



EQUITABLE

Products Included

Life/AD&D
Dental
Vision
Short-Term Disability
Long-Term Disability
Critical Illness
Accident
Hospital Indemnity

Employee Benefits Proposal for:



Policy Form/Contract Numbers:

Dental: MOEBP19DEN; MOEBP19DEN_PPO; AXEBP19DEN and State Variations.

Vision: MOEBP15VN; AXEBP15VN and State Variations.

Group Life Insurance: ICC15 AXEBP15LI; ICC15 MOEBP15LI; MOEBP15LI; AXEBP15LI and State Variations.

Short- and Long-Term Disability: AXEBP15DI; MOEBP15DI and State Variations.

Group Critical Illness/Specified Disease Insurance: MOEBP19 CI; AXEBP19 CI; and State Variations.

Accident: MOEBP19 ACC; AXEBP19 ACC; and State Variations.

Group Hospital Indemnity Insurance: MOEBP22 HI; AXEBP22 HI; and State Variations.

Presented by:

Centerstone Insurance

Effective Date: November 01, 2023

Prepared On: September 19, 2023

Valid Until: November 01, 2023

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This proposal includes optional non-insurance services for specific lines of coverage and carry separate PEPM charges that are added to the cost of insurance. Travel Assistance Program services are provided by AXA Assistance USA, Inc.



Group Term Life

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	\$25,000	
Guarantee Issue	\$25,000	
Age Reduction	35% of the original life amount at age 65 50% of the original life amount at age 70	
Waiver of Premium	Total Disability Prior to Age 60 Any Occupation 9 Month Elimination Period Terminates at age 65	
Accelerated Death Benefit	75% to \$250,000 payable for terminal illness, severe cognitive impairment or loss of Activities of Daily Living	
Conversion Benefit	Included	
Employee Assistance Program	Not Included	
Travel Assistance	Included	
Takeover	No	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contribution		
Employer Contribution	100%	
Participation Requirement	100% of eligible employees	
Cost Summary	Volume	Monthly Rate per \$1,000
	\$475,000	\$0.070
Monthly Premium	\$33.25	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Accidental Death & Dismemberment

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	\$25,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye 25% All Toes on One Foot 25% All Fingers on One Hand 25% Uniplegia 75% Paraplegia 50% Hemiplegia 100% Quadriplegia 50% Speech 50% Hearing in Both Ears 50% One Limb 100% Sight in Both Eyes	
Age Reduction	35% of the original AD&D amount at age 65 50% of the original AD&D amount at age 70	
Common Carrier Benefit	100% of AD&D benefit up to \$250,000	
Exposure and Disappearance Benefit	Included	
Rehabilitation/Physical Therapy Benefit	\$5,000	
Seat Belt Benefit	\$10,000	
Airbag Benefit	\$5,000	
Premium Contribution		
Employer Contribution	100%	
Participation Requirement	100% of eligible employees	
Cost Summary	Volume	Monthly Rate per \$1,000
	\$475,000	\$0.039
Monthly Premium	\$18.53	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Supplemental Life

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	\$10,000 to \$300,000 in \$10,000 increments, not to exceed 5 times employee's Basic Annual Earnings	
Benefit Maximum	\$300,000	
Guarantee Issue	\$100,000	
Age Reduction	35% of the original life amount at age 65 50% of the original life amount at age 70	
Minimum Benefit Amount	\$10,000	
Waiver of Premium	Total Disability Prior to Age 60 Any Occupation 9 Month Elimination Period Terminates at age 65	
Accelerated Death Benefit	75% to \$250,000 payable for terminal illness, severe cognitive impairment or loss of Activities of Daily Living	
Portability	Included	
Conversion Benefit	Included	
Enrollment	Open enrollment for the policy effective date only (EOI is required for any amounts above the GI amount); for future annual enrollments coverage can be increased during the annual enrollment period by 2 increment(s) without EOI; EOI is required for any increases above this amount, for any amounts above the GI amount, and for all late entrants	
Takeover	No	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 4 enrolled lives or 20% of eligible employees	
Cost Summary	Volume	Monthly Rate per \$1,000
<25	TBD	\$0.050
25-29	TBD	\$0.069
30-34	TBD	\$0.080
35-39	TBD	\$0.104
40-44	TBD	\$0.155
45-49	TBD	\$0.240
50-54	TBD	\$0.372
55-59	TBD	\$0.580
60-64	TBD	\$0.834
65-69	TBD	\$1.328
70-74	TBD	\$2.531
75-79	TBD	\$5.413
80+	TBD	\$12.038
Monthly Premium	TBD	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Supplemental Accidental Death & Dismemberment

