PAYGO PLUS, LLC

Plans designed for the full time employees of
PayGo Plus, LLC
` Benefits Effective Date: January 1, 2016

Enrollment Period: November 23rd through December 7th, 2015 BENEFITS

ADMINISTERED BY SPEYER MERIDIAN INSURANCE SERVICES, LLC

877.824.6256

2016 Employee Open Enrollment Guide

PayGo Plus, LLC

2016 Open Enrollment Guide

The Enrollment Process

PayGo Plus, LLC. now offers a comprehensive assortment of benefit options to all full-time eligible employees, as required by the Affordable Care Act (ACA, or Obamacare). You may review your available benefit options and make your desired selections either on-line through our web-based employee benefits enrollment portal or by calling The PayGo Plus Benefit Enrollment at 877.824.6256. You should be aware of your individual responsibility under requirement of the ACA. Should you choose to decline coverage, you will be subject to fines imposed by the IRS. In accordance with the regulations of the ACA, all PayGo Plus employees eligible for medical insurance have been enrolled in the least expensive plan that meets the requirements for the individual employee. Further information regarding your health care options under the Affordable Care Act can be found in the employee benefits enrollment portal. While you **are not** obligated to purchase health coverage, you **are required by the ACA to participate in the enrollment process**. If you neither select a benefit plan nor actively decline coverage, you will stay enrolled in The Essential Health Plan and the premiums will be payroll deducted from your paycheck. We think it is important for all PayGo Plus employees to understand that the after-tax cost of The Essential Value Plan is actually less than the IRS fine for not having insurance. The IRS will fine all full-time working Americans $12.98 per week if they do not have qualifying health insurance in 2016, the after tax cost of The Essential Health Plan is approximately $11.92 per week (varies slightly by tax bracket).

In an effort to help you best understand what is required of you under the Affordable Care Act and the various insurance options available to you, PayGo Plus, LLC. is making available to you our company-sponsored PayGo Plus Employee Benefits Service Center. The Employee Benefits Service Center is staffed with licensed insurance professionals that are knowledgeable about your requirements under the ACA, all health plans that PayGo Plus is offering, all voluntary insurance plans that you can participate in including: Dental, and Vision insurance from CIGNA and a complete array of AFLAC products you can choose from. All plans offer low group rates and the convenience of payroll deduction.
During your open enrollment period (November 23 - December 7, 2015) you may contact the Employee Benefits Service Center with any questions you have regarding your

benefits enrollment. The Service Center will assist you with understanding different plan options, enrolling in a plan, or declining coverage completely. Please make sure you have the plan information contained in this packet readily available during the time of your call. The benefit counselors in the enrollment center will spend as much time with you as you need, but it is essential that you have a basic overview of the options available to you during the call.

- During open enrollment (November 23 - December 7) the Employee Benefits Enrollment Center can be reached Monday through Friday from 10:00 am to 8:00 pm Eastern Time at 877.824.6256.

- The Employee Benefits Enrollment Center can provide detailed information about each benefit plan and how to enroll, and can assist you in changing or declining coverage. The Center can help you understand what you need to do to comply with The Individual Mandate of the Affordable Care Act and avoid IRS penalties for being uninsured in 2016.

Health and Welfare Benefits

Plan Year

The Plan Year runs from January 1st, 2016 through December 31st, 2016. Enrollment into the plan requires your input and action. You **must** respond with your benefits selections **no later than Monday December 7th, 2015**. Failure to respond with your selections will result in your automatic enrollment into the Essential Value medical plan. Once enrolled, you will not be able to make changes until the next open enrollment period. While you are free to make your selections on line or through The Employee Benefit Enrollment Center, we strongly encourage you to use The Enrollment Center. We understand that this insurance information as well as your legal obligations under The Affordable Care Act is new to you. The Benefit Counselors in the enrollment center have been specifically trained on all plans we offer, can help you determine what the best option for individual situation is and electronically select those options for you. We have set up this Enrollment Center so you fully understand what options are available to you, and so the choices you make are the best for your personal circumstances and individual insurance needs.

Eligibility

Eligible Employees

All PayGo Plus, LLC. employees working on average 30+ hours per week will be eligible. You will need to complete your enrollment during the open enrollment period of November 9th through November 20th. The effective date of your coverage will be January 1st, 2016.

Eligible Dependents

When you become eligible for health and welfare benefits, so do your eligible dependent children. This includes children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include biological, adopted, or placed for adoption. Stepchildren and foster children are not eligible for any plans.

PayGo Plus, LLC. does not offer coverage to spouses or domestic partners at this time. If you have a spouse or domestic partner that needs to obtain coverage they should inquire with their employer or go to the State Insurance Marketplace in the state of your residence. Open enrollment for all Federal State Insurance Marketplaces opens November 1st, 2015 for the 2016 plan year. To find the web address of The Insurance Marketplace for your state go to: https://www.healthcare.gov/marketplace-in-your-state/

When you enroll a dependent, you certify that he or she meets the definition of an eligible dependent under the terms of the plan. If your dependent loses eligibility for coverage, you are responsible for contacting the Employee Benefits Service Center to remove the dependent from coverage within 30 days of the loss of eligibility.

If it is determined that you have enrolled, or failed to remove, an individual who does not meet the definition of an eligible dependent, coverage for the ineligible dependent may be terminated prospectively from the date of determination of ineligibility. If it is found that you obtained coverage through fraud or an intentional misrepresentation of material fact as prohibited by the terms of the plan, coverage for you and the ineligible dependent may be rescinded (you will be given 30 days written notice of the rescission). You may also be subject to disciplinary action, up to and including termination.

Changes in Benefit Elections

Your 2016 elections will be in effect through December 31st, 2016. Each year during open enrollment, you will have the opportunity to change your elections for the following plan year. During open enrollment, you will have the opportunity to:

» Add, update, or drop benefit coverage

» Add or delete eligible dependents from coverage.

» Enroll in Health Care, Dental, Life, or Vision Coverage as well as purchase from an array of

AFLAC voluntary insurance products such as Accident Indemnity, Hospital, Advantage and Cancer Care policies. While these polices do not provide the same comprehensive coverage as a major medical plan, they are very affordable and can be an attractive supplement to those employees enrolled in The Essential Value Plan or who have waived qualifying coverage all together. The Employee Benefit Enrollment Center can review all of these polices with you and help you make the right selection.

Remember, the selections you make during open enrollment will stay in effect until open enrollment next year. While you can make some limited changes during the year due to a Qualified Status Change, you must notify the HR Department within 30 days of the Qualifying Event. (Please see attached notice for the requirements of the qualifying event).

