DILLARD UNIVERSITY

2026 BENEFITS GUIDE

YOUR HEALTH & WELLNESS

Table of Contents

Medical Insurance

	HMO Louisiana Blue Connect Savings Plus 80/60 $4000		HMO Louisiana Blue POS Copay 100/80 $6250		Louisiana Blue Premier Blue Copay 100/70A	
Deductible	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$4,000	$8,000	$6,250	$12,500	$0	$1,000
Family	$8,000	$16,000	$12,500	$25,000	$0	$3,000
Coinsurance						
Member %	80%	60%	100%	80%	100%	70%
Out of Pocket Maximum						
Single	$6,350	$12,700	$7,900	$15,800	$1,250	$2,500
Family	$12,700	$25,400	$15,800	$31,600	$2,500	$5,000
Commonly Used Services						
Primary Care Physician Office Visit	Deductible then Coinsurance	Deductible then Coinsurance	$50	Deductible then Coinsurance	$20	Deductible then Coinsurance
Specialist Office Visit	Deductible then Coinsurance	Deductible then Coinsurance	$60	Deductible then Coinsurance	$35	Deductible then Coinsurance
Urgent Care	Deductible then Coinsurance	Deductible then Coinsurance	$60	Deductible then Coinsurance	$35	Deductible then Coinsurance
Emergency Room	Deductible then Coinsurance	Deductible then Coinsurance	350 (waived if admitted)	350 (waived if admitted)	350 (waived if admitted)	350 (waived if admitted)
Prescription Drug Coverage						
Generic (Tier 1)	80% Coinsurance after deductible	80% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	$7	$21
Brand Name (Tier 2)	60% Coinsurance after deductible	60% Coinsurance after deductible	80% Coinsurance after deductible	80% Coinsurance after deductible	$30	$90
Non-Preferred (Tier 3)	N/A	N/A	N/A	N/A	$70	$210

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck

Employee Only	$38.06	$100.00	$283.66
Employee + Spouse	$181.12	$397.50	$564.82
Employee + Child(ren)	$140.01	$215.00	$507.09
Family	$386.68	$597.50	$840.98

What is Nonstop Health?

Nonstop Health is a type of healthcare program that allows organizations to fund a portion of their employees' healthcare premiums and out-of-pocket expenses (e.g. deductibles, copays, and coinsurance) while also saving on premium expenses annually. The Nonstop Health program combines an ACA-compliant health plan with a section 105 medical expense reimbursement plan (MERP) – and provides you, the member, with a Visa card to help pay for in-network, covered medical expenses, up to the allowed amount of $7,900 for employee plans and $15,800 for employee + dependent plans.

With Nonstop Health, you will receive two cards in the mail after you enroll: your identification card from BCBS-LA and your Nonstop Visa card from Nonstop Administration and Insurance Services, Inc. (Nonstop).

What should I do with each card?

BCBS-LA ID CARD

Your ID card comes from BCBS-LA, and includes information relevant to the HDHP.

You must present your ID card from BCBS-LA during every doctor visit and for prescription purchases. This is important to ensure that BCBS-LA is apprised of the charge and properly credits your services toward your in-network deductible/out-of-pocket maximum.

NONSTOP VISA CARD

The Nonstop Visa card comes from Nonstop and can be used to pay for covered medical services and prescriptions received at in-network providers/facilities, up to the allowed amount for your plan. You cannot use the Nonstop Visa card to purchase over-the-counter drugs.

You will receive two Nonstop Visa cards, both in your name. If you need additional cards, contact us. We recommend that you do NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

How do I use Nonstop Health at my provider or pharmacy?

First:

Always use in-network* providers and make sure any services or prescriptions you receive are covered by your health insurance plan.

("Covered" means that the expenses for that service or prescription are applied toward your in-network deductible and/or out-of-pocket maximum. Not sure if something is covered? Check with your health insurance carrier.)

Next:

When you visit a provider or pharmacy, present your **HEALTH INSURANCE ID CARD** before paying for any services or prescriptions, to make sure the provider/pharmacy processes any payments through your medical carrier.

And finally:

When asked for payment at the pharmacy or when you receive a bill from your provider, simply pay for those costs using your **NONSTOP VISA CARD**. No need to pay for anything out of your own pocket (up to the allowed amount for your plan), as long as the doctor/pharmacy is in-network* and your service or prescription is covered by your health insurance plan!

** If you're on a version of Nonstop Health that allows you to use your Nonstop Visa card for out-of-network providers, this does not apply to you. Most Nonstop Health accounts do not have that option! If you're not sure, contact your HR team or Nonstop.*

If/when you receive a bill for in-network services, please pay that bill with your Nonstop Visa card. You cannot use the Nonstop Visa card for dental or vision payments. You will be responsible for any out-of-network or unapproved charges on the card.

Please note!

+ The Nonstop Visa card is coded for medical services and prescriptions, but it cannot tell the difference between a covered or non-covered service OR an in-network versus out-of-network provider. Just because your Visa card works at a provider or other merchant, that doesn't automatically mean the item or service you are paying for qualifies for Nonstop Health! If you aren't sure if a service or prescription is covered under your plan or a provider is in-network, contact your carrier.
+ The Nonstop Visa card works with digital wallets such as Apple Pay, Google Pay, and Samsung Pay. With just four quick steps you can connect your Nonstop Visa card to any of these services.
+ Nonstop Health is only designed for medical services and prescriptions. As such, you cannot use the Nonstop Visa card for dental or vision payments.
+ You will be responsible for any out-of-network or unapproved charges on the card.
+ If you receive a reimbursement check from BCBS-LA or a provider, please know that money needs to be re-deposited back into your employer's account with Nonstop. We request that you endorse the check and mail it to Nonstop at 1800 Sutter St. Suite 730 Concord CA 94520
+ There is a $100 Nonstop Health copay for all Emergency Room visits (waived if admitted). This copay is NOT covered under the Nonstop Health program. It will be your responsibility to pay out of pocket.

What to do if your Nonstop Visa card declines

There are times when your Nonstop Visa card may decline due to issues outside of Nonstop's control. One of the most common reasons is that there is an issue with the vendor's card machine and it won't read the Nonstop Visa card for payment. Please know this is outside of Nonstop's control and we are not able to fix it.

Other reasons for a declined card are listed below. Before calling Nonstop for help, consider:

Did you activate your card? When you received your card, did you call the number on the sticker on the front of the card? If not, the card won't work. Call 866.898.9795 as soon as possible.

Are you trying to use your card at a small, local pharmacy? They may not be set up properly to accept the Nonstop Visa card. Try larger national pharmacies and retail chains.

Are you trying to purchase ineligible items, such as over-the-counter medications? The Nonstop Visa card cannot be used for these expenses.

Are you trying to use the card to pay for dental or vision services? Nonstop Health is a Medical Expense Reimbursement Program (MERP), which is designed to cover medical expenses. As such, the Visa card is only coded for medical services and prescriptions and will **not** work for services that are coded as dental or vision.

Are you trying to use your card at an unapproved vendor? Vendors such as Amazon.com, FSA/HSA stores, weight loss programs, FullScripts, FreeSpira, Massage Envy, Carex, Smile Direct Club, PeopleCare, Warby Parker and Hero Health are **not** covered by Nonstop Health, so you may **not** use your Nonstop Visa card with them.

Is there enough money left on the card to cover the expense? To find out your card balance, call us at 877.626.6057, email us at clientsupport@nonstophealth.com or log in to the Nonstop Exchange (NSE) member portal at members.nonstophealth.com.

Sometimes, things just don't work properly. A merchant or vendor's card reader (including Square) may not have been coded correctly to accept the Nonstop Visa card. This is an issue with the card reader itself. Nonstop is not able to fix the problem.

If your card declines at a medical provider, you have three options:

- Pay out of pocket and submit a claim to Nonstop for reimbursement. For info, visit www.nonstophealth.com/claims.
- Ask the provider to bill you, then submit that bill, the relevant Explanation of Benefits (EOB), and all required Nonstop claims info to Nonstop via our claims process. We will pay the provider directly on your behalf.
- Ask the provider to bill Nonstop directly on your behalf. **But before doing that, contact us.** We have information explaining this process that you should share with your provider.

If your card declines and you need a prescription urgently:

Your option is to pay for that prescription out of your own pocket then be reimbursed by Nonstop via our claims process. Visit www.nonstophealth.com/claims.

