE

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, HOSPITAL CONFINEMENT INDEMNITY INSURANCE
Outline of Coverage for Policy Form Series B40100

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" furnished by Aflac.

(1) **Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Hospital Confinement Indemnity Coverage:** The policy provides coverage in the form of a fixed benefit during periods of hospitalization or care resulting from Sickness or Injury, subject to any limitations set forth in your policy. It does not provide any benefits other than the fixed indemnity for Hospital Confinement or Mental Illness Facility Confinement and any additional benefits described below.

(3) **Benefits:** Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital or U.S. government Mental Illness Facility does not require a charge for benefits to be payable.

A. **HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay $[_____] when a Covered Person requires Hospital Confinement for 18 or more hours for a covered Sickness or Injury and a room charge is incurred. This benefit is payable once per Calendar Year, per Covered Person. No lifetime maximum.

The Hospital Confinement Benefit and the Rehabilitation Facility Benefit are not payable on the same day. The highest eligible benefit will be paid.

The Hospital Confinement Benefit and the Mental Illness Facility Confinement Benefit are not payable in the same Calendar Year.

B. **MENTAL ILLNESS FACILITY CONFINEMENT BENEFIT:** Aflac will pay $[_____] when a Covered Person requires Mental Illness Facility Confinement for 18 consecutive hours or more for a covered Mental Illness and a room charge is incurred. This benefit is payable once per Period of Mental Illness Facility Confinement, per Calendar Year, per Covered Person. No lifetime maximum.

The Hospital Confinement Benefit and the Mental Illness Facility Confinement Benefit are not payable in the same calendar year.

C. **REHABILITATION FACILITY BENEFIT:** Aflac will pay $100 per day when a Covered Person is confined in a Hospital and is transferred to a room in a Rehabilitation Facility for treatment of a covered Sickness or Injury and a charge is incurred each day for such treatment. This benefit is limited to 15 days per Period of Hospital Confinement and is limited to a Calendar Year maximum of 30 days, per Covered Person. No lifetime maximum.

The Rehabilitation Facility Benefit and the Hospital Confinement Benefit are not payable on the same day. The highest eligible benefit will be paid.

D. **HOSPITAL EMERGENCY ROOM BENEFIT:** Aflac will pay $100 when a Covered Person receives treatment for a covered Sickness or Injury in a Hospital Emergency Room, including triage, and a charge is incurred for such treatment. This benefit is payable twice per Calendar Year, per Covered Person. No lifetime maximum.

The Hospital Emergency Room Benefit and the Hospital Short-Stay Benefit are not payable on the same day.

E. **HOSPITAL SHORT-STAY BENEFIT:** Aflac will pay $100 when a Covered Person receives treatment for a covered Sickness or Injury in a Hospital, including an observation room, or an Ambulatory Surgical Center, for a period of less than 18 hours and a charge is incurred for such treatment. This benefit is not payable for

treatment received in a Hospital Emergency Room or Urgent Care Center. This benefit is payable twice per Calendar Year, per policy. No lifetime maximum.

The Hospital Short-Stay Benefit and the Hospital Emergency Room Benefit are not payable on the same day.

F. **WAIVER OF PREMIUM BENEFIT:** Upon written notice, Aflac will waive from month to month any premium(s) falling due during a continued Period of Hospital Confinement or Period of Mental Illness Facility Confinement for the Named Insured only. This benefit will begin after the Period of Hospital Confinement or Period of Mental Illness Facility Confinement for the Named Insured has exceeded 30 consecutive days. When such continued Period of Hospital Confinement or Period of Mental Illness Facility Confinement has ended, premium payments must be resumed. Once premium payments are resumed, any new Period of Hospital Confinement or Period of Mental Illness Facility Confinement must again satisfy the 30-day continued confinement for premiums to be waived.

If you die and your Spouse becomes the new Named Insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

(4) Optional Benefits:

EXTENDED BENEFITS RIDER: (SERIES B40050) Applied for ❑ Yes ❑ No

Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

A. **PHYSICIAN VISIT BENEFIT:** Aflac will pay $25 when a Covered Person incurs a charge for a visit (including a Telemedicine Visit) to a Physician, Psychologist, or Urgent Care Center. Services must be under the supervision of a Physician or Psychologist. If the Type of Coverage for the policy is Individual, the benefit is limited to three visits per Calendar Year, per policy. If the Type of Coverage is Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family, the benefit is limited to a total of six visits per Calendar Year, per policy. No lifetime maximum.

The Sickness or Injury of a Covered Person is not required for the Physician Visit Benefit to be payable. This benefit is not subject to the Pre-existing Condition Limitations or Limitations and Exclusions section of the policy. No lifetime maximum.

B. **LABORATORY TEST AND X-RAY BENEFIT:** Aflac will pay $35 when a Covered Person requires, and incurs a charge for, a laboratory test or an X-ray. The laboratory test or X-ray must be performed in a Hospital, Medical Diagnostic Imaging Center, Physician's office, an Urgent Care Center, or an Ambulatory Surgical Center. This benefit is limited to two payments per Covered Person, per Calendar Year. **The Laboratory Test and X-Ray Benefit is not payable for exams listed in the Medical Diagnostic and Imaging Exams Benefit.** No lifetime maximum.

The Sickness or Injury of a Covered Person is not required for the Laboratory Test and X-ray Benefit to be payable. This benefit is not subject to the Pre-existing Condition Limitations or Limitations and Exclusions section of the policy. No lifetime maximum.