PayGo Plus, LLC. 2016 Benefit Options

So that you may compare the various options being offered to you, the following is a brief outline of the health insurance benefits available during this open enrollment. More detailed information on all benefits, as well as pricing, will be available to you the benefits portal and by contacting the PayGo Plus Employee Benefit Enrollment Center at 877.824.6256.

To log into the PayGo Plus, LLC. Employee Benefits Portal and review your available benefit plan options, please follow the instructions below exactly as they appear on this sheet:

1. **Go to www.paygoplus.com and click on the tab titled "Open Enrollment"**
2. **Login using your username and password**
    a. **Username: first initial of your first name + last name + last 4 of your social security number.**
    b. **Password: last 4 digits of your social security number**
    c. ***Example: Michael L. Smith, SS# 123-45-6789 // username: msmith6789, password: 6789***

The Essential Value Plan: Most Affordable Coverage – Meets Individual Requirement of the ACA.

This plan meets your individual obligations under the Affordable Care Act and will protect you against the IRS fine in 2016 if you select this option. Keep in mind that the after tax cost of this plan is actually less than the fine you will have to pay for not having insurance. If you are not covered by other qualifying health insurance, you should think very carefully before you decline this coverage. Logically it makes more sense to pay less, comply with the ACA AND have the insurance to use, than not to have insurance and pay the fine. Unless an alternative healthcare option is pursued, or coverage is actively declined, all PayGo Plus eligible employees will be enrolled in the Essential Value Plan as January 1st , 2016. This plan uses the PHCS PPO Network of Doctors, which encompasses over 700,000 participating physicians in the U.S.A. This plan covers all preventative treatment as well as unlimited well care visits, and also offers 5 primary care visits per plan year to network doctors and generic prescriptions with a low $10.00 copay at the pharmacy.

Additionally, when you select this plan you and your eligible family members have unlimited access to doctors on call at TelaDoc. These board-certified physicians are available to you and your family members 24 hours a day 365 days a year. TelaDoc physicians can consult, diagnose and prescribe medicine exactly the same as any doctor you would see in person. There is no cost to you, your spouse and children (in conjunction with parent) to use this program. The only limitation is that TelaDoc will not prescribe narcotics or other regulated controlled substances. Please note that this plan does not cover hospitalization or outpatient surgical facilities.

Affordable Value Plan. – High Deductible Major Medical Coverage Includes Full Hospitalization:

While still very affordable, this option covers inpatient hospitalization, specialists, surgical fees, primary care doctors' visits and unlimited well care visits. This plan has a $6,850 per year deductible for hospitalization and surgical fees, $50 copay for primary doctors' visits, $70 copay for specialist. The Affordable Value Plan provides an 60/40 co-insurance agreement until you have spent the maximum out-of-pocket expense ($6,850), after which time the insurance covers 100% of costs. While you would still use the PHCS network for doctors, the hospitalization and surgery benefits pay at 125% of Medicare eligible charges. During your pre-authorization process prior to a hospital admission, your Third Party Administrator will help you locate the nearest hospital that will accept your insurance. This is a high deductible plan and should be looked at as the most affordable way to provide for catastrophic illness or injury for you and eligible dependents.

Elite Value Plan: Low Deductibles, Full Hospitalization Premiere Coverage:

When you choose to "buy-up" to the Elite Value Plan network, you will have total peace of mind knowing you have affordable primary care through the PHCS in-network doctors and full hospitalization and surgical coverage with a low $2,000 annual deductible. Once your deductible has been satisfied, the plan will pay 80% of all eligible charges while you pay 20%, up to the maximum out of pocket expense of $6,850). Your visits to the doctor with this plan are only $20.00 copay for primary care and $40.00 copay for specialist. Additionally, when you select this plan, you and your eligible family members have unlimited access to doctors on call at TelaDoc. These board-certified physicians are available to you and your family members 24 hours a day 365 days a year. TelaDoc physicians can consult, diagnose and prescribe medicine exactly the same as any doctor you would see in person. There is no cost to you, your spouse and children (in conjunction with parent) to use this program. The only limitation is that TelaDoc will not prescribe narcotics or other regulated controlled substances.

The choices that you make regarding medical, dental, life and AFLAC Voluntary coverage for you and your children will go into effect either on January 1st, 2016, or the day you become eligible, whichever is later. Benefits will remain in effect until December 31st, 2016. You will have the cost of your selections deducted from your paychecks starting on the first pay date in December. All deductions will be on a pre-tax basis with the exception of dental, vision, life and AFLAC voluntary products.

Important Reminders

Remember, you MUST actively participate in this open enrollment or you will be assigned the Essential Value Plan, premiums will be payroll deducted, and you will not be able to make any changes until open enrollment next year. You are welcome to make your choices on line at www.paygoplus.com, and clicking the open enrollment button or call the PayGo Plus Benefit Enrollment center at: 877.824.6256. November 23 through December 7 ~ The Enrollment Center is open M-F 10 am to 8 pm. You will have the choice to keep The Essential Value Plan, upgrade to either The Affordable or Elite Value Plan, purchase dental, life, and/or vision insurance, as well as select from a wide array of quality AFLAC voluntary products. You may also decline coverage altogether, but remember, if you do so you may pay an IRS fine that is greater than the cost of The Essential Value Plan that is being offered. Aflac policies are only available by calling the Benefits Enrollment Center.

Benefits Description:

PayGo Plus 2016 Medical Plan Options

Covered Benefits	Essential Value Plan	Affordable Value Plan	Elite Value Plan
Deductible (Single/Family)	No Deductible Plan is limited to Outpatient Services	$6,850/$13,700	$2,000/$6,000
Coinsurance	None	60%	80%
Out of Pocket Maximum (Single/Family)	$6,850/$13,700	$6,850/$13,700	$6,850/13,700
PPO Network	PHCS Physicians Only	PHCS Physicians Only	PHCS Physicians Only
Emergency Room Services	Not Covered	$6,850 deductible	$2,000 deductible
Inpatient Hospital Services	Not Covered	$6,850 deductible	$2,000 deductible
Teledoc: Unlimited telephone and video consultation	100% Covered	Not Covered	100% covered
Primary Care visit to treat an Injury or illness	3 visits/year, 100% after $20 copay	$50 copay and 60% Coinsurance	5 visits/year, 100% after $20 copay
Specialist Visit	May be covered under teledoc	$70 copay and 60% coinsurance	5 Visits/year 100% after $40.00 copay
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	Not Covered	Not Covered	Not Covered
Imaging (CT, PET, MRIs)	Not covered	$6,850 deductible	$2,000 deductible
Rehabilitative Speech Therapy	Not Covered	Not Covered	5 visits/year, 100% after $40 copay
Rehabilitative Occupational and Rehabilitative Physical Therapy	Not Covered	Not Covered	5 visits/year, 100% after $40 copay
Preventative Care/Screening/Immunization (MEC)	100% Covered -No Copay -No Deductible	100% Covered -No Copay -No Deductible	100% Covered -No Copay -No Deductible
Laboratory Outpatient and Professional Services	Not Covered	$6,850 deductible	80% after deductible
X-Rays and Diagnostic Imaging	Covered only if done in doctor's office	60% after deductible	80% after deductible
Skilled Nursing Facility	Not Covered	Not Covered	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Not Covered	Not Covered	80% after deductible
Outpatient Surgery Physician/Surgical Services	Not Covered	Not Covered	80% after deductible
Chronic Disease Management (CDM) Benefit	Not Covered	100% Covered	100% Covered
PRESCRIPTION DRUGS			
Certain Generics	Covered after $10 copay	$6,850 deductible	50% coinsurancee
Certain Preferred Brand Drugs	Not Covered	$6,850 deductible	50% coinsurance
Certain Non-Preferred Brand Drugs	Not Covered	Not Covered	50% coinsurance
Specialty Drugs & Compounds	Not Covered	Not Covered	Not Covered
	Most Affordable Meets ACA Requirements No Hospitalization	High Deductible Catastrophic Coverage Low Price	Premier Coverage Most Expensive Best Coverage