If the prescription is **not** urgent and the cost is more than you're comfortable paying yourself, contact Nonstop. We'll see what we can do to help you.

What are some good tips and tricks I should know about?

Make sure any provider or facility you visit is in-network for your medical plan, and any medical prescription or service you receive is covered under your medical plan. It's better to check before receiving services or filling a prescription.

Don't go out of network for services or prescriptions unless you have written permission from BCBS-LA and confirmation that those expenses will be counted toward your in-network deductible.

Medical discount or coupon programs may not allow prescription/service costs to be applied toward your plan's in-network deductible, which means that these expenses would not qualify for Nonstop Health. If this happens, you will be responsible for covering those costs. We recommend checking with BCBS-LA before accessing a discount/coupon program.

If a provider asks you to prepay for a scheduled surgery or procedure, ask if you can hold off paying for anything until after you receive the final bill and Explanation of Benefits (EOB). If you cannot do that, we recommend you pay as little as you possibly can. That's important for two reasons:

- If you use up all the money on your Nonstop Visa card to prepay for surgery, you won't have any left for post-surgery expenses.
- By paying the bill after you receive the EOB, you will pay the correct amount and not have to worry about a potential provider overpayment and getting a refund.

Cosmetic surgery is not covered unless BCBS-LA deems it medically necessary.

If you require **medically necessary ophthalmology or dental procedures** and BCBS-LA has approved it as part of your medical plan, please know that you will not be able to use your Nonstop Visa card to pay for services as they will be coded for vision or dental. Please call Nonstop before your procedure and we will help pay the provider directly.

How to access Nonstop Health without a Visa card

While Nonstop makes every effort to get you your Nonstop Visa card as quickly as possible, there are times when you may not have it in hand on the first day of coverage. Additionally, if you lose your Nonstop Visa card or it is stolen, it may take a few weeks for your new one to arrive.

But not to worry! As long as you are enrolled in Nonstop Health, you can still access all of the benefits of the program – even if you don't have your Nonstop Visa card available. Let's review how to do this for both covered medical expenses and prescriptions received at in-network providers and facilities.

Prescriptions

If you need to pick up a prescription and do not have your Nonstop Visa card, you have two options:

1. If you need a prescription urgently and your card declines, your option is to pay for that prescription out of your own pocket, then be reimbursed by Nonstop via our claims process. Visit www.nonstophealth.com/claims.
2. If the prescription is **not** urgent and the cost is more than you want to pay yourself, contact Nonstop. We'll see what we can do to help you.

Medical Services

If you receive medical services before receiving your Nonstop Visa card in the mail, please request that your provider bill you for those services. Typically bills can take 30-60 days to move through the medical insurance and provider systems. As such, you should have your Nonstop Visa card by the time you receive the bill.

Alternatively, you can request that your provider bill Nonstop directly! Contact us and we can send you a letter/form that explains this process to your provider.

If you need to pay a copay or coinsurance at the point of service, you will need to pay for those costs out-of-pocket and submit a claim to be reimbursed by Nonstop Health. For information on submitting a claim, visit www.nonstophealth.com/claims.

Quick Tip! For both medical services and prescriptions, make sure you provide your medical plan information to the pharmacy or provider so all costs are applied to your in-network deductible and out-of-pocket maximum! This is an important step in the process.

What is/isn't covered under Nonstop Health

The Nonstop Health program only works with in-network providers/facilities and covered services and prescriptions. But what exactly does this mean?

Key terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.

In-network providers are those who have a contract with your insurance company, and have set up a pre-negotiated rate for different services. As such, the provider can only charge your insurance – and you – a set price for the services you receive. This results in lower costs, as in-network providers almost always charge less than an out-of-network provider.

Covered services: A covered service is one that BCBS-LA has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service please check with BCBS-LA first. They may have a cost or visit limit for specified services, or other limitations.

Covered prescriptions: BCBS-LA will set a "formulary" or drug list at the beginning of each plan year, which lists what prescriptions will be covered under your medical plan. Just because a doctor prescribes you a medication doesn't mean it's automatically covered by your insurance! So before paying for a new prescription, be sure to call BCBS-LA or ask your pharmacist if it's covered.

BCBS-LA approved: This means that your insurance has agreed to cover a service or prescription as part of your underlying medical plan. This includes covered services and prescriptions. However, it also can indicate that BCBS-LA has given you explicit/written permission to see an out-of-network provider for services and agreed that those costs will be considered in-network and covered under your plan.

Examples of what Nonstop Health covers – and what It doesn't

COVERED EXPENSES

Nonstop Health may be used to pay for all services and prescriptions that are covered under your medical plan. In essence, this means that if your health insurance has agreed to pay for a medical service or prescription as part of your medical coverage, then you can use your Nonstop Visa card to pay for it. If BCBS-LA does not cover a service or prescription, then you will be responsible for 100% of those costs. If you're not sure if a service or prescription is covered, check your Summary of Benefits and Coverage (SBC) or contact BCBS-LA before receiving care.

NON-COVERED EXPENSES

Because medical plans cover services and prescriptions differently, there's not an exhaustive list of where you can/can't use your Nonstop Visa card. **However, below are a few examples of services/providers/facilities that are never covered by Nonstop Health.** These are only examples! If you're not sure if a service or prescription is covered, please check with BCBS-LA!

- Amazon.com or any FSA/HSA stores
- Weight Loss Programs
- FullScripts
- FreeSpira
- Massage Envy
- Carex
- Smile Direct Club
- PeopleCare
- Warby Parker
- Hero Health

As a general rule, the Nonstop Visa card cannot be used for the following:

- Over-the-counter medication, vitamins or supplements
- Dental services, unless covered under your medical plan
- Vision services, unless covered under your medical plan
- Services and medications not approved by your health insurance
- Durable Medical Equipment (DME) not approved by your health insurance
- Alternative care that is not approved by your health insurance
- Mental health services not approved by your health insurance
- Feminine hygiene products

Nonstop Visa card substantiation policy

You may use the Nonstop Visa card for covered, in-network services and prescriptions, up to the allowed amount for your plan. The card may not be used for out-of-network or elective procedures or anything that BCBS-LA would not apply towards your in-network deductible and out-of-pocket tracking. In addition, the Nonstop Health program does not cover dental or vision costs so you cannot use your Nonstop Visa card to pay for these services.

Charges on your card may need to be substantiated to ensure they are in-network and covered. Substantiation simply means that we are confirming acceptable use of your Nonstop Visa card. **Nonstop reserves the right to ask you for documentation to confirm that the charges on the card were allowed and approved by BCBS-LA, and counted toward your deductible and out-of-pocket tracking.** Documentation typically includes an Explanation of Benefits (EOB). *Please see the next page for how to find and read your EOB.*

If charges on your Nonstop Visa card cannot be substantiated and/or have not been approved by BCBS-LA, we may request that you repay the amount that does not qualify for the Nonstop Health program back into your employer's healthcare plan. If we do not receive documentation or repayment, your card may be suspended. If you still don't respond after your card is suspended, your account may be sent to collections if you haven't made a required repayment and/or your debt isn't repaid via claims offsetting. Before serious actions are taken, we want to work with you to settle the matter.

THE SUBSTANTIATION PROCESS:

1. Nonstop's system **REVIEWS CHARGES DAILY, AND FLAGS ANY THAT NEED A CLOSER LOOK.** This is called substantiation.
2. If a charge on your Nonstop Visa card is flagged, **NONSTOP WILL EMAIL YOU UP TO THREE TIMES.**
3. Still no response from you? **WE MAY CONTACT YOUR HR DEPARTMENT** to make sure we have your correct contact info, and to ask them for help in reaching you. If you're waiting for info from your carrier, contact us ASAP; we may be able to give you more time before further action is taken.
4. **IF WE STILL DON'T HEAR FROM YOU, YOUR NONSTOP VISA CARD WILL BE SUSPENDED.** If you still don't respond after your card is suspended, your account may be sent to collections if you haven't made a required payment and/or your debt isn't repaid via claims offsetting.