C. **MEDICAL DIAGNOSTIC AND IMAGING EXAMS BENEFIT:** Aflac will pay $150 when a Covered Person requires, and incurs a charge for, one of the following exams: computerized tomography (CT or CAT scan), magnetic resonance imaging (MRI), electroencephalogram (EEG), Sleep Study, thallium stress test, myelogram, angiogram, or arteriogram. These exams must be performed in a Hospital, Medical Diagnostic Imaging Center, Physician's office, Sleep Center, an Urgent Care Center, or an Ambulatory Surgical Center. This benefit is limited to two payments per Calendar Year, per Covered Person. No lifetime maximum.

D. **AMBULANCE BENEFIT:** Aflac will pay $200 if, due to a covered Sickness or Injury, a Covered Person requires, and incurs a charge for, ground ambulance transportation to or from a Hospital. If a Covered Person requires, and incurs a charge for, air ambulance transportation to or from a Hospital due to a covered Sickness or Injury, Aflac will pay $2,000. A licensed professional ambulance company must provide the ambulance service. The Ambulance Benefit is limited to two trips per Calendar Year, per Covered Person. No lifetime maximum.

HOSPITAL STAY AND SURGICAL CARE RIDER: (SERIES B40051) Applied for ❑ Yes ❑ No

Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in

force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital or U.S. government Mental Illness Facility does not require a charge for benefits to be payable.

A. **INITIAL ASSISTANCE BENEFIT:** Aflac will pay $100 when a Covered Person requires a Hospital Admission. This benefit is payable once per Calendar Year, per rider. No lifetime maximum. This benefit is not subject to the Pre-existing Condition Limitations or the Limitations and Exclusions section of the policy. **Payment of this benefit is based solely on a Covered Person's Hospital Admission, as defined in the rider. Any additional benefits that may be due as a result of a Hospital Admission remain subject to the terms of the policy, including any limitations and/or exclusions.**

B. **SURGERY BENEFIT:** Aflac will pay according to the benefits in the Schedule of Operations in the rider when, due to a covered Sickness or Injury, a Covered Person has a surgical procedure, including a vaginal or cesarean delivery, performed in a Hospital or an Ambulatory Surgical Center and a charge is incurred for such surgical procedure. If any surgical procedure for the treatment of the covered Sickness or Injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the surgical procedure most nearly similar in severity and gravity. **The Surgery Benefit is only payable one time per 24-hour period, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. The Surgery Benefit and the Invasive Diagnostic Exams Benefit are not payable on the same day. The highest eligible benefit will be paid. No lifetime maximum.**

IMPORTANT: The Surgery Benefit is not payable for surgical procedures performed in a Physician's or dentist's office, a clinic, or other such location.

C. **INVASIVE DIAGNOSTIC EXAMS BENEFIT:** Aflac will pay $100 when a Covered Person requires one of the following exams, with or without biopsy, and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, endoscopy, gastroscopy, laparoscopy, laryngoscopy, sigmoidoscopy, or esophagoscopy. These exams must be performed in a Hospital or an Ambulatory Surgical Center. This benefit is limited to one exam per Covered Person, per 24-hour period. No lifetime maximum.

The Invasive Diagnostic Exams Benefit and the Surgery Benefit are not payable on the same day. The highest eligible benefit will be paid.

D. **HOSPITAL INTENSIVE CARE UNIT CONFINEMENT BENEFIT:** Aflac will pay $500 per day when a Covered Person incurs a room charge for a Period of Hospital Intensive Care Unit Confinement for a covered Sickness or Injury. This benefit is payable in addition to the Hospital Confinement Benefit and the Daily Hospital Confinement Benefit. The maximum benefit period for any one Period of Hospital Intensive Care Unit Confinement is 30 days. No lifetime maximum.

E. **DAILY HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay $100 per day for the Period of Hospital Confinement when a Covered Person requires Hospital Confinement for a covered Sickness or Injury and a room charge is incurred. This benefit is payable in addition to the Hospital Confinement Benefit. The maximum benefit period for any one Period of Hospital Confinement is 365 days. No lifetime maximum.

F. **SECOND SURGICAL OPINION BENEFIT:** Aflac will pay $50 when a charge is incurred for a second surgical opinion by a Physician concerning surgery for a covered Sickness or Injury. This benefit is payable once per Calendar Year, per Covered Person. No lifetime maximum.

G. **DAILY MENTAL ILLNESS FACILITY CONFINEMENT BENEFIT:** Aflac will pay $100 per day when a Covered Person requires Mental Illness Facility Confinement for 18 consecutive hours or more in a Mental Illness Facility and a room charge is incurred each day for such confinement. This benefit is limited to 30 days per Period of Mental Illness Facility Confinement, per Calendar Year, per Covered Person. No lifetime maximum.

The Daily Hospital Confinement Benefit and the Daily Mental Illness Treatment Facility Confinement Benefit are not payable on the same day.

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(5) Exceptions, Reductions, and Limitations of the Policy (policy is not a daily hospital expense plan):

A. Aflac will not pay benefits for care or treatment that is: (1) caused by a Pre-existing Condition, unless it begins more than 12 months after the Effective Date of coverage, or (2) received prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any illness, disease, infection, disorder, or condition that is medically evaluated, diagnosed, or treated by a Physician or Mental Health Provider before coverage has been in force 30 days, unless the loss begins more than 12 months after the Effective Date of coverage.

C. Benefits for a covered Sickness for all persons added to the policy (including newborns) are subject to a 30-day waiting period. Aflac will waive the waiting period for newborns added after the policy has been in force for ten full months.

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

E. Aflac will not pay benefits whenever fraud is committed in making a claim under the coverage. If you have received benefits that were not contractually due under the coverage, then Aflac reserves the right to offset any benefits payable under the coverage up to the amount of benefits you received that were not contractually due.