TELADOC™

Talk to a  anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
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- For short-term prescription refills

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- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

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Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
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With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

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Optional Voluntary Coverage[1]

Life AD&D

Life insurance helps provide employees and their families with financial protection in the event of the employee's death. This insurance doubles the life insurance amount if you die in a covered accident.

Accidental Injury

Accidental Injury insurance coverage is an affordable way to make up for expenses not covered by traditional insurance. In the event of a covered accident, it pays lump sum cash benefit with no restrictions on how the money is used.

Dental Insurance

With one of the largest networks in the nation, we can provide access and discounts on dental care costs. We offer a wide range of dental products and features to our customers.

Short Term Disability Insurance

We offer Disability Insurance that pays you a monthly benefit in the event you become disabled. Benefit amounts are between $500 and $6,000 a month and benefit terms of 6, 12, 18 and 24 months.

Hospital Indemnity Insurance

Employees can elect to have the up to a $3,000 hospital deductible waived and receive a daily cash benefit when confined to a hospital from illness or injury.

Vision Insurance

Our cost---effective vision benefit solution with an in and out---of---network coverage through one of the nation's largest routine vision networks. We offer access to quality eye care professionals and 24/7 claim, eligibility and customer service.

Cigna®

PayGo Plus proudly offers a complete array of quality AFLAC and Cigna voluntary insurance plans that are available to all employees.

Aflac®

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Product availability may vary by state. All plans have exclusions and limitations. Complete terms are set forth in the applicable group policy or group service agreement. These products offer limited benefits and are not intended to be a substituted for major medical insurance*

Benefit Pricing Sheet

COVERAGE ELECTIONS Monthly Deductions						
COVERAGE TYPE	**Essential Value Plan**	**Affordable Value Plan**	**Elite Value Plan**	**Dental DPPO**	**DHMO**	**Vision**
Waive Coverage	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Employee Only	$ 75.00	See Below**	$ 275.00	` $ 23.99	$ 13.92	$ 6.56
Employee & Child(ren)	$ 140.00	$ 533.00	$ 690.00	$ 57.83	$ 29.89	$13.24
Employee & Spouse	$ 180.00	Not Available	Not Available	$ 43.87	$ 23.99	$13.11
Employee & Family	$ 220.00	Not Available	Not Available	$ 87.70	$ 42.74	$21.14

The prices for Hospital Advantage, Accident Indemnity, Cancer Care, and Short Term Disability are only available by calling the Benefit Enrollment Center from 10am to 8pm Eastern Time at 877.824.6256.

**Affordable Value Plan Rates Per Pay Rate:

$7.25 to $8.99	per hour:	$104.00
$9.00 to $10.99	per hour:	$130.00
$11.00 to12.99	per hour:	$158.00
$13.00 and up	per hour:	$187.00

The Affordable Value Plan rates are based on your wage rate. The Affordable Care Act limits the amount you must pay for this coverage based upon your rate of pay. Please note, this is only for Single Affordable Value coverage, all other rates are fixed.

Cigna Healthcare Financial Exhibit for:

Paygo Plus

Effective Date: January 01, 2016

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	$1000, Class I Applies	$1000, Class I Applies
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-Rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-Rays	80%, No Deductible	80%, No Deductible
Class II Expenses - Basic Restorative Care		
Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Brush Biopsy	60%, After Deductible	60%, After Deductible
Class III Expenses - Major Restorative Care		
Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns / Inlays / Onlays Dentures Bridges Stainless Steel/Resin Crowns	40%, After Deductible	40%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children Only	50%, No Ortho Deductible	50%, No Ortho Deductible
Lifetime Maximum	$1000	$1000
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for a specified time period; thereafter, considered a Class III expense.	
Late Entrant Limit	50% coverage on Class III and IV for a specified time period.	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed.	
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

Cigna Healthcare Financial Exhibit for:

Paygo Plus

Effective Date: January 01, 2016

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis Over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	For dependent children, up to age 19.

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installatio
* Replacement of a bridge or denture which can be made useable according to accepted dental standard
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusio
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molar
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any typ
* Instruction for plaque control, oral hygiene and die
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pa
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a conditio connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profi
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurre
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents)
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surger
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a publi program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written t comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will tak into account any adjustment option chosen under such part by you or any one of your Dependent
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dent Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsore or made available by your Employer

In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms o coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the associatio of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
Paygo Plus
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit**	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$25	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $120	Up to $66	12 months
** Your Frequency Period begins on January 1 (Calendar year basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 18 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults,) all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below.

3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

LIFE PROTECTOR 10-YEAR TERM POLICY - Series A63200

Female Applicant Face Amount: $50,000.00 Rates are per week. Rates stay level for 10 years.