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	\$10,000 to \$300,000 in \$10,000 increments, not to exceed 5 times employee's Basic Annual Earnings	
Benefit Maximum	\$300,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye 25% All Toes on One Foot 25% All Fingers on One Hand 25% Uniplegia 75% Paraplegia 50% Hemiplegia 100% Quadriplegia 50% Speech 50% Hearing in Both Ears 50% One Limb 100% Sight in Both Eyes	
Age Reduction	35% of the original AD&D amount at age 65 50% of the original AD&D amount at age 70	
Common Carrier Benefit	100% of AD&D benefit up to \$250,000	
Rehabilitation/Physical Therapy Benefit	\$5,000	
Seat Belt Benefit	\$10,000	
Airbag Benefit	\$5,000	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 4 enrolled lives or 20% of eligible employees	
Cost Summary	Volume	Monthly Rate per \$1,000
	TBD	\$0.037
Monthly Premium	TBD	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Supplemental Dependent Life

Eligibility	
Class Description	Class 1: All Active Full Time Employees
Minimum Hours Requirement	30 Hours per week
Eligibility Waiting Period	TBD
Definition (as defined in the policy)	Spouse and Child(ren) must be living in the United States and performing the normal activities of a person of like age/sex on the effective date of insurance. Child(ren) covered from birth to age 26.
Benefit Plan and Features	
Plan Schedule	Spouse: \$5,000 to \$100,000 in \$5,000 increments, not to exceed 50% of the employee's Supplemental Life amount. Child: Live birth to 14 days: \$500 15 days to age 26: \$10,000 to \$10,000 in \$10,000 increments
Guarantee Issue	Spouse: \$25,000
Age Reduction	35% of the original life amount at age 65 50% of the original life amount at age 70
Waiver of Premium	Total Disability Prior to Age 60 Any Occupation 9 Month Elimination Period Terminates at age 65
Spouse Accelerated Death Benefit	75% to \$250,000 payable for terminal illness, severe cognitive impairment or loss of Activities of Daily Living
Enrollment	Open enrollment for the policy effective date only for spouse coverage; EOI is required for any spouse amounts above the GI amount; for future annual enrollments coverage can be increased on spouses during the annual enrollment period by 2 increment(s) without EOI; EOI is required for any increases above this amount, for any amounts above the GI amount, and for all late entrants. Employees can add or increase coverage on their child(ren) at any annual enrollment period without EOI.
Premium Contribution	
Employer Contribution	0%
Participation Requirement	Greater of 4 enrolled lives or 20% of eligible employees



Group Supplemental Dependent Life

Cost Summary	Volume	Monthly Rate per \$1000
SPOUSE		
<25	TBD	\$0.050
25-29	TBD	\$0.069
30-34	TBD	\$0.080
35-39	TBD	\$0.104
40-44	TBD	\$0.155
45-49	TBD	\$0.240
50-54	TBD	\$0.372
55-59	TBD	\$0.580
60-64	TBD	\$0.834
65-69	TBD	\$1.328
70-74	TBD	\$2.531
75-79	TBD	\$5.413
80+	TBD	\$12.038
CHILD(REN)	TBD	\$0.104
Monthly Premium	TBD	
Eligible Employees with Dependents	19	
Enrolled Employees with Dependents	TBD	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Supplemental Dependent Accidental Death & Dismemberment