F. The policy does not cover losses caused by or resulting from:

1. Giving birth within the first ten months of the Effective Date of coverage; or pregnancy in existence prior to the Effective Date of coverage, including any resulting Complications of Pregnancy or maternal-fetal intervention procedure. For pregnancy beginning on or after the Effective Date of coverage, Complications of Pregnancy are covered to the same extent as a Sickness;
2. Receiving routine nursing or routine well-baby care for a newborn child;
3. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any type of poison or inhaling any type of gas or fumes;
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being detained in any detention facility or penal institution;
5. Being intoxicated or under the influence of alcohol, drugs, or any narcotic, unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the cause of the loss occurred);
6. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
7. Having dental treatment, except as a result of Injury;
8. Having cosmetic surgery;
9. Having elective surgery within the first 12 months of the Effective Date of coverage;
10. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
11. Actively participating in a riot, insurrection, or terrorist activity; or
12. Donating an organ within the first 12 months of the Effective Date of coverage.

A "Pre-existing Condition" is an illness, disease, infection, disorder, condition, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, advice, consultation, or treatment was recommended or received, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

If the coverage is a replacement of similar coverage, we will give credit for the period of time the person was covered under the previous coverage, if the previous coverage was continuously in force to a date not more than 62 days before the Effective Date of the new coverage, when determining the Pre-existing Condition Limitations, exclusive of any applicable waiting periods under the new coverage.

(6) **Renewability:** The policy is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact relating in any way to the policy, including claims for benefits under

the policy. Aflac may change the established premium rate, but only if the rate is changed for all policies of the same form number and premium classification in the state in which the policy was sold that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 45 days before the change becomes effective.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

COVERED PERSON: Any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children) or two-parent family (named insured, spouse and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured for 30 days from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child beyond the first 30 days, you must notify Aflac in writing within 31 days of the child's birth that you want to change your coverage type to one-parent family or two-parent family coverage. If timely notice is given, (1) Aflac may not charge an additional premium for coverage of the newborn child during the first 30 days from the moment of birth and (2) Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. If notice is given within 60 days of the birth, Aflac will not deny coverage for a child due to failure to timely notify us of the birth. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability and who became so disabled prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, legally adopted children, foster children, or children in your custodial care pursuant to a court order who are under 26. All health insurance benefits applicable for children shall be payable with respect to a foster child or other child in court-ordered temporary or other custody of a covered person, prior to the child's 18th birthday. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

EFFECTIVE DATE: The date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date is not the date you signed the application for coverage.

HOSPITAL CONFINEMENT: A stay of a covered person confined to a bed in a hospital for 18 or more hours for which a room charge is made. The hospital confinement must be the result of a covered sickness or injury.

INJURY: A bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity or any other cause. An injury must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable. See the Limitations and Exclusions section for injuries not covered by the policy.

MENTAL ILLNESS: A psychiatric or psychological condition including but not limited to the following: schizophrenia; bipolar disorders; depressive disorders; anxiety disorders; eating disorders; post-traumatic stress; and substance and alcohol use disorders.

MENTAL ILLNESS FACILITY CONFINEMENT: A stay of a covered person confined to a mental illness facility for 18 consecutive hours or more for which a room charge is made. The mental illness facility confinement must be the result of a covered mental illness.

PERIOD OF HOSPITAL CONFINEMENT: The number of days a covered person is assigned to and incurs a charge for a room in a hospital. Confinements must begin while coverage under the policy is in force. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: The number of days a covered person is assigned to and incurs a charge for a room in a hospital intensive care unit. Confinements must begin while coverage under the rider is in force. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF MENTAL ILLNESS FACILITY CONFINEMENT: The number of days a covered person is confined to, and incurs a charge for, a room in a mental illness facility. Confinements must begin while coverage is in force. Confinement that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement. Confinement not separated by at least 30 days will be considered one confinement.

SICKNESS: An illness, disease, infection, disorder or condition not caused by an injury, medically evaluated, diagnosed or treated by a physician or mental health provider more than 30 days after the effective date of coverage and while coverage is in force.

ADDITIONAL INFORMATION

An ambulatory surgical center does not include a physician's or dentist's office, a clinic or other such location.

The term hospital does not include any institution or part thereof used as an emergency room; a rehabilitation facility; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

The term hospital intensive care unit does not include units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

The term hospital emergency room does not include urgent care centers.

The term mental illness does not include Alzheimer's disease or similar forms of senility or senile dementia. Covered loss resulting from Alzheimer's disease, or similar forms of senility or senile dementia will be covered to the same extent as any other sickness.

The term mental illness facility does not include any institution or part thereof used as a school or a custodial, recreational, or training institution.

The term rehabilitation facility does not include a hospice unit, including: any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care or treatment for persons suffering from mental disease or disorders, care for the aged or care for persons addicted to drugs or alcohol.

The term urgent care center does not include hospital emergency rooms.

Admissions into the emergency room of a hospital, admissions for same day surgical procedures or admissions for observation are not considered a hospital admission.

A physician or mental health provider is not you or a member of your immediate family.

The policy does not cover losses caused by or resulting from giving birth within the first ten months of the effective date of coverage; or pregnancy in existence prior to the effective date of coverage, including any resulting complications of pregnancy or maternal-fetal intervention procedure. For pregnancy beginning on or after the effective date of coverage, complications of pregnancy are covered to the same extent as a sickness. Complications of pregnancy do not include any of the following: premature delivery, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Cesarean deliveries are not considered complications of pregnancy. For pregnancy beginning on or after the effective date of coverage, complications of pregnancy are covered to the same extent as a sickness, subject to the Limitations and Exclusions.

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Aflac.