Age	Non-Tobacco User	Tobacco User	Policy Fee	Non-Tobacco Total	Tobacco Total
18	$1.25	$1.92	$0.90	$2.15	$2.82
19	$1.25	$1.92	$0.90	$2.15	$2.82
20	$1.25	$1.92	$0.90	$2.15	$2.82
21	$1.25	$1.92	$0.90	$2.15	$2.82
22	$1.25	$1.92	$0.90	$2.15	$2.82
23	$1.25	$1.92	$0.90	$2.15	$2.82
24	$1.25	$1.92	$0.90	$2.15	$2.82
25	$1.25	$1.92	$0.90	$2.15	$2.82
26	$1.25	$1.92	$0.90	$2.15	$2.82
27	$1.25	$1.92	$0.90	$2.15	$2.82
28	$1.25	$1.92	$0.90	$2.15	$2.82
29	$1.25	$1.92	$0.90	$2.15	$2.82
30	$1.25	$1.92	$0.90	$2.15	$2.82
31	$1.25	$2.01	$0.90	$2.15	$2.91
32	$1.25	$2.08	$0.90	$2.15	$2.98
33	$1.25	$2.17	$0.90	$2.15	$3.07
34	$1.25	$2.28	$0.90	$2.15	$3.18
35	$1.25	$2.40	$0.90	$2.15	$3.30
36	$1.34	$2.61	$0.90	$2.24	$3.51
37	$1.43	$2.86	$0.90	$2.33	$3.76
38	$1.55	$3.14	$0.90	$2.45	$4.04
39	$1.68	$3.46	$0.90	$2.58	$4.36
40	$1.82	$3.83	$0.90	$2.72	$4.73
41	$1.98	$4.25	$0.90	$2.88	$5.15
42	$2.12	$4.71	$0.90	$3.02	$5.61
43	$2.31	$5.22	$0.90	$3.21	$6.12
44	$2.52	$5.82	$0.90	$3.42	$6.72
45	$2.75	$6.51	$0.90	$3.65	$7.41
46	$2.98	$7.20	$0.90	$3.88	$8.10
47	$3.23	$8.01	$0.90	$4.13	$8.91
48	$3.53	$8.93	$0.90	$4.43	$9.83
49	$3.85	$9.97	$0.90	$4.75	$10.87
50	$4.22	$11.17	$0.90	$5.12	$12.07
51	$4.57	$12.23	$0.90	$5.47	$13.13
52	$4.98	$13.41	$0.90	$5.88	$14.31
53	$5.42	$14.72	$0.90	$6.32	$15.62
54	$5.91	$16.20	$0.90	$6.81	$17.10
55	$6.46	$17.84	$0.90	$7.36	$18.74
56	$7.11	$19.32	$0.90	$8.01	$20.22
57	$7.85	$20.93	$0.90	$8.75	$21.83
58	$8.68	$22.68	$0.90	$9.58	$23.58
59	$9.62	$24.62	$0.90	$10.52	$25.52
60	$10.68	$26.75	$0.90	$11.58	$27.65
61	$11.72	$28.25	$0.90	$12.62	$29.15
62	$12.88	$29.82	$0.90	$13.78	$30.72
63	$14.17	$31.48	$0.90	$15.07	$32.38
64	$15.62	$33.23	$0.90	$16.52	$34.13
65	$17.26	$35.08	$0.90	$18.16	$35.98

Male Applicant Face Amount: $50,000.00 rates are quoted per week. Premiums stay level for 10 years.

LIFE PROTECTOR 10-YEAR TERM POLICY - Series A63200

Age	Non-Tobacco User	Tobacco User	Policy Fee	Non-Tobacco Total	Tobacco Total
18	$1.29	$2.01	$0.90	$2.19	$2.91
19	$1.29	$2.01	$0.90	$2.19	$2.91
20	$1.29	$2.01	$0.90	$2.19	$2.91
21	$1.29	$2.01	$0.90	$2.19	$2.91
22	$1.29	$2.01	$0.90	$2.19	$2.91
23	$1.29	$2.01	$0.90	$2.19	$2.91
24	$1.29	$2.01	$0.90	$2.19	$2.91
25	$1.29	$2.01	$0.90	$2.19	$2.91
26	$1.29	$2.01	$0.90	$2.19	$2.91
27	$1.29	$2.01	$0.90	$2.19	$2.91
28	$1.29	$2.01	$0.90	$2.19	$2.91
29	$1.29	$2.01	$0.90	$2.19	$2.91
30	$1.29	$2.01	$0.90	$2.19	$2.91
31	$1.29	$2.08	$0.90	$2.19	$2.98
32	$1.29	$2.17	$0.90	$2.19	$3.07
33	$1.29	$2.26	$0.90	$2.19	$3.16
34	$1.29	$2.38	$0.90	$2.19	$3.28
35	$1.29	$2.49	$0.90	$2.19	$3.39
36	$1.38	$2.72	$0.90	$2.28	$3.62
37	$1.50	$2.98	$0.90	$2.40	$3.88
38	$1.62	$3.28	$0.90	$2.52	$4.18
39	$1.75	$3.62	$0.90	$2.65	$4.52
40	$1.89	$3.99	$0.90	$2.79	$4.89
41	$2.05	$4.41	$0.90	$2.95	$5.31
42	$2.22	$4.89	$0.90	$3.12	$5.79
43	$2.40	$5.42	$0.90	$3.30	$6.32
44	$2.61	$6.05	$0.90	$3.51	$6.95
45	$2.86	$6.76	$0.90	$3.76	$7.66
46	$3.09	$7.50	$0.90	$3.99	$8.40
47	$3.37	$8.35	$0.90	$4.27	$9.25
48	$3.67	$9.30	$0.90	$4.57	$10.20
49	$4.02	$10.38	$0.90	$4.92	$11.28
50	$4.41	$11.63	$0.90	$5.31	$12.53
51	$4.78	$12.74	$0.90	$5.68	$13.64
52	$5.19	$13.96	$0.90	$6.09	$14.86
53	$5.65	$15.35	$0.90	$6.55	$16.25
54	$6.16	$16.87	$0.90	$7.06	$17.77
55	$6.72	$18.58	$0.90	$7.62	$19.48
56	$7.41	$20.12	$0.90	$8.31	$21.02
57	$8.17	$21.81	$0.90	$9.07	$22.71
58	$9.05	$23.63	$0.90	$9.95	$24.53
59	$10.02	$25.66	$0.90	$10.92	$26.56
60	$11.12	$27.85	$0.90	$12.02	$28.75
61	$12.21	$29.42	$0.90	$13.11	$30.32
62	$13.41	$31.06	$0.90	$14.31	$31.96
63	$14.77	$32.79	$0.90	$15.67	$33.69
64	$16.27	$34.62	$0.90	$17.17	$35.52
65	$17.98	$36.53	$0.90	$18.88	$37.43

peace of Mind *and* real cash Benefits

LIFE PROTECTOR
TERm LIFE INSURANCE

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Aflac®
We've got you under our wing.®

LIFE PROTECTOR

TERm LIFE INSURANCE

Policy Series A63000

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is your family protected if something unexpected happens to you?

Life is a series of unexpected twists and turns. If something happens to you, will your family have the funds to pay the bills without your income? We are here to help: Our 10-year, 20-year, or 30-year term life insurance policies are designed to help your loved ones through the tough times. You may apply for up to $200,000 ($100,000 for applicants over age 50) of life insurance protection.