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	Spouse: \$5,000 to \$100,000 in \$5,000 increments, not to exceed 50% of the employee's Supplemental Life amount. Child: Live birth to 14 days: \$500 15 days to age 26: \$10,000 to \$10,000 in \$10,000 increments	
Benefit Maximum	Spouse: \$100,000 Child: \$10,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye 25% All Toes on One Foot 25% All Fingers on One Hand 25% Uniplegia 75% Paraplegia 50% Hemiplegia 100% Quadriplegia 50% Speech 50% Hearing in Both Ears 50% One Limb 100% Sight in Both Eyes	
Age Reduction	35% of the original AD&D amount at age 65 50% of the original AD&D amount at age 70	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 4 enrolled lives or 20% of eligible employees	
Cost Summary	Volume	Monthly Rate per \$1,000
SPOUSE	TBD	\$0.029
CHILD(REN)	TBD	\$0.126
Monthly Premium	TBD	
Eligible Employees	19	
Covered Employees	TBD	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group PPO Dental

Eligibility	
Class Description	Class 1: All Active Full Time Employees
Minimum Hours Requirement	30 Hours per week
Eligibility Waiting Period	TBD
Benefit Plan and Features	
Coinsurance	100/80/50 In-Network 100/80/50 Out-Network (R&C)
R&C Percentile	90th
Annual Deductible In-Network	\$50 Calendar Year
Annual Deductible Out-Network	\$50 Calendar Year
Deductible Waived for Preventive Services In-Network	Yes
Deductible Waived for Preventive Services Out-Network	Yes
Family Deductible In-Network	\$150
Family Deductible Out-Network	\$150
Annual Maximum In-Network	\$1,500 Calendar Year
Annual Maximum Out-Network	\$1,500 Calendar Year
Periodic and Comprehensive Oral Evaluations	Included in Preventive Services
Limited Oral Evaluations	Included in Preventive Services
Professional Consultations	Included in Preventive Services
Professional Office Visits	Included in Preventive Services
X-Rays (Complete Series/Panoramic)	Included in Preventive Services
X-Rays (Bitewings)	Included in Preventive Services
X-Rays (All Others)	Included in Basic Services
Prophylaxis (Cleanings)	Included in Preventive Services
Fluoride Treatments	Included in Preventive Services
Lab and Tests	Included in Preventive Services
Sealants	Included in Preventive Services
Basic Restorative Services - Amalgam Fillings and Composites Fillings on Anterior Teeth	Included in Basic Services
Basic Restorative Services - Composites on Posterior Teeth Fillings	Included in Basic Services
Space Maintainers	Included in Basic Services
Palliative (Emergency) Treatment	Included in Basic Services
Simple Extractions	Included in Basic Services
Surgical Extractions and Removal of Impacted Teeth	Included in Basic Services
Oral Surgery	Included in Basic Services
Surgical Endodontics	Included in Basic Services
Non-Surgical Endodontics	Included in Basic Services
Periodontal Maintenance	Included in Basic Services
Non-Surgical Periodontics	Included in Basic Services
Surgical Periodontics	Included in Basic Services
Anesthesia	Included in Basic Services
Occlusal Guards	Not Covered



Group PPO Dental

Benefit Plan and Features		
Inlays/ Onlays/ Crowns	Included in Major Services	
Veneers	Not Covered	
Dentures	Included in Major Services	
Bridges	Included in Major Services	
Implants	Included in Major Services	
Adjustments, Repairs, Reline and Rebase of Dentures	Included in Major Services	
Other Prosthetics	Included in Major Services	
Teeth Whitening	Not Included	
Orthodontics	Not Included	
TMJ	Not Included	
Benefit Waiting Periods	Standard All Employees None	Late Entrants 12 Months Basic Services 12 Months Major Services
Enrollment	Initial and Annual Open Enrollment	
Takeover	No	
Prior Coverage Deductible Credit	No	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 53% of eligible employees	
Cost Summary	# of Employees	Monthly Rates
Employee Only	5	\$41.21
Employee & Spouse	2	\$84.16
Employee & Child	1	\$94.87
Family	2	\$150.65
Monthly Premium	\$770.54	
Commissions	Flat 10%	
Rate Guarantee	24 Months	



Group PPO Dental

Plan Specifications

Dependent Children	To Age 26
Reasonable & Customary (R&C)	Out-Network benefits are calculated by applying the coinsurance percentage to the dentist's charge, subject to the reasonable and customary limit, less the deductible.