Rate sheet prepared by Web User on 7/25/2023 5:11:39 PM.
Florida Payroll Premium rates are Biweekly for industry Class B.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

AFLAC HOSPITAL CHOICE - Option 1 Benefit Amount 1000 - Series B40100

		Premium	EBR	Total
18-49	INDIVIDUAL	$12.48	$5.40	$17.88
50-59		$12.72	$6.12	$18.84
60-75		$13.08	$6.18	$19.26
18-49	INSURED/SPOUSE	$17.70	$11.34	$29.04
50-59		$18.72	$12.72	$31.44
60-75		$20.04	$12.84	$32.88
18-49	ONE-PARENT FAMILY	$15.84	$10.74	$26.58
50-59		$16.08	$10.98	$27.06
60-75		$16.38	$11.22	$27.60
18-49	TWO-PARENT FAMILY	$18.78	$13.74	$32.52
50-59		$18.96	$13.98	$32.94
60-75		$20.28	$14.58	$34.86

EBR: Extended Benefit Rider Premium (Available for ages 18-75)*
**Note – The Extended Benefit Rider and Hospital Stay and Surgical Care Rider are not available with Option H.*

Aflac

OPTIONAL LUMP SUM
CRITICAL ILLNESS BENEFIT RIDER

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac.

AFLAC PLUS RIDER

OPTIONAL LUMP SUM CRITICAL ILLNESS BENEFIT RIDER

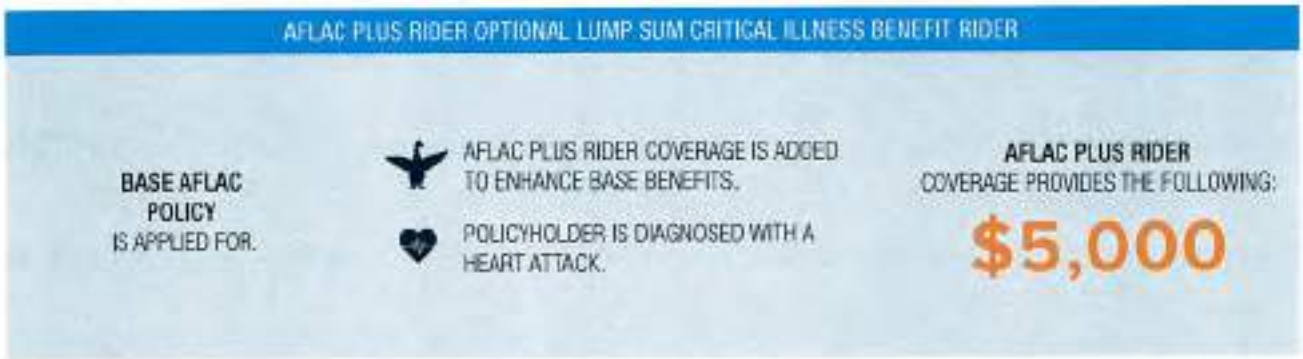
Rider Series CPRIDER

Boost your protection with the Aflac Plus Rider

Like many people, you probably have insurance to cover auto accidents, fires, burglaries, and standard hospital bills. But what would happen to your family's finances if you experienced a catastrophic event, such as a heart attack, stroke, advanced Alzheimer's disease, or advanced Parkinson's disease–an event that knocked you off your feet? Even a severe case of COVID, flu or pneumonia and accompanying costs could change your life forever.

The Aflac Plus Rider can help. This rider can be attached to select policies, further boosting your benefits. The Aflac Plus Rider pays a specific benefit amount when you are diagnosed with a covered event. You can use the cash to help pay out-of-pocket expenses, such as utility bills, car payments, and mortgage or rent payments. **For a list of policies the Aflac Plus Rider can be added to, please contact your Aflac insurance agent/producer.**

How it works



The above example is based on a scenario for Aflac Lump Sum Critical Illness Benefit Rider that includes the following benefit conditions: Heart Attack (Critical Illness Event Benefit) of $5,000. The Critical Illness Event Benefit pays $5,000 for a covered critical illness event.

Benefits and/or premiums may vary based on state. The rider has limitations, exclusions and pre-existing conditions limitations that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy and rider for complete benefit details, definitions, limitations and exclusions.

Aflac herein means American Family Life Assurance Company of Columbus.

Aflac Plus Rider Benefit Overview

BENEFIT:	DESCRIPTION:
CRITICAL ILLNESS EVENT BENEFIT	**$5,000** upon a covered person's onset date of one of the following: 1. Heart Attack 2. Stroke 3. Coma 4. Paralysis 5. Type 1 Diabetes 6. Traumatic Brain Injury 7. Advanced Alzheimer's Disease 8. Advanced Parkinson's Disease 9. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) 10. Loss of Independence 11. Sustained Multiple Sclerosis 12. Permanent Loss of Sight 13. Permanent Loss of Hearing 14. Permanent Loss of Speech 15. Sudden Cardiac Arrest This benefit is payable once per covered person, per lifetime.
SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT	**$2,500** upon a covered person's onset date of: • a recurrence of that **same** Critical Illness Event, or • an occurrence of a **different** Critical Illness Event. This benefit is not payable on the same day as the Critical Illness Event Benefit.
CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT	**$1,250** when a covered person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per covered person, per lifetime.
CRITICAL VIRAL/ BACTERIAL ILLNESS EVENT BENEFIT	Pays the highest applicable benefit amount listed per period of hospital confinement or period of intensive care unit confinement upon a covered person's onset date of the following: 1. Human Coronavirus 2. Bird Flu/H5N1 3. Influenza 4. Pneumonia 5. Ebola **Benefit amounts:** Hospital confinement 4-9 days **$1,250** Hospital confinement 10 days or more **$3,125** Intensive care unit confinement **$5,000** Maximum amount payable per 180 days is $5,000.

Refer to the following outline of coverage for benefit details, definitions, limitations and exclusions.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS RIDER

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)
Visit our website at aflac.com.