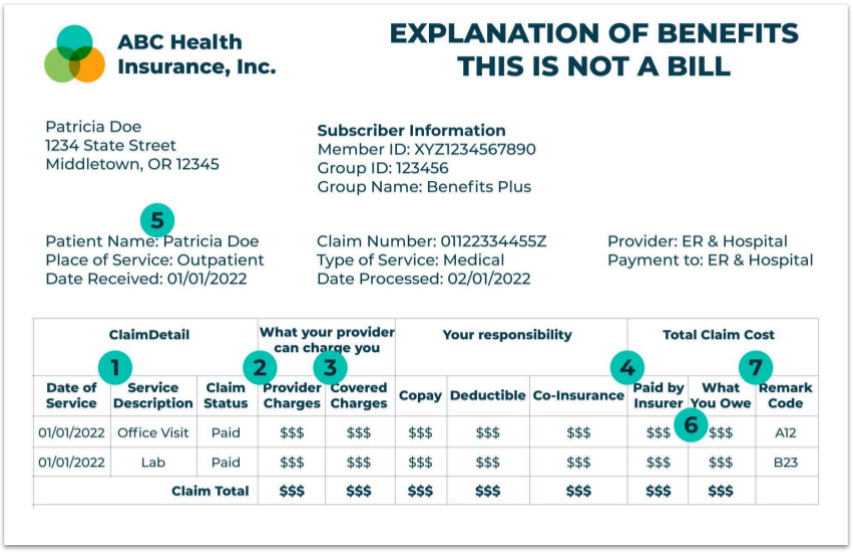
Please note: If/when we leave you a message or send an email, we cannot include personal health information due to HIPAA compliance regulations. We will simply ask you to call us back or respond to our email.

How to find and read your EOB

An Explanation of Benefits (EOB) is a statement generated by your health insurance company summarizing how it processed a claim from a doctor, hospital, or other medical provider**. This is the most critical piece of paperwork that Nonstop will need to substantiate a charge on your Visa card or process a claim for reimbursement or provider payment!** ***We cannot do either without an EOB.***

BCBS-LA is required to provide you with an EOB for each medical service that you receive under your insurance plan. Most health insurance companies mail EOBs to your home, although you can opt out of receiving paper EOBs and instead sign up for an online account with BCBS-LA to access your documents digitally. Each health insurance company has slightly different approaches to EOB delivery so if you aren't sure where to find your EOBs, contact BCBS-LA directly.

The below example shows what an EOB may look like (*actual format varies*) and what information will be provided:



ABC Health Insurance, Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Patricia Doe
1234 State Street
Middletown, OR 12345

Subscriber Information
Member ID: XYZ1234567890
Group ID: 123456
Group Name: Benefits Plus

5
Patient Name: Patricia Doe
Place of Service: Outpatient
Date Received: 01/01/2022

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2022

Provider: ER & Hospital
Payment to: ER & Hospital

ClaimDetail			What your provider can charge you		Your responsibility			Total Claim Cost		
1			2	3			4		7	
Date of Service	Service Description	Claim Status	Provider Charges	Covered Charges	Copay	Deductible	Co-Insurance	Paid by Insurer	What You Owe 6	Remark Code
01/01/2022	Office Visit	Paid	$$$	$$$	$$$	$$$	$$$	$$$	$$$	A12
01/01/2022	Lab	Paid	$$$	$$$	$$$	$$$	$$$	$$$	$$$	B23
	Claim Total		$$$	$$$	$$$	$$$	$$$	$$$	$$$	

1. **Service Description** is a description of the health care services you received, like a medical visit, lab tests, screenings, surgery or lab tests.
2. **Provider Charges** is the amount your provider bills for your visit.
3. **Allowed Charges** is the amount that your provider will be reimbursed, negotiated between the carrier and the provider (this may not be the same as the Provider Charges).
4. **Paid by Insurer** is the amount your insurance plan will pay to your provider.
5. **Payee** is the person who will receive any reimbursement for over-paying the claim.
6. **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid. You may have already paid part of this amount, and payments made directly to your provider may not be subtracted from this amount. Wait to receive a bill from your provider before paying for the services.
7. **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

HELPFUL TIP

It's a good idea to have an online account with your insurance carrier so you can access EOBs, look up providers, review plan benefits/coverage and more. If you need help setting up your account, logging in or finding your information, contact your carrier.

What information Nonstop needs from your EOB:
Nonstop needs the information/dollar amounts listed as "your responsibility" on your EOB; this includes: in-network deductible, copays, and coinsurance. Before sending us an EOB, please make sure this information is accurate and matches your provider bill. In addition, we will be looking at the remarks or comments section to confirm that the service was covered under your plan and received at an in-network provider.

Nonstop is not affiliated with your insurance carrier. This, in addition to HIPAA privacy laws, means that we cannot request EOBs or any other documents on your behalf.

Key dates and deadlines

When using the Nonstop Health program there are some key dates and deadlines that apply to the Nonstop Visa card as well as the Nonstop claims process. Please read this information carefully so you don't miss any critical deadlines for reimbursement! If you need to submit a claim, visit www.nonstophealth.com/claims.

The Nonstop Visa card is available to use as of your start date:

The Nonstop Visa card cannot be used for claims prior to your start date on the Nonstop Health program. For example, if you first started on the Nonstop Health program on September 1, 2025, you cannot use the card to pay for claims with dates of service prior to this date (e.g. August 14, 2025).

The Nonstop Visa card can only be used within the current plan year:

The Nonstop Visa card should not be used to pay for expenses from the prior plan year. The Nonstop Visa card can only be used in the same year as the services were rendered. For example, medical services received between **September 1, 2025** and **August 31, 2026,** must be paid for using the Nonstop Health Visa card in that timeframe. Once the date turns to September 1, 2026, you cannot pay for 2025-2026 expenses with the Nonstop Visa card. Instead, to receive reimbursement or have a provider paid for 2025-2026 bills/claims, you will need to submit those to Nonstop.

Claims submission deadlines while enrolled in Nonstop Health:

All Nonstop Health claims must be submitted no later than 90 days after the end of the plan year. As such, all 2025-2026 claims are due by or **before November 30, 2026**.

Every September 1st deductibles and out-of-pocket maximums reset:

All medical plan deductible and out-of-pocket maximum calculations are based on a plan year and reset to $0 every **September 1**. The Nonstop Visa card also resets on **September 1**.

Claims deadlines when benefits and/or employment is terminated:

If you leave your employer or are no longer eligible for benefits, you are required to submit all past claims to the Nonstop Health office within **90 days** of your last day of coverage. Your Nonstop Visa card will be canceled on your last day of coverage and all services performed before the last day of coverage should be submitted to Nonstop.

Using the Nonstop Exchange (NSE) member portal

Once you are enrolled with Nonstop Health, you will be able to access your plan information via the Nonstop Exchange (NSE) member portal (members.nonstophealth.com). When you log into the system all your information will be available, allowing you to:

+ View available card balances
+ View demographic information
+ View documents about your plan (e.g. summary plan description, benefits summary)
+ Navigate to our member help site through the HELP button, where you can find fast answers to questions
+ File and view claims submissions

Refer to the Member Documents tab in the Nonstop Exchange (NSE) member portal to access and view all complete plan summaries for your medical benefits. All legal and compliance-related notices are also under the Member Docs tab.

Logging into the NSE for the first time

1. Go to members.nonstophealth.com. Click on "Don't Remember Your Password?" on the login page and enter your email address (If you're unsure about what email to use, contact Nonstop). You will be emailed a link to set a personal and private password.
2. Then come back to members.nonstophealth.com and re-enter your email and new password.
3. When you log in for the first time you must go through our two-factor authentication process. You will be asked to enter your mobile phone number, and then a six-digit code will be texted to you. Enter that code to log into NSE. A second "backup" code will be provided when you log in and we recommend writing down or taking a picture of this backup code. If you're using a trusted computer/browser, you can click "Remember This Browser" to bypass two-factor authentication for 30 days. If you don't have a mobile phone number, please contact us!

Three Ways To Check Your Nonstop Visa Card Balance:

1. Call Nonstop (877.626.6057) and press **Option 1**
- Make sure you know the last four digits of your Nonstop Visa card and the last four digits of the subscriber's Social Security number.
- If the card has just been activated, wait 24 hours, then call for your balance.

2. Email clientsupport@nonstophealth.com

3. Log in to the Nonstop Exchange (NSE) member portal at members.nonstophealth.com. (See "Using the Nonstop Exchange (NSE) member portal" section in this guide for all the details.)

Submitting a Claim to Nonstop

While the Nonstop Health program is set up to help you pay for a portion of your medical expenses, there may be times when you'll need to pay upfront and be reimbursed later. If needed, the claims submission process is quick and easy with reimbursement checks typically processed within 7-10 days of submission.