And remember: With us, you get the security that comes from knowing your policy is backed by a market leader with more than 50 years of experience in the insurance industry. If you are looking for peace of mind in a life insurance company, look no further.

how we can help

No one likes to think he or she needs life insurance: After all, we all like to believe the unpleasant things in life only happen to others. But when people depend on you, assuring their financial futures with life insurance benefits is simply the right thing to do. With our policies, your premiums can be deducted from your paycheck. Plus:

1. Your coverage is portable, which means it goes with you if you change jobs.
2. Our policies are easy to understand—and we make things even simpler by offering two types of coverage: whole life and term life.
3. Our premiums are guaranteed for the selected term option, so you know how much your coverage will cost from month to month and year to year.

Aflac herein means American Family Life Assurance Company of Columbus.

why choose TerM life?

1 **Lower Premiums //** Depending on your age and smoking status, term life premiums may be lower than those for whole life insurance policies.

2 **highest Face Amount Coverage //** Typically, term life insurance offers the most face amount coverage for the lowest cost.

3 **Flexible Coverage //** Provides protection for a specified time period or term–most often 10, 20, or 30 years–and is designed for temporary circumstances. Term coverage often is purchased by those who need coverage for a specific time period, such as while they have young children, children in college, or are carrying a large debt load.

4 **Policy Renewal //** If, at the end of your 20-year or 30-year term, your policy has not lapsed and is still in force, you will have the option to renew your policy on an annual basis.

whaT is covered?

ACCELERATED DEATh BENEFIT *(primary insured only)*: We will pay 50 percent of the face amount upon diagnosis if the primary insured is diagnosed with a terminal condition. This benefit will be paid only once. The payment can help you and your loved ones with the expenses of a terminal condition (such as home nursing care, special equipment, and hospitalization). An administrative charge of $150 will be required when benefits are payable for a terminal condition and will be deducted from the Accelerated Death Benefit. Any Accelerated Death Benefit paid will reduce the death benefit and premium.

WAIvER OF PREmIUm BENEFIT *(primary insured only)*: Policy premiums will be waived if you become totally disabled under the terms of the policy. Please refer to Limitations and Exclusions for additional information.

Premiums are guaranteed for the selected term option. You may convert the policy while it is in force to a whole life policy without evidence of insurability, subject to policy requirements. The conversion privilege in the term policies must be exercised on or before the policy anniversary date following your 65th birthday. Refer to the policy for additional information.

OPTIONAL RIDERS

SPOUSE 10-YEAR (ISSUE AgES 18–65) TERm LIFE INSURANCE RIDER *(payroll sales only)*: We will pay 50 percent of the policy's face amount up to a maximum of $50,000 for your spouse.

ChILD TERm LIFE INSURANCE RIDER: We will pay term insurance coverage equal to 25 percent of the policy's face amount up to a maximum of $15,000 for each dependent child to age 25. To become insured, the child must be at least 14 days old and less than 18 years old at the time of application. The Effective Date of coverage for any eligible newborn child will not begin until the later of: (1) the date any eligible newborn child attains the age of 14 days, or (2) the date any eligible newborn child is first released from the hospital after birth.

ACCIDENTAL-DEATh BENEFIT RIDER *(primary insured only)*: We will pay an additional amount equal to the face amount selected if your death is the result of a covered accident and occurs within 180 days of the covered accident. Also, we will pay an additional 25 percent of the face amount selected if your death is the result of an automobile accident while you were wearing an unaltered, properly fastened seatbelt installed by the automobile manufacturer, and you were not at fault for the accident, according to the police report. Please refer to the Limitations and Exclusions for additional information.

whaT is noT covered liMiTaTions and exclusions

Any death benefit of the policy will not be payable if you or anyone covered by additional riders commits suicide, while sane or insane, within two years from the policy or rider Effective Date. Benefits will be limited to the amount of premiums paid.

A physician does not include a member of your immediate family.

peace *of* Mind.
cash BenefiTs.

OUR INSURANCE POLICIES hELP PROvIDE BOTh.

The following information only applies to the Waiver of Premium Benefit and the Accidental-Death Benefit Rider:

The Waiver of Premium Benefit will not waive premiums if the total disability is due to intentional self-inflicted injury, while sane or insane, or insurrection or war, declared or undeclared, or any act incident thereto.

The Accidental-Death Benefit Rider will not be payable if your death results from or is caused by your:

- Committing suicide, while sane or insane;
- Committing or attempting to commit a felony (*felony* is as defined by the law of the jurisdiction in which the activity takes place), or participating in a riot;
- Being exposed to insurrection or war, declared or undeclared, or any act incident thereto;
- Actively serving in any of the armed forces of any country, or units auxiliary thereto, including the National Guard or Reserve;
- Participating in any hazardous activities, including sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain climbing;
- Operating, riding in, or descending from any aircraft if you are a pilot, officer, or member of the crew of such craft, are giving or receiving any kind of training or instruction, or have any duties aboard or requiring descent from such craft;
- Having any infirmity, illness, or disease, including a bacterial infection, unless such bacterial infection also occurred simultaneously with and in consequence of a covered accident, or having an error, mishap, or malpractice during medical or surgical treatment, including diagnosis for any infirmity, illness, or disease;
- Participating in any activity or event, including the operation of a vehicle, while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred) or while under the influence of a controlled substance (unless prescribed by a physician and taken according to the physician's instructions);
- Using any drug, narcotic, hallucinogen, or chemical substance, or voluntarily taking any kind of poison or inhaling any kind of gas or fumes.

41% *Percentage of* AmERICAN ADULTS (95 million) who are uninsured. Two-thirds of uninsured households say they need more life insurance.*

*Cheryl D. Retzloff, LLIF, ACS, *Person-Level Trends in U.S. Life Insurance Ownership,* LIMRA, 2011, p. 8.

why do people purchase life insurance?

51%

reason no. 01

TO PAY BURIAL AND FINAL EXPENSES

40%

reason no. 02

TO REPLACE INCOME

3%

reason no. 03

TO PAY OFF A MORTGAGE

James O. Mitchel, Ph.D., CEBS, *2011 Insurance Barometer Study*, LIMRA, p. 11.

We've got you under our wing.®

aflac.com/social | 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

Pay Go Plus, Inc.
Rate sheet prepared by Web User on 10/14/2015 10:37:21 AM.
Georgia Payroll Premium rates are Weekly 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.