The rider described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS RIDER
Outline of Coverage for Rider Form Series CIRIDERFL

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company.

(1) **Read Your Contract Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your rider. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY.**

(2) **Critical Illness Insurance Coverage** is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Critical Illness Events or other conditions as specified. Critical Illness Events are: Heart Attack, Stroke, Coma, Paralysis, Type 1 Diabetes, Traumatic Brain Injury; Advanced Alzheimer's Disease; Advanced Parkinson's Disease; Amyotrophic Lateral Sclerosis; Loss of Independence; Sustained Multiple Sclerosis; Permanent Loss of Sight, Hearing, or Speech; or Sudden Cardiac Arrest. Critical Viral/Bacterial Illness Events are: Human Coronavirus, Bird Flu/H5N1, Influenza, Pneumonia, or Ebola. Coverage is provided for the benefits outlined in (3) Benefits. The benefits described in (3) Benefits may be limited by (4) Exceptions, Reductions, and Limitations of the Rider.

(3) **Benefits:** While coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Conditions Limitation and Limitations and Exclusions, as well as all other policy provisions, unless modified herein.

Benefits will not be payable for Advanced Alzheimer's Disease when Alzheimer's disease was diagnosed prior to the Effective Date of coverage, Advanced Parkinson's Disease when Parkinson's disease was diagnosed prior to the Effective Date of coverage, or Sustained Multiple Sclerosis when multiple sclerosis was diagnosed prior to the Effective Date of coverage.

Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. **CRITICAL ILLNESS EVENT BENEFIT:** Aflac will pay $5,000 upon a Covered Person's Onset Date of one of the following Critical Illness Events:

1. Heart Attack
2. Stroke
3. Coma
4. Paralysis
5. Type 1 Diabetes
6. Traumatic Brain Injury
7. Advanced Alzheimer's Disease
8. Advanced Parkinson's Disease
9. Amyotrophic Lateral Sclerosis
10. Loss of Independence
11. Sustained Multiple Sclerosis
12. Permanent Loss of Sight
13. Permanent Loss of Hearing
14. Permanent Loss of Speech
15. Sudden Cardiac Arrest

This benefit is payable once per Covered Person, per lifetime.

B. **SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT:** After a Covered Person has previously qualified for benefits for a Critical Illness Event under Benefit A above, Aflac will pay $2,500 upon that Covered Person's Onset Date of:

1. a recurrence of that same Critical Illness Event, or
2. an occurrence of a different Critical Illness Event.

For this benefit to be payable, the Onset Date of the subsequent Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Critical Illness Event Benefit.

C. **CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT:** Aflac will pay $1,250 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery.

This benefit is payable once per Covered Person, per lifetime.

D. **CRITICAL VIRAL/BACTERIAL ILLNESS EVENT BENEFIT:** Following the Onset Date of a Critical Viral/Bacterial Illness Event, Aflac will pay the highest applicable benefit amount stated below in a., b., or c. when a Covered Person has a qualifying Period of Hospital Confinement or Period of Intensive Care Unit Confinement as a direct result of their Critical Viral/Bacterial Illness Event.

Critical Viral/Bacterial Illness Events:

1. Human Coronavirus
2. Bird Flu/H5N1
3. Influenza
4. Pneumonia
5. Ebola

Benefit amounts:

a. Period of Hospital Confinement lasting 4-9 days	$1,250
b. Period of Hospital Confinement lasting 10 or more days	$3,125
c. Period of Intensive Care Unit Confinement	$5,000

Only the highest benefit amount above will be payable under this benefit. In the event a lower benefit amount was previously paid under this benefit for any Period of Hospital Confinement and that confinement is extended or the Covered Person is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided. The maximum amount payable per 180 days is $5,000.

For any subsequent Critical Viral/Bacterial Illness Event Benefit to be covered, the Onset Date of the subsequent Critical Viral/Bacterial Illness Event must be 180 days or more after the date the Covered Person first qualified for any previously paid Critical Viral/Bacterial Illness Event Benefit.

If the Onset Date of any Critical Illness Event or subsequent Critical Illness Event for a Covered Person is within 30 days after the date such Covered Person first qualifies for a Critical Viral/Bacterial Illness Event Benefit, only the Critical Illness Event Benefit or Subsequent Critical Illness Event Benefit, as applicable, is payable. In the event the Critical Viral/Bacterial Illness Event Benefit has already been paid, then the maximum benefit amount payable for both events will be limited to the amount of either the Critical Illness Event Benefit or Subsequent Critical Illness Event Benefit, as applicable.

(4) **Exceptions, Reductions, and Limitations of the Rider (This is not a daily hospital expense plan.):**

A. Aflac will not pay benefits for any loss that is caused by a Pre-existing Condition, unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered loss at a time per Covered Person. Aflac will not pay benefits for any condition when diagnosis occurred prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.

C. For any benefit to be payable, the Onset Date of the loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

D. The rider does not cover loss caused by or resulting from:

1. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and 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);
2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted ("felony" is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any detention facility or penal institution;
4. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
5. Being exposed to war or any act of war, declared or undeclared; or
6. Actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

PRE-EXISTING CONDITIONS LIMITATION

A "Pre-existing Condition" is any illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medication prescribed by a medical professional was taken or medical testing, medical advice, consultation, or treatment was recommended by or received from a medical professional, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment from a medical professional. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the Pre-existing Conditions Limitation, exclusive of any applicable waiting periods under the new coverage.

(5) Renewability: The rider is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term, except that we may discontinue or terminate the rider if you have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of material fact relating in any way to the rider, including claims for benefits under the rider. Premium rates may change only if changed on all riders of the same form number and class in force in your state (in which the policy was sold). If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 45 days before the change becomes effective.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
CONSULT THE CONTRACT ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring a person's level of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing personal independence in everyday living.