SUBMITTING A CLAIM ONLINE

1. **LOG IN TO THE NONSTOP EXCHANGE PORTAL** (members.nonstophealth.com)
2. **CLICK ON THE SUBMIT NEW CLAIM BUTTON** and fill in all of the required information.
3. **UPLOAD THE PROPER DOCUMENTATION.** For a provider visit, upload the Explanation of Benefits and provider bills. For prescriptions, upload the detailed pharmacy bag receipt.*
4. **REVIEW YOUR CLAIM AND SUBMIT!** A ticket number will be provided that you can use as a reference when checking on the status of your claim.
5. Expect a **REIMBURSEMENT OR PROVIDER PAYMENT** to be mailed out after a 7–10 day processing period.**

* For a claim to be processed, the service date you enter on the first page must match the date stated on the uploaded documentation.
** During peak claims season (annually Jan. 1 – April 30), it may take up to 30 days for Nonstop to process your claim.

Alternatively, you can submit a claim manually by filling out a claims form and emailing it or faxing it to Nonstop. Visit www.nonstophealth.com/claims for a claims form.

What if my reimbursement check doesn't arrive?

In the rare instance that a payment or reimbursement check is lost, Nonstop will re-issue a check after 30 days and confirmation from the service provider that they have not received payment.

How can I track a claim or reimbursement?

If the claim is submitted via Nonstop Exchange, it will appear as a pending claim on your dashboard. When you submit a claim via email, a reference number will be assigned to that claim and you'll receive a confirmation response. Visit www.nonstophealth.com/claims for more details on filing and viewing claims. If claims were submitted via fax or through the US Postal System, contact Nonstop Health at 877-626-6057 or via email at claims@nonstophealth.com for details on whether the claim was received or has been paid.

What happens if Nonstop pays my provider directly?

When a bill has been paid by Nonstop, you will not receive a notification from Nonstop that payment has been made. If you continue to receive bills from providers after a claims submission to Nonstop Health, we recommend that you follow up with the Nonstop Health team directly. The bill has likely been paid, but has not been credited to your account with your provider yet.

Nonstop Health Contact Information

	Phone / Fax / Email	Website
Nonstop Administration & Insurance Services, Inc. (Member Support)	General Phone: 877.626.6057 Member Support Email: clientsupport@nonstophealth.com Substantiation Fax: 719.270.9845 Substantiation Email: eob@nonstophealth.com Claims Fax: 877.463.1175 Claims Email: claims@nonstophealth.com	www.nonstophealth.com Nonstop Exchange (NSE) member portal: members.nonstophealth.com

Dental Insurance

Louisiana Blue

BlueDental Traditional Dental Plan B Ortho

Deductible	Benefits
Single	$50
Family	$150
Maximum the carrier will pay	
Annual Maximum	$2,000
Dental Coverage	
Cleanings	100%
Exams	100%
X-Rays	100%
Sealants	100%
Fillings	80%
Simple Extractions	80%
Root Canal	80%
Periodontal Gum Disease	80%
Oral Surgery	80%
Crowns	50%
Dentures	50%
Bridges	50%
Implants	50%
Orthodontia	50%
Out of Network Explanation	
	Blue Dental benefits are the same for in- and out-of-network. Standard reimbursement for out-of-network claims is 90% percentile.
Plan Information	
Waiting Period for Major Services	None
Member Website	www.lablue.com/FindCare

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck

Employee Only	$18.47
Employee + Spouse	$41.19
Employee + Child(ren)	$34.67
Family	$58.53

Vision Insurance

Louisiana Blue

Vision Plan 8

Vision Coverage	In-Network	Out-of-Network
Eye Exam	$10	up to $30
Single Vision Lens	Included	up to $40
Lined Bi-Focal Lens	Included	up to $60
Lined Tri-Focal Lens	Included	up to $80
Lenticular Lens	Included	up to $100
Contact Lens Allowance	up to $130	up to $105
Frame Allowance	up to $130 or $180	up to $30
Frequencies		
Exam Frequency	Once Every: 12 Months	
Lens Frequency	Once Every: 12 Months	
Frame Frequency	Once Every: 24 Months	
Plan Information		
Member Website	www.lablue.com/FindCare	
Customer Service Phone Number	1-800-247-9368	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck

Employee Only	$2.77
Employee + Spouse	$5.43
Employee + Child(ren)	$5.68
Family	$8.45

Group Life and AD&D Insurance (100% Employer Paid)

Equitable

Basic Life/AD&D insurance

Life Insurance Benefits	
Life Benefit Amount	1X Basic Annual Earnings
Life Maximum Benefit	$500,000
Life Age Reduction	35% reduction at age 65, an additional 50% reduction at age 70
Accelerated Death Benefit	75% up to $250,000
Plan Information	
Member Website	www.equitable.com/employeebenefits
Customer Service Phone Number	(866)274-9887

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

EQUITABLE

Group name: DILLARD UNIVERSITY
Policy number: 005051
Form created: 08/05/2025

Protection for you and your loved ones

Life insurance benefit summary

The importance of Life insurance

The right life insurance coverage can help protect your loved ones and help provide financial stability when they need it most. They can use the benefit to fund a child's education, pay off a mortgage or pay for everyday expenses.

Watch this quick video to learn more

Did you know?

More than ⅓ of households would feel the financial impact in less than 6 months if the primary wage earner died.[1]

Today, few have the coverage they need. And 48% of households (60 million) have an average life insurance coverage gap of

$200,000

Voluntary Life Benefit plan and features

Class definition: Class 1 – All Active Full Time Employees

Life Benefit	Employee	Spouse	Children	
Life Benefit Amount	Increments of $10,000	Increments of $5,000	Live birth to 14 days:	$500
			15 days to age 26:	Increments of $10,000
Life Maximum Benefit	The lesser of 5 times Basic Annual Earnings or $400,000	$200,000, not to exceed 50% of employee coverage amount	$10,000	
Guaranteed Issue Amount	$150,000	$10,000	$10,000	
Life Age Reduction				

Life Benefit	Employee	Spouse	Children
Age 65 but less than 70	65%	Matches Employee	None
Age 70 or over	50%	Matches Employee	None
Any reduction pursuant to this provision will take place on the next Policyholder anniversary date			
Accelerated Death Benefit	75% up to $250,000	75% up to $250,000	Not Applicable
Waiver of Premium	Included	Included	Included
Portability	Included	Included	Included
Conversion	Included	Included	Included

Understanding your benefits

Commonly Used Terms

Guarantee Issue Amount	This is the amount of insurance available without having to provide evidence of insurability (also known as proof of good health).
Accelerated Death Benefit	Allows you access to a portion of your Life insurance while you are alive if you have a qualifying condition, such as a terminal illness, cognitive impairment, or the inability to perform two or more activities of daily living without assistance.
Waiver of Premium	Provides for the continuation of insurance without premium payment if you become disabled (details around ages).
Basic Annual Earnings	Means your regular rate of pay from your employer in effect on the date immediately prior to the date the covered loss occurs. It includes any deductions made for pre-tax contributions to a qualified deferred compensation plans, section 125 plan, or flexible spending account. It does not include commissions, bonuses, tips, tokens, overtime pay or any other fringe benefits or extra compensation.
Portability	Allows you to take your group term Life insurance coverage with you if you leave your employer.
Conversion	Allows you convert your group term Life insurance coverage to an individual, whole life policy if your coverage is reduced or ends.

Frequently Asked Questions

When can I enroll for coverage?	You can enroll when you are initially eligible, during any annual enrollment period, or within 31 days of a family status change. Evidence of insurability (also known as proof of good health) may be required. Please see your coverage certificate for details.
When can I change my amount of coverage?	You can change your amount of coverage during any annual enrollment period or within 31 days of a family status change. Evidence of insurability (also known as proof of good health) may be required. Please see your coverage certificate for details.
Are my spouse and dependent children eligible for coverage?	Yes, your spouse, domestic partner, or civil union partner and your dependent children are eligible for coverage. Your dependent children are eligible for coverage up to the date on which they turn 26 years old.
Does the coverage decrease as I get older?	Yes, the age reductions are shown in the "Benefit Plan & Features" section. The coverage on you and your spouse will reduce on the next Policyholder anniversary date following your attainment of the ages shown. The percentages referenced are what the coverage reduces to and are all based on the original amount of coverage. For example, if you are covered for $50,000 and the coverage reduces to 65% at age 65, your coverage will reduce to $32,500 on the policy anniversary following your 65th birthday.