Benefit Category

Type I: Diagnostic and Preventive Services

Periodic and Comprehensive Oral Evaluations	2 per 12 consecutive months inclusive of Limited Evaluations and Office Visits After Regularly Scheduled Hours.
Limited Oral Evaluations	Limited Oral Evaluations: 2 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations and Office Visits After Regularly Scheduled Hours.
Professional Consultations	Professional Consultations: 1 per 12 consecutive months per specialty and no more than 2 for all specialties within this period, inclusive of Office Visit for Observation During Regularly Scheduled Hours- No Other Services Performed.
Professional Office Visits	Professional Office Visits: 1 per 12 consecutive months inclusive of Periodic and Comprehensive Evaluations, Limited Evaluations and Professional Consultations.
Prophylaxis (Cleanings)	2 per 12 consecutive months inclusive of Periodontal Maintenance and Full Mouth Debridements.
Fluoride Treatment	2 per 12 consecutive months to age 16.
Sealants	Covered to Age 13 limited to one per tooth per 36 months for non-restored first and second permanent molars.
Bitewing X-Rays	2 sets per 12 consecutive months
Complete Series/ Panoramic X-Rays	Once per 36 consecutive months
Tests	Limited to Adjunctive Pre Diagnostic, HBA1c, and Pulp Vitality - 1 per 12 consecutive months
Labs	Brush Biopsy, Accession of Tissue and Laboratory Accession of Sample - 1 per 12 consecutive months

Type II: Basic Services

Periapicals and Other X-Rays	Once per 36 consecutive months
Space Maintainers	Limited to initial appliance only up to age 16. Includes all adjustments within 6 months of installation
Palliative (Emergency) Treatment	Eligible only when no other procedure is performed on the same day except for Diagnostic procedures.
Anesthesia	General Anesthesia is covered when medically or dentally necessary in conjunction with covered surgical dental services. Local Anesthesia is included in the fee for procedure being performed.
Basic Restorative Services - Amalgam Fillings and Composites Fillings on Anterior Teeth	1 per tooth surface in 12 consecutive months
Basic Restorative Services - Composites Fillings on Posterior Teeth	1 per tooth surface in 12 consecutive months
Simple Extractions	1 per tooth per lifetime. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services.
Surgical Extractions and Removal of Impacted Teeth	1 per tooth per lifetime. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services.
Oral Surgery	Limited to 1 unique site per 36 months
Surgical Endodontics	1 per 36 consecutive months



Group PPO Dental

Non-Surgical Endodontics	Root Canal and Miscellaneous Services - 1 per tooth per lifetime. Retreatment of Root Canal - 1 per tooth per 12 consecutive months.
Periodontal Maintenance	Only where Periodontal Treatment has been performed, limited to 4 per 12 consecutive months less the number of regular Cleanings and Debridements (if covered) received during such period. If more than one periodontal treatment covered, they must be 3 months apart.
Non-Surgical Periodontics	Full Mouth Debridement - 1 per 5 years when Necessary to enable comprehensive evaluation and diagnosis. Counted towards Periodontal Maintenance and regular Cleanings. Scaling in Presence of Generalized Gingival Inflammation - 1 per full mouth per 24 consecutive months. Other Non-Surgical procedures - 1 per quadrant per 36 consecutive months.
Surgical Periodontics	1 per quadrant per 36 consecutive months
Type III: Major Services	
Inlays/Onlays/Crowns	1 replacement per tooth in 60 consecutive months
Dentures	1 replacement in 60 consecutive months, subject to the Missing Tooth clause.
Bridges	1 replacement in 60 consecutive months, subject to the Missing Tooth clause.
Implants	1 per tooth per lifetime subject to the Missing Tooth clause.
Adjustments, Repairs, Relines and Rebase	Denture Adjustments, Repairs and Replacement of services - 1 per 12 consecutive months. Reline and Rebase - 1 per 24 consecutive months. If by same dentist who performed the installation. Adjustments allowed only after 6 months of installation.
Other Prosthetics	Overdentures - 1 replacement per arch per 60 consecutive months against Dentures. Tissue Conditioning - 1 per arch per 12 consecutive months.