Accident Advantage - 24-HOUR ACCIDENT OPTION 2 - Series A36000

	Premium	Total
18-75 INDIVIDUAL	$4.92	$4.92
18-75 NAMED INSURED/SPOUSE	$6.57	$6.57
18-75 ONE-PARENT FAMILY	$7.74	$7.74
18-75 TWO-PARENT FAMILY	$9.75	$9.75

AFLAC HOSPITAL ADVANTAGE SELECT 1500 - Option1 Series A49100

Age	Individual	One Parent Family	Insured/Spouse	Two Parent Family
18-75	$9.90	$12.96	$15.03	$16.23

AFLAC HOSPITAL ADVANTAGE SELECT 1500 - Option2 Series A49200

Age	Individual	One Parent Family	Insured/Spouse	Two Parent Family
18-75	$11.67	$16.26	$18.69	$20.52

AFLAC HOSPITAL ADVANTAGE SELECT 3000 - Option1 Series A49100

Age	Individual	One Parent Family	Insured/Spouse	Two Parent Family
18-75	$17.94	$21.93	$26.34	$27.12

AFLAC HOSPITAL ADVANTAGE SELECT 3000 - Option2 Series A49200

Age	Individual	One Parent Family	Insured/Spouse	Two Parent Family
18-75	$19.68	$25.23	$30.00	$31.41

To sell Select 1500, Select 2000, Select 2500, Select 3000 or Option H (HSA-compatible) of the Aflac Hospital Advantage Product (Series A49000), the field force member must obtain prior approval.

Pay Go Plus, Inc.
Rate sheet prepared by Web User on 10/14/2015 10:37:21 AM.
Georgia Payroll Premium rates are Weekly 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 CANCER CARE PLAN SELECT - Series A78200

		Premium	IDR* (5 units)	Total
18-75	**INDIVIDUAL**	$4.14	$1.35	$5.49
18-75	**INSURED/SPOUSE**	$6.69	$3.00	$9.69
18-75	**ONE-PARENT FAMILY**	$4.14	$1.35	$5.49
18-75	**TWO-PARENT FAMILY**	$6.69	$3.00	$9.69

IDR = Optional Initial Diagnosis Rider (Series A-78050) premium 1-5 units*

AflAc HospitAl AdvAntAge

HospitAl confineMent indeMnitY insURAnce

policY seRies A49000

pRefeRRed

This brochure is for a hospital confinement indemnity policy providing limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or a major medical expense insurance.

Aflac will pay the following benefits, as applicable, for a covered sickness or accidental injury that occurs while coverage is in force. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

Benefit	Benefit Amount	Additional Benefit Information
Option 1 **HOSPITAL CONFINEMENT**	$1,000	Aflac will pay a Hospital Confinement Benefit of $1,000 when a covered person requires hospital confinement for 23 or more hours for a covered sickness or accidental injury and a charge is incurred. This benefit is payable once per period of hospital confinement, per covered person. Confinements must be separated by a minimum of 90 days from the previous covered hospital confinement for this benefit to be payable. No lifetime maximum.
REHABILITATION FACILITY	$100 per day	Aflac will pay $100 per day when a covered person is confined in a hospital and is transferred to a bed in a rehabilitation facility for a covered sickness or accidental injury and a charge is incurred. 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.
HOSPITAL EMERGENCY ROOM	$100	Aflac will pay $100 when a covered person receives treatment for a covered sickness or accidental injury in a hospital emergency room, including triage, and a charge is incurred. This benefit is payable twice per calendar year, per policy. The Hospital Emergency Room Benefit and the Hospital Short-Stay Benefit are not payable on the same day. No lifetime maximum.
HOSPITAL SHORT-STAY	$100	Aflac will pay $100 when a covered person receives treatment for a covered sickness or accidental injury in a hospital, including an observation room or an ambulatory surgical center, for a period of less than 23 hours and a charge is incurred. This benefit is not payable for treatment received in a hospital emergency room. This benefit is payable twice per calendar year, per policy. The Hospital Short-Stay Benefit and the Hospital Emergency Room Benefit are not payable on the same day. No lifetime maximum.
WAIVER OF PREMIUM	Upon written notice, Aflac will waive from month to month any premium(s) falling due during a continued period of hospital confinement for the named insured only. This benefit will begin after the period of hospital confinement for the named insured has exceeded 30 consecutive days. When such continued period of hospital confinement has ended, premium payments must be resumed. Once premium payments are resumed, any new period of hospital confinement must again satisfy the 30-day continued confinement for premiums to be waived.	
CONTINUATION OF COVERAGE	Aflac will waive all monthly premiums due for the policy and riders, if any, for up to two months if you meet all of the following conditions: • The policy was in force for at least six months. • We received premiums for at least six consecutive months. • Your premiums were paid through payroll deduction, and you left your employer for any reason. • You or your employer notified us in writing within 30 days of the date your premium payments ceased because of leaving employment. • You re-established premium payments with Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months.	
Option 2 *All benefits of option 1 plus the following* **PHYSICIAN VISIT**	$25	Aflac will pay $25 when a covered person incurs a charge for a physician visit. Services must be under the supervision of a physician. 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. The sickness or accidental injury of a covered person is not required for this benefit to be payable. Covered physician visits include but are not limited to eye exams, well-baby visits, immunizations, periodic health exams, and routine physicals. This benefit is not subject to the Pre-existing Condition Limitations or to the Limitations and Exclusions. No lifetime maximum.

Peace of mind *and* real Cash Benefits

ACCident indemnity AdvAntAge®

24-Hour ACCidentAL meAnS onLy inSurAnCe

AC²

Aflac®

We've got you under our wing.®

Benefit	Benefit Amount	Additional Benefit information
Wellness	$60 once per policy, per 12-month period, payable after the policy has been in force for 12 months	Payable if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your Spouse and the Dependent Children of either you or your Spouse. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Service must be under the supervision of or recommended by a physician, received while the policy is in force, and a charge must be incurred.
Aflac will pay the following benefits as applicable if a Covered Person's Accidental Death, dismemberment, or Injury is caused by a covered accident. Accidental Death, dismemberment, 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 Accidental Death, dismemberment, or Injury must also occur while coverage is in force and is subject to the limitations and exclusions. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.		
Accident emergency treatment	$120 once per 24-hour period and only once per covered accident, per Covered Person	Payable when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a physician or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable.
X-ray	$25 once per covered accident, per Covered Person	Payable when a Covered Person requires an X-ray while receiving emergency treatment **in a hospital or a hospital emergency room** for Injuries sustained in a covered accident. **This benefit is not payable for X-rays received in a physician's office.** The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.
Accident Follow-up treatment	$35 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person	Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed, certified acupuncturist. The Accident Follow-Up Treatment Benefit is not payable for the same days the Physical Therapy Benefit is paid.
Initial Accident Hospitalization	$1,000 once per period of Hospital Confinement or $2,000 once when a Covered Person is admitted directly to an intensive care unit; payable once per calendar year, per Covered Person	Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or if a Covered Person is admitted directly to an intensive care unit of a hospital for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.
Accident Hospital Confinement	$250 per day up to 365 days per covered accident, per Covered Person	Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.
Intensive Care unit Confinement	An additional $400 per day for up to 15 days per covered accident, per Covered Person	Payable for each day a Covered Person receives the Accident Hospital Confinement Benefit, and is confined and charged for a room in an intensive care unit for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.