How do I port or convert my coverage?	Contact your employer's HR department for the applicable portability and/or conversion forms. You can also call Equitable customer service at (866)274-9887 or access the forms at https://equitable.com/employee-benefits/customer-service/forms
How much does the portability coverage cost?	The rate for portability coverage is the same as the rate under your employer's plan.
How do I name a beneficiary?	Your employer will provide you with a form that will allow you to name primary and contingent beneficiaries.
Can I change my beneficiary?	Yes, you just need to complete a new beneficiary form and be sure to provide a copy to your employer.
What happens if I die and didn't name a beneficiary?	The insurance proceeds may be paid out to a specific family member or your estate, check your insurance certificate for the language applicable to your plan.

Cost Summary

Monthly Sample Costs – Employee Life

	Coverage Amount									
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
Less than 25	$0.41	$0.82	$1.23	$1.64	$2.05	$2.46	$2.87	$3.28	$3.69	$4.10
25-29	$0.34	$0.68	$1.02	$1.36	$1.70	$2.04	$2.38	$2.72	$3.06	$3.40
30-34	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.59	$2.96	$3.33	$3.70
35-39	$0.53	$1.06	$1.59	$2.12	$2.65	$3.18	$3.71	$4.24	$4.77	$5.30
40-44	$0.78	$1.56	$2.34	$3.12	$3.90	$4.68	$5.46	$6.24	$7.02	$7.80
45-49	$1.22	$2.44	$3.66	$4.88	$6.10	$7.32	$8.54	$9.76	$10.98	$12.20
50-54	$1.88	$3.76	$5.64	$7.52	$9.40	$11.28	$13.16	$15.04	$16.92	$18.80
55-59	$2.92	$5.84	$8.76	$11.68	$14.60	$17.52	$20.44	$23.36	$26.28	$29.20
60-64	$4.06	$8.12	$12.18	$16.24	$20.30	$24.36	$28.42	$32.48	$36.54	$40.60
65-69	$6.46	$12.92	$19.38	$25.84	$32.30	$38.76	$45.22	$51.68	$58.14	$64.60
70-74	$12.32	$24.64	$36.96	$49.28	$61.60	$73.92	$86.24	$98.56	$110.88	$123.20
75-79	$26.36	$52.72	$79.08	$105.44	$131.80	$158.16	$184.52	$210.88	$237.24	$263.60
80 and over	$58.61	$117.22	$175.83	$234.44	$293.05	$351.66	$410.27	$468.88	$527.49	$586.10

This chart is a summary and does not include all the coverage options available.

Monthly Sample Costs – Spouse Life

	Coverage Amount									
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Less than 25	$0.21	$0.41	$0.62	$0.82	$1.03	$1.23	$1.44	$1.64	$1.85	$2.05
25-29	$0.17	$0.34	$0.51	$0.68	$0.85	$1.02	$1.19	$1.36	$1.53	$1.70
30-34	$0.19	$0.37	$0.56	$0.74	$0.93	$1.11	$1.30	$1.48	$1.67	$1.85
35-39	$0.27	$0.53	$0.80	$1.06	$1.33	$1.59	$1.86	$2.12	$2.39	$2.65
40-44	$0.39	$0.78	$1.17	$1.56	$1.95	$2.34	$2.73	$3.12	$3.51	$3.90
45-49	$0.61	$1.22	$1.83	$2.44	$3.05	$3.66	$4.27	$4.88	$5.49	$6.10
50-54	$0.94	$1.88	$2.82	$3.76	$4.70	$5.64	$6.58	$7.52	$8.46	$9.40

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
55-59	$1.46	$2.92	$4.38	$5.84	$7.30	$8.76	$10.22	$11.68	$13.14	$14.60
60-64	$2.03	$4.06	$6.09	$8.12	$10.15	$12.18	$14.21	$16.24	$18.27	$20.30
65-69	$3.23	$6.46	$9.69	$12.92	$16.15	$19.38	$22.61	$25.84	$29.07	$32.30
70-74	$6.16	$12.32	$18.48	$24.64	$30.80	$36.96	$43.12	$49.28	$55.44	$61.60
75-79	$13.18	$26.36	$39.54	$52.72	$65.90	$79.08	$92.26	$105.44	$118.62	$131.80
80 and over	$29.31	$58.61	$87.92	$117.22	$146.53	$175.83	$205.14	$234.44	$263.75	$293.05

This chart is a summary and does not include all the coverage options available.

Monthly Sample Costs – Children Life

Coverage Amount
$10,000
$1.00

*Regardless of the number of children covered.

Email: Customer Service at EBCustomerService@equitable.com.

Contact us at (866) 274-9887 with any questions you may have.

This includes questions on how we can provide language translation services at no cost to you and how we can assist the visually impaired with form completion and other information.

Members requiring assistance with hearing impairment can contact our TDD line directly at (800) 877-8973.

Visit equitable.com/employeebenefits and log on to EB360® to view your account details.

[1] 2022 Insurance Barometer Study, Life Happens and LIMRA.

[2] limra.com/en/newsroom/news-releases/2021/industry-associations-unite-to-help-address-the-life-insurance-coverage-gap-in-the-united-states/, accessed August 2022.

Important Information

Limitations and exclusions: The following is a summary. A complete list of applicable exclusions and limitations are included in the policy and certificate. State variations may apply. If an Insured Person dies by suicide within two years from their coverage issue date, we will only pay the amount of premiums paid.

This policy provides limited benefits: The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. For costs and complete details of the coverage, please see the actual policy or contact your benefits representative. Benefits payable are subject to all terms and conditions of the certificate. Plan documents are the final arbiter of coverage. Policy contract forms: ICC18 MOEBPLI; ICC18 AXEBPLI; MOEBP0618 LI; AXEBP0618 LI; and state variations.

Legal disclosures: Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company with an administrative office located in Charlotte, NC, and Equitable Distributors, LLC. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI and TN). All group insurance products are issued either by Equitable Financial or Equitable America, which have sole responsibility for their respective insurance and backed solely by their claims-paying obligations. Some products are not available in all states.

EQUITABLE

Plan Highlights

Group Short Term Disability Insurance

Dillard University

COVERAGE

Disability income protection insurance provides a benefit for short term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY

Each Active Full-Time Employee working 40 hours or more per week, except for any person working on a temporary or seasonal basis.

BENEFIT AMOUNT

The benefit amount is equal to 70% of your weekly covered earnings, to a maximum benefit of $1,000 per week.

DAY BENEFITS BEGIN

Injury (accident) and Sickness (illness): benefits begin on the 31st consecutive day of disability.

MAXIMUM BENEFIT DURATION

Benefits for one period of disability will be paid up to a maximum of 9 weeks.

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employer Paid.

FEATURES

- Maternity covered as any other illness
- Non-occupational coverage
- Partial Disability
- Transfer of Coverage provision
- FMLA Continuation
- Military Services Leave of Absence Continuation
- W-2 Services

VALUE-ADDED SERVICES

- Telephonic Claim Intake Service

LIMITATIONS

- Offsets: Your benefit may be reduced by other income sources such as, but not limited to, Social Security, Workers Compensation, State Disability Plans.

Plan Highlights

Group Long Term Disability Insurance

Dillard University

COVERAGE

Disability income protection insurance provides a benefit for long term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY

Each Active Full-Time Employee excluding Executives working 40 hours or more per week, except for any person working on a temporary or seasonal basis.

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employer Paid.

ELIMINATION PERIOD

90 consecutive days of total disability.

BENEFIT AMOUNT

The benefit amount is equal to 60% of your monthly covered earnings, from a minimum of $100, to a maximum benefit of $6,000 per month.

MAXIMUM BENEFIT DURATION

Benefits will not extend beyond the longer of your Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
61 or less	To Age 65
62	3 1/2 Years
63	3 Years
64	2 1/2 Years
65	2 Years
66	1 3/4 Years
67	1 1/2 Years
68	1 1/4 Years
69 or more	1 Year

FEATURES

- Extended Disability Benefit
- Military Services Leave of Absence
- FMLA Continuation
- Own Occupation Coverage – 24 Months
- Rehabilitation Provision
- Residual and Partial Disability
- Specific Indemnity Benefit
- Survivor Benefit – 3 months
- Transfer of Coverage Provision
- Work Incentive & Child Care Provisions
- Worksite Modification Benefit

VALUE-ADDED SERVICES

- Employee Assistance Program
- Travel Assistance Services
- ID Theft Recovery Services

LIMITATIONS

- Pre-Existing Condition Limitation: 3/12
- Mental & Nervous Limitation – 24 months outpatient
- Substance Abuse Limitation – 24 months
- Offsets: your benefit may be reduced by other income sources such as, but not limited to, Social Security, Workers Compensation, State Disability Plans

reliancestandard
LIFE INSURANCE COMPANY

www.reliancematrix.com

Plan Highlights

Group Long Term Disability Insurance

Dillard University

COVERAGE

Disability income protection insurance provides a benefit for long term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY

Each Active Full-Time Executive Employees working 40 hours or more per week, except for any person working on a temporary or seasonal basis.