The ADLs are:

1. Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
2. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
3. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
4. Dressing: putting on and taking off all necessary items of clothing;
5. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
6. Eating: performing all major tasks of getting food into one's body.

ADVANCED ALZHEIMER'S DISEASE: Alzheimer's disease that causes a person to be incapacitated. Alzheimer's disease is a progressive degenerative brain disease that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease. To be incapacitated due to Alzheimer's disease, a covered person must:

1. Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, **and**
2. Be unable to perform three or more activities of daily living (ADLs), as certified by a physician, and require direct personal assistance to perform such ADLs.

ADVANCED PARKINSON'S DISEASE: Parkinson's disease that causes a person to be incapacitated. Parkinson's disease is a chronic progressive neurological disease that is diagnosed by a psychiatrist or neurologist as Parkinson's disease. To be incapacitated due to Parkinson's disease, a covered person must:

1. Exhibit two or more of the following clinical manifestations:
   - Muscle rigidity
   - Tremor
   - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses), **and**
2. Be unable to perform three or more activities of daily living (ADLs), as certified by a physician, and require direct personal assistance to perform such ADLs.

AMYOTROPHIC LATERAL SCLEROSIS (ALS or Lou Gehrig's disease): a chronic, progressive neurological disease resulting in permanent clinical impairment of motor function and is definitively diagnosed by a neurologist as amyotrophic lateral sclerosis.

BIRD FLU/H5N1: a viral respiratory disease of poultry and other bird species that can be transmitted to humans.

COMA: a continuous state of profound unconsciousness diagnosed or treated on or after the effective date of coverage, lasting for a period of seven or more consecutive days and characterized by the absence of: (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term coma does not include any medically induced coma.

CORONARY ARTERY BYPASS GRAFT SURGERY: open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

COVERED PERSON: any person insured under the policy to which the rider is attached.

CRITICAL ILLNESS EVENT: Heart Attack; Stroke; Coma; Paralysis; Type 1 Diabetes; Traumatic Brain Injury; Advanced Alzheimer's Disease; Advanced Parkinson's Disease; Amyotrophic Lateral Sclerosis; Loss of Independence; Sustained Multiple Sclerosis; Permanent Loss of Sight, Hearing, or Speech; or Sudden Cardiac Arrest.

CRITICAL VIRAL/BACTERIAL ILLNESS EVENT: Human Coronavirus, Bird Flu/H5N1, Influenza, Pneumonia, or Ebola.

EBOLA: an infectious disease marked by fever and severe internal bleeding spread through contact with infected body fluids.

EFFECTIVE DATE: the effective date of the rider is as stated in the Policy Schedule.

HEART ATTACK: a myocardial infarction. The attack must be positively diagnosed (includes post-mortem diagnosis by autopsy) by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system.

HUMAN CORONAVIRUS: a severe type of virus having a lipid envelope studded with club-shaped spike proteins that infects humans, leading to an upper respiratory infection or pneumonia, and spread through the air by coughing, sneezing, close personal contact, or touching a contaminated object or surface. This does not include the following human coronaviruses: 229E, NL63, OC43, and HKU1.

INFLUENZA: an acute, highly contagious, respiratory disease caused by influenza viruses.

LOSS OF INDEPENDENCE: being unable to perform three or more activities of daily living (ADLs), as certified by a physician, due to a covered

injury and requiring direct personal assistance to perform such ADLs for a continuous period of at least 90 days.

ONSET DATE: is as follows for each covered condition:

- Heart Attack: the date of occurrence of a heart attack as defined in the rider.
- Stroke: the date of occurrence of a stroke as defined in the rider.
- Coma: the date a physician confirms a coma as defined in the rider.
- Paralysis: the date a physician establishes the diagnosis of paralysis (as defined in the rider) on clinical or laboratory findings as supported by medical records.
- Type 1 Diabetes: the date a physician initially establishes the diagnosis of type 1 diabetes on clinical or laboratory findings as supported by medical records.
- Traumatic Brain Injury: the date of occurrence of a traumatic brain injury as defined in the rider.
- Advanced Alzheimer's Disease: the date a physician initially certifies that a covered person is incapacitated due to Alzheimer's disease as defined in the rider.
- Advanced Parkinson's Disease: the date a physician initially certifies that a covered person is incapacitated due to Parkinson's disease as defined in the rider.
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease): the date of diagnosis of amyotrophic lateral sclerosis as defined in the rider.
- Loss of Independence: the date of diagnosis of loss of independence as defined in the rider.
- Sustained Multiple Sclerosis: the date of diagnosis of sustained multiple sclerosis (as defined in the rider) by a physician.
- Permanent Loss of Sight, Hearing, or Speech: the date that permanent loss of sight, hearing, or speech (as defined in the rider) is initially diagnosed by a physician.
- Sudden Cardiac Arrest: the date of occurrence of sudden cardiac arrest as defined in the rider.
- Coronary Artery Bypass Graft Surgery: the date of surgery.
- Human Coronavirus, Bird Flu/H5N1, Influenza, Pneumonia and Ebola: the date of initial diagnosis by a physician.

PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord injury that occurred on or after the effective date of coverage. The paralysis must be confirmed by the attending physician.

PERIOD OF HOSPITAL CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital. Confinements must begin while coverage under the rider is in force. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF INTENSIVE CARE UNIT CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in an intensive care unit. Confinements must begin while coverage under the rider is in force. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERMANENT LOSS OF SIGHT, HEARING, or SPEECH:

- Loss of Sight: the restriction of visual field to 20 degrees or less in both eyes, or the reduction of sight in the better eye to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-chart Acuity), and diagnosed by a physician.
- Loss of Hearing: the total, irreversible, and uncorrectable loss of all hearing in both ears and diagnosed by a physician.
- Loss of Speech: the permanent, total, and irreversible loss of the ability to speak, including loss of speech due to surgery or medical treatment for an illness, and diagnosed by a physician.