Dental ID cards are not needed in order to receive treatment from a dentist, but can help to simplify our members' office experience so we encourage that members have them available when visiting a dentist.

We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured. A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed based on eligible services and subject to benefits availability at the time that the pre-treatment is received. A pre-treatment estimate is not required in order to receive benefits for covered services.

This proposal provides a summary of benefits only. Complete benefit frequencies, limitations, alternate benefits provisions, plan provisions and procedures requiring technical review are shown in the certificate of coverage. If this case is sold, refer to Group Dental Insurance certificate for complete benefits information.



Group Vision

Eligibility				
Class Description		Class 1: All Active Full Time Employees		
Minimum Hours Requirement		30 Hours per week		
Eligibility Waiting Period		TBD		
Covered Services	Description	In-Network Benefit	In-Network Copay	Frequency*
Eye Examination	Wellness examination to evaluate eye health	Covered in Full	\$10	Every 12 Months
Prescription Eyeglasses			\$25	See Frame and Lenses
Frames		\$150 allowance for a wide selection of frames; \$170 allowance for featured frame brands; 20% savings on the amount over your allowance	Included in Prescription Eyeglasses	Every 24 Months
Lenses	Single Vision, Lined Bifocal and Lined Trifocal and Lenticular Lenses; Polycarbonate lenses for Dependent Children	Covered in Full	Included in Prescription Glasses	Every 12 Months
Lens Enhancements	Standard Progressive Premium Progressive Custom Progressive		\$55 \$95-\$105 \$150-\$175	Every 12 Months
Elective Contact Lenses	Available in lieu of prescription eyeglasses	\$150 allowance for contacts	Included in Prescription Glasses	Every 12 Months
		Contact Lens exam (fitting and evaluation)	Up to \$60	
Necessary Contact Lenses	Available in lieu of prescription eyeglasses	Covered in Full	\$25	Every 12 Months
Covered Services	Description	Out-of-Network Benefit		Frequency
Eye Examination	Wellness examination to evaluate eye health	Up to \$45		Every 12 Months
Frames		Up to \$70		Every 24 Months
Lenses	Single Vision Lined Bifocal Lined Trifocal Lenticular	Up to \$30 Up to \$50 Up to \$65 Up to \$100		Every 12 Months
Elective Contact Lenses	Available in lieu of prescription eyeglasses	Up to \$105		Every 12 Months
Necessary Contact Lenses		Up to \$210		Every 12 Months
Benefit Plan and Features				
Enrollment		Initial and Annual Open Enrollment		
Takeover		No		

*Frequency is calculated from last date of service/last date of purchase.



Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 53% of eligible employees	
Cost Summary	# of Employees	Monthly Rates
Employee Only	5	\$6.00
Employee & Spouse	2	\$12.00
Employee & Child	1	\$12.84
Family	2	\$20.51
Monthly Premium	\$107.86	
Commissions	Flat 10%	
Rate Guarantee	24 Months	

Quote includes annual open enrollment.