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employer Paid.

ELIMINATION PERIOD

90 consecutive days of total disability.

BENEFIT AMOUNT

The benefit amount is equal to 60% of your monthly covered earnings, from a minimum of $100, to a maximum benefit of $13,000 per month.

MAXIMUM BENEFIT DURATION

Benefits will not extend beyond the longer of your Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
61 or less	To Age 65
62	3 1/2 Years
63	3 Years
64	2 1/2 Years
65	2 Years
66	1 3/4 Years
67	1 1/2 Years
68	1 1/4 Years
69 or more	1 Year

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- Pre-Existing Condition Limitation: 3/12
- Mental & Nervous Limitation – 24 months outpatient
- Substance Abuse Limitation – 24 months
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www.reliancematrix.com

Group Accident Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Initial Accident Treatment Category- Mid	Employee	Spouse	Child
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$150	$150	$150
ER/Urgent Care with X-Ray	$200	$200	$200
Doctor's Office	$75	$75	$75
Doctor's Office with X-Ray	$100	$100	$100
Ambulance - once per day, within 90 days of the accident			
Maximum number of payments per covered accident: No Maximum			
Ground	$300	$300	$300
Air	$900	$900	$900
Major Diagnostic Testing - within six months of the accident Maximum number of diagnostic tests per covered accident: 1	$150	$150	$150
Emergency Room Observation - within 7 days of the accident			
Maximum number of 24-hour periods of observation per covered accident: No Maximum			
Short Observation Period (4-24 Hours)	$35	$35	$35
Long Observation Period (24+ Hours)	$70	$70	$70
Prescriptions - within six months of the accident Maximum number of filled prescriptions per covered accident: 2	$5	$5	$5
Pain Management - within six months of the accident Maximum number of payments per covered accident: 1	$75	$75	$75
Blood/Plasma/Platelets - within six months of the accident Maximum number of days per covered accident: 3	$200	$200	$200
Concussion - once per accident, within six months of the accident	$350	$350	$350
Traumatic Brain Injury - once per accident, within six months of the accident	$3,500	$3,500	$3,500
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a result of a covered accident	$7,500	$7,500	$7,500
Burns - once per accident, within six months of the accident			
Second Degree Burns			
Less than 10%	$75	$75	$75
At least 10%, but less than 25%	$150	$150	$150
At least 25%, but less than 35%	$375	$375	$375
35% or more	$750	$750	$750
Third Degree Burns			
Less than 10%	$750	$750	$750
At least 10%, but less than 25%	$3,750	$3,750	$3,750
At least 25%, but less than 35%	$7,500	$7,500	$7,500
35% or more	$15,000	$15,000	$15,000
Emergency Dental Work - once per accident, within six months of the accident			
Repair with Crown	$120	$120	$120
Extraction	$30	$30	$30
Eye Injury - removal of a foreign body	$175	$175	$175

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

Dislocation Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip	$4,500	$4,500	$4,500	$2,250	$2,250	$2,250
Knee	$2,925	$2,925	$2,925	$1,462.50	$1,462.50	$1,462.50
Shoulder	$2,250	$2,250	$2,250	$1,125	$1,125	$1,125
Foot/Ankle	$1,800	$1,800	$1,800	$900	$900	$900
Hand	$1,575	$1,575	$1,575	$787.50	$787.50	$787.50
Lower Jaw	$1,350	$1,350	$1,350	$675	$675	$675
Wrist	$1,125	$1,125	$1,125	$562.50	$562.50	$562.50
Elbow	$900	$900	$900	$450	$450	$450
Finger/Toe	$360	$360	$360	$180	$180	$180

Lacerations - once per accident, within 7 days of the accident			
Lacerations requiring stitches			
Up to 2"	$75	$75	$75
2" to 6"	$300	$300	$300
Over 6"	$600	$600	$600
Lacerations not requiring stitches	$37.50	$37.50	$37.50

Group Accident Insurance

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

Fracture Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip/Thigh	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Vertebrae/Sternum	$5,400	$5,400	$5,400	$2,700	$2,700	$2,700
Pelvis	$4,800	$4,800	$4,800	$2,400	$2,400	$2,400
Skull (Depressed)	$4,500	$4,500	$4,500	$2,250	$2,250	$2,250
Leg	$3,600	$3,600	$3,600	$1,800	$1,800	$1,800
Forearm/Hand/Wrist	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Foot/Ankle/Kneecap	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Shoulder Blade/Collar Bone	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Lower Jaw	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Skull (Simple)	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050
Upper Arm/Upper Jaw	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050
Facial Bones (except teeth)	$1,800	$1,800	$1,800	$900	$900	$900
Vertebral Processes/Sacrum	$1,200	$1,200	$1,200	$600	$600	$600
Coccyx/Rib/Finger/Toe	$480	$480	$480	$240	$240	$240

Outpatient Surgery and Anesthesia (per day) - within one year of the accident Performed in a Hospital or Ambulatory Surgical Center Maximum number of payments per covered accident: No Maximum	$300	$300	$300
Performed in a Doctor's Office, Urgent Care Facility or Emergency Room Maximum number of payments per covered accident: 2	$35	$35	$35
Facilities Fee for Outpatient Surgery - within one year of the accident Payable once per each Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$75	$75	$75
Inpatient Surgery and Anesthesia (per day) - within one year of the accident Maximum number of payments per covered accident: No Maximum	$750	$750	$750
Transportation - within six months of the accident Maximum number of payments per covered accident: 3 Minimum Required Distance (miles): 100			
Plane	$350	$350	$350
Any ground transportation	$150	$150	$150

(Surgical procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.)

Hospitalization Category - Mid	Employee	Spouse	Child
Hospital Admission (per confinement) - once per accident, within six months of the accident Maximum number of admissions per covered accident: 1	$900	$900	$900
Hospital Confinement (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 365	$225	$225	$225
Hospital Intensive Care (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 30	$300	$300	$300
Intermediate Intensive Care Step-Down Unit (per day) - within six months of the accident Maximum days of confinement per covered accident: 30	$150	$150	$150
Family Member Lodging (per day) - within six months of the accident Maximum days of lodging per covered accident: 30 Minimum Required Distance (miles): 100	$150	$150	$150

Group Accident Insurance

After Care Category - Mid	Employee	Spouse	Child
Appliances - within six months of the accident			
Cane Maximum number of appliances per covered accident: No Maximum	$30	$30	$30
Ankle Brace Maximum number of appliances per covered accident: No Maximum	$30	$30	$30
Walking Boot Maximum number of appliances per covered accident: No Maximum	$75	$75	$75
Walker Maximum number of appliances per covered accident: No Maximum	$75	$75	$75
Crutches Maximum number of appliances per covered accident: No Maximum	$75	$75	$75
Leg Brace Maximum number of appliances per covered accident: No Maximum	$75	$75	$75
Cervical Collar Maximum number of appliances per covered accident: No Maximum	$75	$75	$75
Wheelchair Maximum number of appliances per covered accident: No Maximum	$300	$300	$300
Knee Scooter Maximum number of appliances per covered accident: No Maximum	$300	$300	$300
Body Jacket Maximum number of appliances per covered accident: No Maximum	$300	$300	$300
Back Brace Maximum number of appliances per covered accident: No Maximum	$300	$300	$300
Accident Follow-Up Treatment - within 6 months of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$35	$35	$35
Post Traumatic Stress Disorder (PTSD) - once per accident, within 6 months of the accident	$150	$150	$150
Rehabilitation Unit (per day) Maximum number of days per confinement: 31 No more than 62 days total per calendar year for each insured	$75	$75	$75
Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 10	$35	$35	$35
Chiropractic or Alternative Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$25	$25	$25