PNEUMONIA: a lung disease characterized by inflammation of the airspaces in the lungs and caused by viral or bacterial infections or fungi. This does not include pneumonia caused by trauma such as inhalation of water, smoke or chemicals or traumatic chest or thoracic injuries.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed (includes post-mortem diagnosis by autopsy) by a physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), cerebrovascular insufficiency, or lacunar infarction (LACI).

SUDDEN CARDIAC ARREST: sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the sole cause of death shown on the death certificate is cardiovascular collapse, sudden cardiac arrest, cardiac arrest, or sudden cardiac death shall be deemed to be sudden cardiac arrest for purposes of the rider.

SUSTAINED MULTIPLE SCLEROSIS: a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways, with muscular weakness, loss of coordination, or speech and visual disturbances present for a continuous period of at least 90 days.

TERMINATION: the rider will terminate upon the earlier of the termination of the policy to which it is attached, the failure to pay the premiums for the rider, or our receipt of your written request to cancel the rider, subject to section 125 of the Internal Revenue Code, if applicable.

TRAUMATIC BRAIN INJURY: a nondegenerative, noncongenital injury to the brain from an external nontiological force, requiring hospital confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms. Traumatic brain injury must be positively diagnosed by a physician based upon documented neurological deficits and confirmatory neuroimaging studies.

TYPE 1 DIABETES: a form of diabetes mellitus causing total insulin deficiency of a covered person along with continuous dependence on exogenous insulin in order to maintain life. A diagnosis of type 1 diabetes must be made by a physician who specializes in diabetes.

Aflac.

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

CareerSource BROWARD

Administrative Offices
2890 W. Cypress Creek Rd.
Ft. Lauderdale, FL 33309

MEMORANDUM #04-25 (HR)

TO: CareerSource Broward Staff

FROM: Rosamond Parker-Pickett, VP of Human Resources *R. P. Pickett*

Subject: Holiday Schedule for 2026 Revised

DATE: December 23, 2025

HOLIDAY SCHEDULE - 2026

The following days are designated as official holidays for "regular" employees of CareerSource Broward (CSBD) for the year 2026.

Date	Holiday
Thursday, January 1, 2026	New Year's Day
Monday, January 19, 2026	Martin Luther King, Jr. Day
Monday, February 16, 2026	Presidents' Day
Monday, May 25, 2026	Memorial Day
Friday, June 19, 2026	Juneteenth
Friday, July 3, 2026 (Saturday is July 4th)	Independence Day
Monday, September 7, 2026	Labor Day
Monday, October 12, 2026	Columbus Day
Wednesday, November 11, 2026	Veterans Day
Thursday, November 26, 2026	Thanksgiving Day
Friday, November 27, 2026	Day after Thanksgiving
Friday, December 25, 2026	Christmas Day

Personal Days

Two Personal Days any time after January 1, 2026*	CSBD Personal Leave Days
Personal 3**	One Personal Day in the employee's birthday month **only**

Personal Days - *CSBD "regular" employees qualify for two (2) Personal Leave Days on January 1 each year. Personal Leave Days must be taken by December 31 each year or they are forfeited. Personal leave days must be taken in full day increments and may be used on any working day of the year, with prior written approval of the supervisor.

****Personal 3 -This day can only be taken in the employee's birthday month or it is forfeited.**

For job titles with multiple incumbents, we have provided the salary ranges.

Pay Grade	CSBD Job Titles	Minimum	Maximum
4	Computer Technician	$45,500	$68,300
6	Business Services Manager (Intermediaries)	$50,000	$77,500
7	Executive Secretary	$55,900	$86,600
7	Program Manager	$62,700	$97,200
12	Vice President (BR, COMM, HR, IT, QA)	$98,600	$152,800

For those job titles where there is only one incumbent, the current salary of the individual is provided below.

Pay Grade	CSBD Job Titles	Current Salary
3	Administrative Assistant	$ 46,205.64
4	Administrative/Receptionist	$ 49,673.99
8	Accountant 2	$ 82,951.25
4	Accounts Payable Coordinator	$ 45,009.51
9	Adult Programs Administrator	$ 85,446.47
6	Assistant Program Manager	$ 55,120.07
6	Audit Compliance Coordinator	$ 59,593.95
3	Communications Assistant	$ 32,136.00
4	Community Liaison	$ 43,814.55
4	Coordinate Services Recruitment/Admin Asst	$ 40,950.00
9	Controller	$ 86,527.94
16	Executive VP of Administration	$ 172,604.00
15	Executive VP of Operations	$ 147,000.00
17	General Counsel	$ 246,351.30
5	Human Resources Assistant	$ 65,036.21
7	Paralegal Secretary	$ 59,280.00
5	Payroll Specialist	$ 48,672.00
5	Multimedia Design & Marketing Specialist	$ 55,971.05
9	Network Administrator	$ 92,830.92
18	President/CEO	$ 291,924.17
4	Purchasing Coordinator	$ 45,009.51
7	Quality Assurance Analyst/Dis. Prog.Emp Spec	$ 65,616.14
14	Sr. Vice President of Finance	$ 140,608.07
13	Sr. Vice President of Operations	$ 120,000.00
8	Systems Analyst/Programmer	$ 84,364.80

EXHIBIT E
TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Entity Name: CareerSource Broward **FY 24-25**