Group Short-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Commencement Period	8 days Accident / 8 days Sickness	
Maximum Benefit Duration	12 Weeks	
Benefit Percentage	60%	
Maximum Weekly Benefit	\$1,500	
Minimum Weekly Benefit	\$25	
First Day Hospital	Not Included	
Maternity	Included	
Recurrent Disability	15 Days	
Offset Salary Continuation/Sick Leave (excl PTO)	Dollar for Dollar	
Definition of Disability	Residual	
Pre-Existing Condition Limitation	None	
Coverage Basis	Non-Occupational	
Takeover	No	
Rehabilitation Employment Benefit	Included	
Waiver of Disability Premium	Not Included	
Employee Assistance Program	Not Included	
FICA Match	Not Included	
W2 Services	Included	
Telephonic Claims Submission	Included	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contributions		
Employer Contribution	100%	
Participation Requirement	100% of eligible employees	
Cost Summary	Weekly Covered Benefit (WCB)	Monthly Rate per \$10 WCB
	\$14,533	\$0.264
Monthly Premium	\$383.66	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Short-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Commencement Period	8 days Accident / 8 days Sickness	
Maximum Benefit Duration	12 Weeks	
Benefit Percentage	60%	
Maximum Weekly Benefit	\$1,500	
Minimum Weekly Benefit	\$25	
First Day Hospital	Not Included	
Maternity	Included	
Recurrent Disability	15 Days	
Offset Salary Continuation/Sick Leave (excl PTO)	Dollar for Dollar	
Definition of Disability	Residual	
Pre-Existing Condition Limitation	3/12, Exclusionary	
Coverage Basis	Non-Occupational	
Takeover	No	
Rehabilitation Employment Benefit	Included	
Waiver of Disability Premium	Not Included	
Employee Assistance Program	Not Included	
FICA Match	Not Included	
W2 Services	Included	
Telephonic Claims Submission	Included	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contributions		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 20% of eligible employees	
Cost Summary	Weekly Covered Benefit (WCB)	Monthly Rate per \$10 WCB
<25	\$548	\$0.478
25-29	\$2,400	\$0.520
30-34	\$4,863	\$0.582
35-39	\$3,456	\$0.496
40-44	\$0	\$0.465
45-49	\$2,654	\$0.524
50-54	\$612	\$0.652
55-59	\$0	\$0.823
60-64	\$0	\$0.997
65+	\$0	\$1.084
Monthly Premium	\$784.39	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Short-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Commencement Period	15 days Accident / 15 days Sickness	
Maximum Benefit Duration	11 Weeks	
Benefit Percentage	60%	
Maximum Weekly Benefit	\$1,500	
Minimum Weekly Benefit	\$25	
First Day Hospital	Not Included	
Maternity	Included	
Recurrent Disability	15 Days	
Offset Salary Continuation/Sick Leave (excl PTO)	Dollar for Dollar	
Definition of Disability	Residual	
Pre-Existing Condition Limitation	3/12, Exclusionary	
Coverage Basis	Non-Occupational	
Takeover	No	
Rehabilitation Employment Benefit	Included	
Waiver of Disability Premium	Not Included	
Employee Assistance Program	Not Included	
FICA Match	Not Included	
W2 Services	Included	
Telephonic Claims Submission	Included	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contributions		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 20% of eligible employees	
Cost Summary	Weekly Covered Benefit (WCB)	Monthly Rate per \$10 WCB
<25	\$548	\$0.378
25-29	\$2,400	\$0.410
30-34	\$4,863	\$0.460
35-39	\$3,456	\$0.392
40-44	\$0	\$0.367
45-49	\$2,654	\$0.413
50-54	\$612	\$0.515
55-59	\$0	\$0.650
60-64	\$0	\$0.787
65+	\$0	\$0.856
Monthly Premium	\$619.40	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Short-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Commencement Period	15 days Accident / 15 days Sickness	
Maximum Benefit Duration	11 Weeks	
Benefit Percentage	60%	
Maximum Weekly Benefit	\$1,500	
Minimum Weekly Benefit	\$25	
First Day Hospital	Not Included	
Maternity	Included	
Recurrent Disability	15 Days	
Offset Salary Continuation/Sick Leave (excl PTO)	Dollar for Dollar	
Definition of Disability	Residual	
Pre-Existing Condition Limitation	None	
Coverage Basis	Non-Occupational	
Takeover	No	
Rehabilitation Employment Benefit	Included	
Waiver of Disability Premium	Not Included	
Employee Assistance Program	Not Included	
FICA Match	Not Included	
W2 Services	Included	
Telephonic Claims Submission	Included	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contributions		
Employer Contribution	100%	
Participation Requirement	100% of eligible employees	
Cost Summary	Weekly Covered Benefit (WCB)	Monthly Rate per \$10 WCB
	\$14,533	\$0.208
Monthly Premium	\$302.28	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Long-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Percentage	60%	
Maximum Monthly Benefit	\$6,000	
Elimination Period	90 Days	
Minimum Monthly Benefit	Greater of \$100 or 10% of Gross benefit	
Guaranteed Issue Benefit	\$6,000	
Own Occupation Period	24 Month Own Occ/ Any Occ After	
Earnings Test	Own Occupation 80% / Any Occupation 60%	
Social Security Integration	Direct Family	
Maximum Payment Duration	ADEA1 with SSNRA	
Definition of Disability	Residual	
Recurrent Disability	6 months	
Pre-Existing Condition Limitation	3/12	
Coverage Basis	24 Hour	
Mental Illness/Substance Abuse Limitation	24 Months Lifetime Benefit	
Special Conditions Limitation	Not Included	
Return to Work Incentive Benefit	12 months	
Survivor Income Benefit	3 Month Gross Lump Sum	
Rehabilitation Program	Mandatory Participation	
Family Care Deduction Benefit	Included	
Workplace Modification Benefit	Included	
Waiver of Disability Premium	Included	
Activities of Daily Living	Not Included	
Takeover	No	
Employee Assistance Program	Not Included	
Travel Assistance	Included	
FICA Match	Included	
W2 Services	Included	
Definition of Earnings	Basic Annual Earnings Only	
Premium Contributions		
Employer Contribution	100%	
Participation Requirement	100% of eligible employees	
Cost Summary	Monthly Covered Payroll (MCP)	Monthly Rate per \$100 MCP
	\$104,125	\$0.222
Monthly Premium	\$231.16	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Group Long-Term Disability