Benefit	Benefit Amount	Additional Benefit information
Accident Specific-Sum injuries	$35–$12,500 (according to the policy) for: • Dislocations • Burns • Skin grafts • Eye injuries • Lacerations • Fractures • Concussions • Coma • Paralysis • Surgical procedures	Payable for treatment performed on a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation. Burns must be treated by a physician within 72 hours after a covered accident. If a Covered Person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burn benefit amount that we paid for the burn involved. Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. We will pay 25 percent of the benefit amount shown for the closed reduction of chip fractures and other fractures not reduced by open or closed reduction. We will pay for no more than two fractures per covered accident, per Covered Person. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per Covered Person. The duration of the paralysis must be a minimum of 30 days, and this benefit will be payable once per Covered Person. Coma must last a minimum of seven days. Coma does not include any medically induced coma. Treatment for surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the most expensive procedure. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.
Major diagnostic exams	$200 once per calendar year, per Covered Person	Payable when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a hospital or a physician's office. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit. No lifetime maximum.
Epidural pain management	$100 paid no more than twice per covered accident, per Covered Person	Payable when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure.
Physical therapy	$35 per treatment for one treatment per day, up to a maximum of ten treatments per covered accident, per Covered Person	Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a licensed physical therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.
Rehabilitation unit	$150 per day, limited to 30 days for each Covered Person per period of Hospital Confinement and limited to a calendar year maximum of 60 days	Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. The Rehabilitation Unit Benefit will not be payable the same days the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid. No lifetime maximum.
Appliances	$125 once per covered accident, per Covered Person	Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.

The policy has limitations and exclusions that may affect benefits payable.
This brochure is for illustrative purposes only. Refer to the policy for complete details, definitions, limitations, and exclusions.

Benefit	Benefit Amount	Additional Benefit information
prosthesis	$750 once per covered accident, per Covered Person	Payable when a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth.
blood/ plasma/ platelets	$200 once per covered accident, per Covered Person	Payable when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins.
ambulance	$200 when a Covered Person requires ambulance transportation $1,500 when a Covered Person requires air ambulance transportation	Payable when a Covered Person requires ambulance transportation or air ambulance transportation to a hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service. If the provider of service does not receive payment for services provided from any other source, and provided the benefit under the policy has not been paid, we will directly reimburse such provider of service.
transportation	$600 per round trip, up to three round trips per calendar year, per Covered Person	Payable per round trip to a hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident. This benefit is also payable when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any extended family member. This benefit is not payable for transportation to any hospital located within a 50-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.
family lodging	$125 per night, limited to one motel/ hotel room per night, up to 30 days per covered accident	Payable for one motel/hotel room for a member of the extended family who accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person.
accidental-death	Insured: Common-Carrier Accident $150,000; Other Accident $40,000; Hazardous Activity Accident $10,000 Spouse: Common-Carrier Accident $150,000; Other Accident $40,000; Hazardous Activity Accident $10,000 Child: Common-Carrier Accident $25,000; Other Accident $12,500; Hazardous Activity Accident $3,125	We will pay the applicable lump sum benefit indicated for the Accidental Death of a Covered Person to the beneficiary named in the application. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. Note: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate. Please see the Terms You Need to Know section of this brochure for more details about Common-Carrier Accidents, Other Accidents, and Hazardous Activity Accidents.

Benefit	Benefit Amount	Additional Benefit information
Accidental-dismemberment	$625–$40,000	We will pay the applicable lump sum benefit indicated in the policy for dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.
Continuation of Coverage	Waive all monthly premiums for up to two months	We will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) The policy has been in force for at least six months; (2) We have received premiums for at least six consecutive months; (3) Your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and (5) You re-establish premium payments either through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months. (*Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

What is Not Covered

Limitations and Exclusions

We will not pay benefits for services rendered by you or a member of the extended family of a Covered Person. We will not pay benefits for treatment or loss due to Sickness, including (1) any bacterial, viral, or micro-organism 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. We 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.

We will not pay benefits for an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person's:

- Being under the influence of a controlled substance (unless administered on the advice of a physician) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony (*felony* is as defined by the law of the jurisdiction in which the activity takes place);
- 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;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

Aflac shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

Aflac shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

A hospital does not include any institution or part thereof used as a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; 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.

A physical therapist does not include you or a member of your extended family.

A physician does not include you, a member of your extended family, or anyone who normally resides in your home or residence.

Aflac

Specified Health Event Protection

SPECIFIED HEALTH EVENT INSURANCE – PLAN 2

We've been dedicated to helping provide peace of mind and financial security for nearly 60 years.

Aflac®

We've got you under our wing.®

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Specified Health Event Protection is designed to provide you with cash benefits if you experience a catastrophic event, such as a heart attack or stroke. 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.

An illness or injury can happen to anyone, anytime—and when it does, everyday expenses may suddenly seem insurmountable. Fortunately, Aflac's specified health event insurance policy can help with those everyday expenses, so all you have to focus on is getting well.

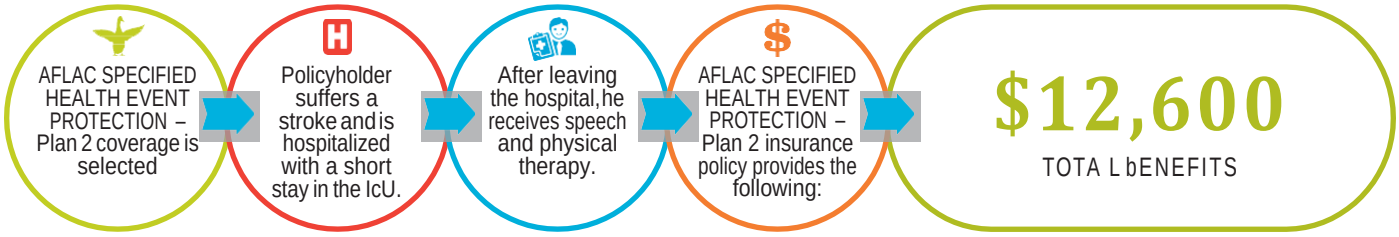
The Specified Health Event Protection insurance policy:

- Pays a lump-sum benefit upon diagnosis of having had a primary specified health event, which increases for dependentchildren.
- Pays benefits for hospital confinement, continuing care, transportation, and lodging.
- Is guaranteed-renewable for your lifetime with some benefits reduced at age 70.
- Has no deductibles, copayments, or network restrictions–you choose your own medical treatment provider.