Life Changing Events Category - Mid	Employee	Spouse	Child
Dismemberment - once per accident, within six months of the accident			
Single Loss	$8,750	$3,750	$1,750
Double Loss	$17,500	$7,500	$3,500
Loss of one or more fingers or toes	$875	$375	$175
Partial Dismemberment (includes at least one joint of a finger or toe)	$87.50	$87.50	$87.50
Paralysis - once per accident, diagnosed by a doctor within six months of the accident			
Paraplegia	$3,500	$3,500	$3,500
Quadriplegia	$7,500	$7,500	$7,500
Prosthesis - once per accident Maximum number of prosthetic devices per covered accident: 2	$2,000	$2,000	$2,000
Prosthesis Repair/Replacement - once per prosthetic device, within three years of initial Prosthesis payment	$2,000	$2,000	$2,000
Residence/Vehicle Modification - once per accident, within one year of the accident	$1,500	$1,500	$1,500

Wellness Rider - Mid-LT	Employee	Spouse	Child
Amount paid will be based on the certificate year in which the wellness test was performed: Maximum number of payments per calendar year, per insured: 1			
Year 1 - Once per calendar year	$50	$50	$50
Year 2 - Once per calendar year	$50	$50	$50
Year 3 - Once per calendar year	$50	$50	$50
Year 4 - Once per calendar year	$50	$50	$50
Year 5 - Once per calendar year	$50	$50	$50
Year 6+ - Once per calendar year	$50	$50	$50

Group Accident Insurance

Accidental Death Rider	Employee	Spouse	Child
Accidental Death - within 90 days of the accident			
Accidental Death	$50,000	$25,000	$10,000
Accidental Common-Carrier Death	$100,000	$50,000	$20,000

Group Accident Insurance

Premium Rates

Monthly Premiums

Coverage	Premium
Employee	$14.78
Employee and Spouse	$23.89
Employee and Child(ren)	$29.63
Family	$38.74

Group Critical Illness Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Base Benefits	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	100%
Major Organ Transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Type I Diabetes	100%

**25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant*

Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$1000 per calendar year
Metastatic Cancer	25%

Health Screening Benefit	
Health Screening (payable for employee and spouse only)	$50
Health Screening (payable for dependent children)	100% of the Health Screening Amount
Payable per calendar year	1

Additional Benefits	
Benign Brain Tumor	100%
Type II Diabetes	10%

Childhood Conditions Rider	
Cystic Fibrosis, Cerebral Palsy, Cleft Lip or Cleft Palate, Down Syndrome, Phenylalanine Hydroxylase Deficiency Disease (PKU), Spina Bifida	50% of employee benefit
Autism Spectrum Disorder	$3000

Progressive Diseases Rider	
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS)	100%
Sustained Multiple Sclerosis (MS)	100%
Chronic Obstructive Pulmonary Disease (COPD)	25%
Crohn's Disease	25%

Specified Diseases Rider	
Tier 1 – Adrenal Hypofunction (Addison's Disease), Cerebrospinal Meningitis, Diphtheria, Encephalitis, Huntington's Chorea, Legionnaire's Disease, Lyme Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis	25%
Tier 2 – Human Corona Virus Only	
Hospitalization: 4+days	10%
Hospitalization: 10+days	25%
Hospitalization: Intensive Care Unit (ICU)	40%

Group Critical Illness Insurance

Premium Rates

Employee - Uni-Tobacco Monthly Premiums						
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$3.11	$6.21	$9.32	$12.42	$15.53	$18.63
30-39	$5.50	$11.00	$16.50	$22.00	$27.50	$33.00
40-49	$9.73	$19.46	$29.20	$38.93	$48.66	$58.39
50-59	$16.07	$32.13	$48.20	$64.27	$80.33	$96.40
60+	$27.66	$55.32	$82.98	$110.64	$138.29	$165.95

Spouse - Uni-Tobacco Monthly Premiums						
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$3.11	$6.21	$9.32	$12.42	$15.53	$18.63
30-39	$5.50	$11.00	$16.50	$22.00	$27.50	$33.00
40-49	$9.73	$19.46	$29.20	$38.93	$48.66	$58.39
50-59	$16.07	$32.13	$48.20	$64.27	$80.33	$96.40
60+	$27.66	$55.32	$82.98	$110.64	$138.29	$165.95

Group Hospital Indemnity Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Hospitalization Benefits - Mid	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	**$1,000**
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	**$150**
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$150**
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$75**

Health Screening Benefit	
Health Screening Benefit Payable once per calendar year per insured.	**$50**

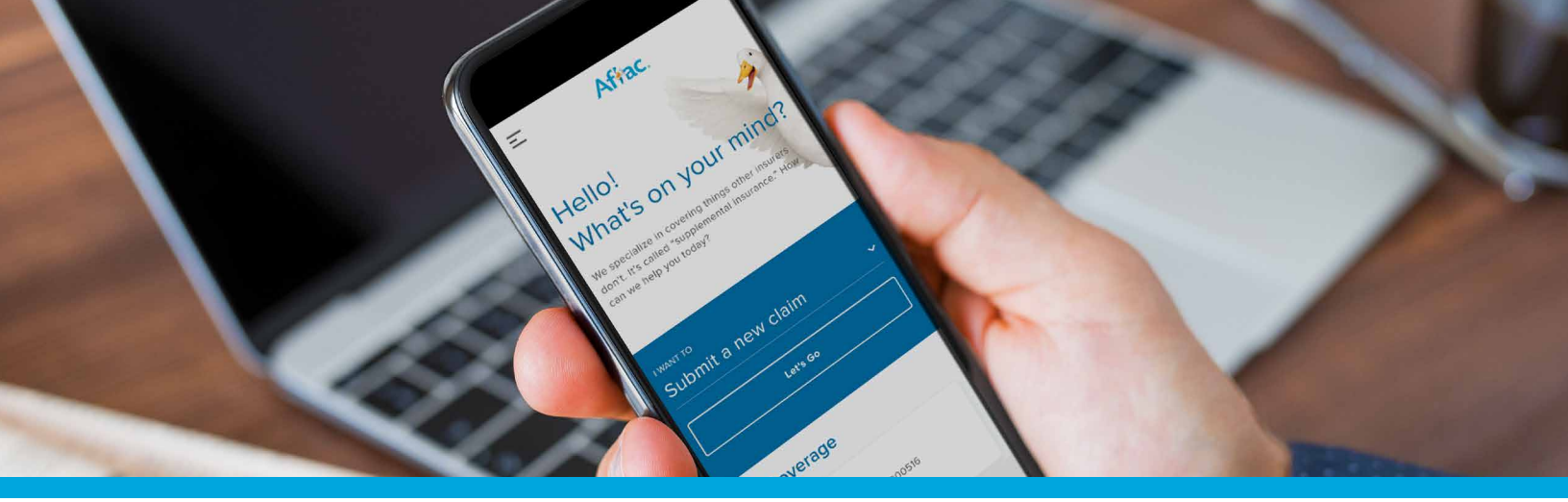
Dependent Child Neonatal and Pediatric Hospital ICU Rider	
Dependent Child Neonatal and Pediatric Hospital ICU Benefit (per day) Maximum of 31 days per confinement to a Neonatal of Pediatric Hospital ICU for each covered sickness or accident per dependent child	**$300**

Group Hospital Indemnity Insurance

Premium Rates

Monthly Premiums

Coverage	Premium
Employee	$22.32
Employee and Spouse	$40.76
Employee and Child(ren)	$34.34
Family	$52.78



MyAflac® digital claims experience

Aflac's products are designed to help cover the expected – and unexpected – that's sure to come life's way. They represent our promise to be there for our customers when they need us most. When customers file eligible claims through our MyAflac mobile app or on our website, they'll experience the easiest way to get benefits paid fast.

Customers who use MyAflac can:*

- Enjoy an end-to-end digital, self-service experience.
- Enable biometric login for convenient access.
- Access their account anytime, from anywhere.
- View coverage details and claims history.
- Download or print an ID card.
- Follow a guided, step-by-step claims submission process.
- Submit documents directly by phone.
- Sign forms electronically.
- Enroll in direct deposit.
- Be confident they're getting paid all eligible benefits because we cross-adjudicate across all coverages based on a single claim.

Connect with your Aflac sales professional to learn more about our MyAflac digital claims experience.

Scan here for a short video that shows how MyAflac makes our claims process easy.

Aflac®

* This flyer describes the user experience for Aflac Group certificate holders. MyAflac functionality may vary depending on type of coverage.