Employee Name	Carol Hylton	Ronald Moffett	Rochelle Daniels	Mark Klincewicz	Kaminnie S Kangal	
Title	President /CEO	Executive VP of Admin	General Counsel	Executive VP of Operations	SR VP of Finance	
Salary	$288,594.32	$177,839.58	$237,591.11	$159,179.66	$137,953.61	
Bonuses						
Earned Leave Distribution	$ 13,728.00	-	-	$ 9,701.28	-	
Cash Equivalents						
Cash Equivalents Description						
Severance Pay						
Retirement Benefits (Pension Plan Accruals and Contributions)						
Employer-Paid Insurance Benefits	$26,074.30	$28,335.79	$1,028.57	$25,698.41	$15,079.51	
Deferred Compensation	$33,832.33	$15,682.59	$15,682.59	$15,682.59	$11,682.59	
Real Property Gifts						
Real Property Gifts Description						
Other Payouts						
Other Payouts Description						
Total Cash Compensation	$362,228.95	$221,857.96	$254,302.27	$210,261.94	$164,715.71	
Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off	$67,057.62	$47,763.14	$67,174.31	$26,547.32	$29,949.52	
Percentage of Total Compensation from Federal or State Funds	74.73%	86.22%	93.25%	93.04%	74.73%	

TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Under penalties of perjury, I declare that I have read the foregoing schedule of Total Compensation of Executive Leadership and Other Specified Employees and that the facts stated in it are true.

K S Kangal

Signature

Kaminnie S Kangal

Printed Name

SR VP of Finance

Title

Definitions:

Executive Leadership: Chief executive officer/executive director of the board and those reporting directly to that position.

Cash Equivalents: Gift cards, vouchers, tickets, or other items of monetary value.

Other payouts: Cell phone allowances, tuition, gym memberships, car allowances, etc.

Employer-Paid Insurance Benefits: Amount of insurance paid by the employer for health, vision, life, dental, disability, etc. (does not include taxes such as FICA, reemployment, etc.)

Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off: Current discounted value of any vested benefits, i.e., those the employee is entitled to, for which the Board has not yet been required to fund.

EXHIBIT E
TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Entity Name: CareerSource Broward **FY 23-24**

Employee Name	Carol Hylton	Ronald Moffett	Rochelle Daniels	Mark Klincewicz	Kaminnie S Kangal	
Title	President /CEO	Executive VP of Admin	General Council	Executive VP of Operations	SR VP of Finance	
Salary	$245,340.00	$158,112.41	$228,136.29	$153,103.21	$130,000.02	
Bonuses						
Earned Leave Distribution	$14,976.00	$4,021.45	-	$8,405.12	$3,333.34	
Cash Equivalents						
Cash Equivalents Description						
Severance Pay						
Retirement Benefits (Pension Plan Accruals and Contributions)						
Employer-Paid Insurance Benefits	$24,361.64	$26,164.59	$1,515.16	$23,714.46	$14,005.13	
Deferred Compensation	$53,313.24	$11,163.50	$11,163.50	$11,163.50	$10,453.91	
Real Property Gifts						
Real Property Gifts Description						
Other Payouts						
Other Payouts Description						
Total Cash Compensation	$337,990.88	$199,461.95	$240,814.95	$196,386.29	$157,792.40	
Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off	$74,686.56	$28,337.67	$41,974.21	$26,371.81	$21,095.33	
Percentage of Total Compensation from Federal or State Funds	79.05%	92.35%	94.40%	96.86%	79.05%	

TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Under penalties of perjury, I declare that I have read the foregoing schedule of Total Compensation of Executive Leadership and Other Specified Employees and that the facts stated in it are true.

Signature

Kaminnie S Kangal

Printed Name

SR VP of Finance

Title

Definitions:

Executive Leadership: Chief executive officer/executive director of the board and those reporting directly to that position.

Cash Equivalents: Gift cards, vouchers, tickets, or other items of monetary value.

Other payouts: Cell phone allowances, tuition, gym memberships, car allowances, etc.

Employer-Paid Insurance Benefits: Amount of insurance paid by the employer for health, vision, life, dental, disability, etc. (does not include taxes such as FICA, reemployment, etc.)

Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off: Current discounted value of any vested benefits, i.e., those the employee is entitled to, for which the Board has not yet been required to fund.

EXHIBIT E
TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Entity Name: **CareerSource Broward** **FY 22-23**

Employee Name	Carol Hylton	Ronald Moffett	Rochelle Daniels	Mark Klincewicz	Kaminnie S Kangal	
Title	President /CEO	Executive VP of Admin	General Council	Executive VP of Operations	SR VP of Finance	
Salary	$235,938.45	$152,053.56	$219,394.31	$145,518.08	$97,266.41	
Bonuses						
Earned Leave Distribution	$1,560.00	-	$50,539.73	$7,060.70	-	
Cash Equivalents						
Cash Equivalents Description						
Severance Pay						
Retirement Benefits (Pension Plan Accruals and Contributions)						
Employer-Paid Insurance Benefits	$22,150.10	$24,057.97	$1,233.39	$21,927.01	$12,804.70	
Deferred Compensation	$12,399.72	$10,249.98	$10,249.98	$10,249.98	$8,014.34	
Real Property Gifts						
Real Property Gifts Description						
Other Payouts						
Other Payouts Description						
Total Cash Compensation	$272,048.27	$186,361.51	$281,417.41	$184,755.77	$118,085.45	
Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off	$74,526.00	$23,580.37	$21,844.39	$22,120.78	$14,434.72	
Percentage of Total Compensation from Federal or State Funds	79.04%	96.73%	93.02%	96.99%	79.04%	

TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Under penalties of perjury, I declare that I have read the foregoing schedule of Total Compensation of Executive Leadership and Other Specified Employees and that the facts stated in it are true.

Signature

Kaminnie S Kangal

Printed Name

SR VP of Finance

Title

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