Primary specified health events covered by the Specified Health Event Protection policy include:

- Coma
- Paralysis
- End-Stage Renal Failure
- Persistent Vegetative State
- Major Human Organ Transplant
- Stroke
- Heart Attack
- Major Third-Degree Burns
- Coronary Artery Bypass Surgery
- Sudden Cardiac Arrest

HOw IT wORkS



the above example is based on a scenario for Aflac specified Health event Protection – Plan 2 that includes the following benefit conditions: stroke (first-occurrence Benefit) of $5,000, Hospital Intensive care Unit Benefit (3 days) of $2,100, Hospital confinement Benefit (5 days) of $1,500, continuing care Benefit (30 days) of $3,750, ground ambulance transportation (Ambulance Benefit) of $250.

the policy has limitations and exclusions 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 for benefit details, definitions, limitations, and exclusions.

Plan 2 Specified Health Event Protection Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
FIRST-OCCURRENCE BENEFIT:	
• NAMED INSURED/SPOUSE	$5,000; lifetime max $5,000 per covered person
• DEPENDENT CHILDREN	$7,500; lifetime max $7,500 per covered person
REOCCURRENCE BENEFIT	$2,500; no lifetime max
SECONDARY SPECIFIED HEALTH EVENT BENEFIT	$250; no lifetime max
HOSPITAL CONFINEMENT BENEFIT	$300 per day; no lifetime max
HOSPITAL INTENSIVE CARE UNIT BENEFIT:	
• CONFINEMENT IN A HOSPITAL INTENSIVE CARE UNIT	SICKNESS: Days 1-7: ..... $700 per day Days 8-15: ..... $1,200 per day Days 16-30: ..... $350 per day INJURY: Days 1-7: ..... $800 per day Days 8-15: ..... $1,300 per day Days 16-30: ..... $350 per day Limited to 15 days per period of confinement; no lifetime max
• CONFINEMENT IN A STEP-DOWN INTENSIVE CARE UNIT	SICKNESS/INJURY: Days 1-15: ..... $350 per day Limited to 15 days per period of confinement; no lifetime max
MAJOR HUMAN ORGAN TRANSPLANT BENEFIT	$25,000; limited to one procedure per 180-day period; no lifetime max
PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP DOWN INTENSIVE CARE UNIT CONFINEMENT	A $2 indemnity benefit will accumulate for the named insured/spouse for each month the policy remains in force
CONTINUING CARE BENEFIT	$125 each day for up to 75 days; no lifetime max
MAMMOGRAPHY BENEFIT	$150 per policy year; no lifetime max
AMBULANCE BENEFIT	$250 ground or $2,000 air; no lifetime max
TRANSPORTATION BENEFIT	$.50 per mile; up to $1,500 per occurrence; no lifetime max
LODGING BENEFIT	Up to $75 per day; limited to 15 days per occurrence; no lifetime max

refer to the following outline of coverage for Benefit Details, Definitions, Limitations, and Exclusions.

Aflac
Short-Term Disability Insurance

We've been dedicated to helping provide peace of mind and financial security for nearly 60 years.

Aflac®

AFLAC SHORT-TERM DISABILITY INSURANCE

Policy Series A57600

SD

Helping Pay Your Bills, While You Pay Attention to Your Health

Imagine this. One day, not very far in the future, you become disabled. And you can't go to work. It could happen to you. In fact, last year millions of families found themselves in this situation.[1] How would you pay the mortgage? Buy groceries? Make your car payment? And pay all the other bills that won't go away, just because your paycheck is gone? That's where Aflac's short-term disability insurance policy can help make the difference. The difference that means you will still have a source of income and you will know Aflac is helping take care of your bills while you're taking care of yourself.

Why Aflac Short-Term Disability may be the best choice for you:

- Aflac short-term disability is sold on an individual basis. So you actually choose the plan that's right for you. We'll give you what you need based on your financial needs and income.
- We now offer the option of guaranteed-issue[2] short-term disability coverage. That means no medical questionnaire is required. That should help give you some peace of mind.
- We pay you a cash benefit for each day you are disabled.[3]

The facts say you need the protection of the Aflac Short-Term Disability plan:

FACT NO. 1

BEFORE THEY RETIRE,

1-in-3

AMERICANS ENTERING THE WORKFORCE TODAY WILL BECOME DISABLED.[1]

FACT NO. 2

NEARLY

90%

OF DISABILITIES ARE NOT WORK RELATED.[1]

[1]2013 Disability Insurance Awareness Month, Facts from LIMRA.
[2]Subject to certain conditions.
[3]Subject to your benefit period and elimination period.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Short-Term Disability benefits provide you with a source of income while you concentrate on getting better. This means that you will have added financial resources to help with expenses incurred due to medical treatment, to help with ongoing living expenses, or to help with any purpose you choose.

Here's how we can help

When disabled, you may not only lose the ability to earn a living, but you may also lose savings or retirement funds. The financial obligations can be overwhelming. Disability insurance plays an integral and important role in your financial planning.

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

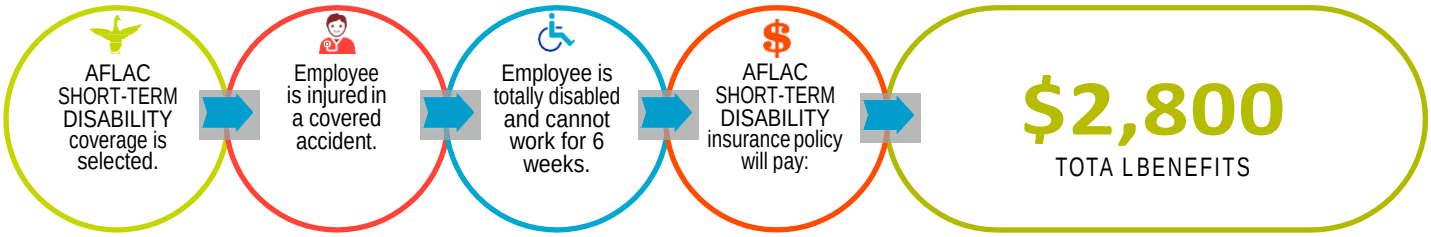
Aflac does not coordinate benefits. Regardless of any other disability insurance you may have, including Social Security, we will pay you directly.

Coverage Options

Choose the Policy You Need

- Monthly Benefit: $500–$6,000 (subject to income requirements)
- Total Disability Benefit Periods: 6, 12, 18, or 24 months
- Partial Disability Benefit Period: 3 months
- Elimination Periods (Injury/Sickness): 0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180

How it works



The above example is based on a scenario for Aflac Short-Term Disability that includes the following benefit conditions: ages 18–49, employed full-time at the time disability began, $2,000 monthly disability benefit amount, $40,000 annual salary, elimination period 0/7 days, 6 month benefit period, benefits based on policy premiums being paid with after-tax dollars.

The policy has limitations and exclusions 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 for benefit details, definitions, limitations, and exclusions.