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Filing your claim has never been easier

Register your account at aflac.com/login to access and manage your coverage, submit and track claims, enroll in direct deposit for fast claim payment and more.

What you'll need to get started:

- Your Aflac policy or certificate number (that's included in your welcome letter or policy packet), or you can use your Social Security number and mobile phone number.
- We'll also need your date of birth and zip code to verify your coverage. Make sure your name matches what you used at enrollment (for example, Michael vs. Mike for first name).

Follow the steps to complete your registration:

Once you're finished, go ahead and log in and set up direct deposit to get your money faster, often within 48 hours.*

1. Select My Account > Manage Account from top-right navigation.
2. Select Billing & Direct Deposit.
3. Select Manage Direct Deposit to add your banking information and get paid fast!

You can also take advantage of these features 24/7:

Submit claims & track status

- Follow the steps for easy claims filing.
- Complete and upload supporting documentation if requested.
- Sign your claim electronically.
- Check the status and get updates while your claim is processing.

Manage your policies

- Update your contact information.
- Assign beneficiaries.

Questions? Connect whenever you need us, 24/7, by scanning this QR code, logging in to your account or chatting with us at aflac.com/contact-aflac.

*Registration of a new account can take up to 24 hours to take effect.

To submit your claim by mail, send your completed forms and supporting documents to the Aflac WWHQ address below, Attn: Claims Department. Coverage is underwritten by Aflac. WWHQ | 1932 Wynnton Road |Columbus, Georgia 31999. In New York, coverage is underwritten by Aflac New York. 22 Corporate Woods Boulevard, Suite 2 | Albany, New York 12111

Life and long-term care policies and coverage in Puerto Rico do not qualify for Aflac Always but can be switched to direct billing once the employer has paid its final Aflac invoice.

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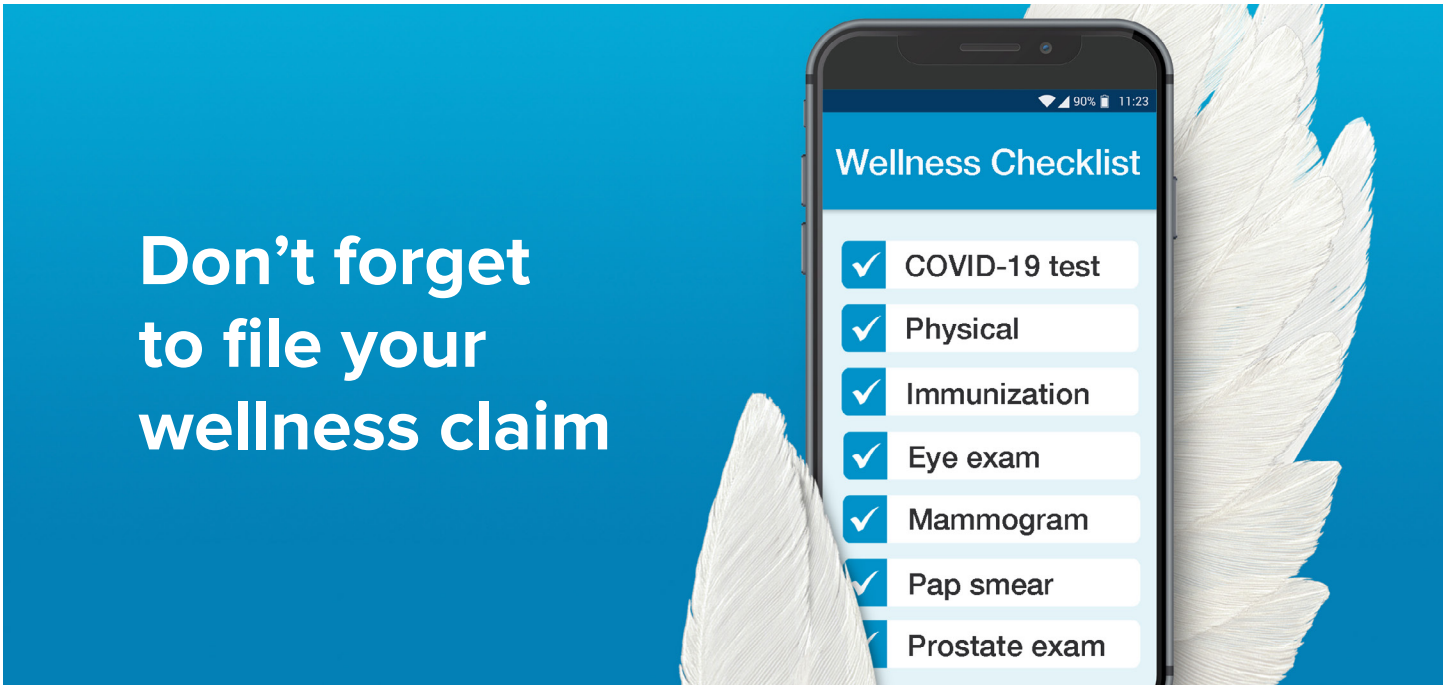

There could be cash waiting for you

As part of your benefits package, you had the chance to sign up for an Aflac plan. Your plan helps with expenses health insurance doesn’t cover, and benefits can be used in any way you want – whether that’s to pay unexpected medical bills or everyday living expenses.

Aflac wants to put money into your pocket by encouraging you to file a wellness claim. Put simply, many of our plans provide an annual benefit for proactively managing your health with a COVID-19 screening or antibody test, annual physical or eye exam, mammogram, pap smear, prostate exam or another covered exam.*

Filing a claim is easy: Simply log in to **www.aflac.com/myaflac** or download the MyAflac ® mobile app and follow the instructions to file a claim. Don’t want to wait for a check? Signing up for direct deposit will get your money to you faster.

Available on the App Store

GET IT ON Google Play

Download the MyAflac ® mobile app

Continental American Insurance Company
In California, Continental American Life Insurance Company

Aflac ®

*These are examples of common exams that may be covered under your wellness benefit and not a guarantee of benefits paid. Coverage varies by state and plan selected. Please refer to your certificate for details and a list of covered exams.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico or the Virgin Islands. For groups situsted in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situsted in New York, coverage is underwritten by Aflac of New York.
Continental American Insurance Company | Columbia, SC

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Exp 5/24

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ALLONE HEALTH

Assistance Program is Here to Help

Life comes with challenges.

Reach out to your Assistance Program for short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health and make life easier. The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions

Up to 3 telephonic sessions to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Life Coaching

To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation

To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, and saving for retirement or tuition.

Legal Consultation

To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Management

To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant

To help manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining and personal services.

Medical Advocacy

To help navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Member Portal and App

Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through AllOne Health's 24/7, live-answer, toll-free number.

EAP services are provided by AllOne Health, under agreement with Reliance Matrix.

Contact AllOne Health: Call 855-RSL-HELP (855-775-4357) or visit allonehealth.com/reliance-matrix. Code: RSLI859

RS-2505 (12/24)

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ALLONE HEALTH

Introducing Your Member Portal

Browse benefits. Request services. Enjoy 24/7/365 access.

Your Assistance Program offers a wide range of benefits to help improve mental health, reduce stress and make life easier — all easily accessible through your member portal.

Request a Mental Health Session

Request counseling by submitting an online form or live chat. Choose from in-person or virtual counseling options to meet your needs.

Request Referrals & Resources

Submit a request for family care and lifestyle support including childcare and eldercare referrals, legal referrals and financial consultation, personal assistant referrals and medical advocacy consultation.

Explore Thousands of Self-Care Articles & Resources

Health and lifestyle assessments, interactive checklists, soft skills courses, podcasts, resource locators, exclusive discounts, and expansive articles on whole health and well-being.

Visit Your Online Financial Center

Featuring worksheets, calculators, and a wide range of financial resources and tools to help reach personal goals and build financial wellness.

Getting Started Is Easy

1. Visit **allonehealth.com/reliance-matrix** and click on "Sign Up" below the login form
2. To create an account and sign in, enter your email address and company code: **RSLI859**
3. For login assistance, select "Email Support"

EAP services are provided by AllOne Health, under agreement with Reliance Matrix.

Contact AllOne Health: Call 855-RSL-HELP (855-775-4357) or visit allonehealth.com/reliance-matrix. Code: RSLI859

RS-2731 (12/24)

Notes

This Benefit Booklet

Presented by

Health & Wealth Consultants

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