Eligibility	
Class Description	Class 1: All Active Full Time Employees
Minimum Hours Requirement	30 Hours per week
Eligibility Waiting Period	TBD
Benefit Plan and Features	
Benefit Percentage	60%
Maximum Monthly Benefit	\$6,000
Elimination Period	90 Days
Minimum Monthly Benefit	Greater of \$100 or 10% of Gross benefit
Guaranteed Issue Benefit	\$6,000
Own Occupation Period	24 Month Own Occ/ Any Occ After
Earnings Test	Own Occupation 80% / Any Occupation 60%
Social Security Integration	Direct Family
Maximum Payment Duration	ADEA1 with SSNRA
Definition of Disability	Residual
Recurrent Disability	6 months
Pre-Existing Condition Limitation	6/12
Coverage Basis	24 Hour
Mental Illness/Substance Abuse Limitation	24 Months Lifetime Benefit
Special Conditions Limitation	Not Included
Return to Work Incentive Benefit	12 months
Survivor Income Benefit	3 Month Gross Lump Sum
Rehabilitation Program	Mandatory Participation
Family Care Deduction Benefit	Included
Workplace Modification Benefit	Included
Waiver of Disability Premium	Included
Activities of Daily Living	Not Included
Takeover	No
Employee Assistance Program	Not Included
Travel Assistance	Included
FICA Match	Included
W2 Services	Included
Definition of Earnings	Basic Annual Earnings Only
Premium Contributions	
Employer Contribution	0%
Participation Requirement	Greater of 10 enrolled lives or 20% of eligible employees



Group Long-Term Disability

Cost Summary	Monthly Covered Payroll (MCP)	Monthly Rate per \$100 MCP
<25	\$3,958	\$0.110
25-29	\$17,333	\$0.130
30-34	\$29,208	\$0.224
35-39	\$30,875	\$0.432
40-44	\$0	\$0.629
45-49	\$18,333	\$0.869
50-54	\$4,417	\$1.208
55-59	\$0	\$1.323
60-64	\$0	\$1.181
65+	\$0	\$1.000
Monthly Premium	\$438.36	
Eligible Employees	19	
Covered Employees	19	
Commissions	Flat 15%	
Rate Guarantee	24 Months	



Critical Illness

Eligibility		
Class Description	Class 1: All Active Full Time Employees	
Minimum Hours Requirement	30 Hours per week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	\$5,000 to \$20,000 in \$5,000 Increments	
Benefit Minimum	\$5,000	
Benefit Maximum	\$20,000	
Guarantee Issue	\$20,000	
Age Reduction	No age reductions	
Additional Occurrence	Included	
Recurrence	Unlimited	
Lifetime Maximum	Unlimited	
Portability	To age 70	
Pre-Existing Condition Limitation	12/12	
Premium Rate Basis	Attained Age Rating	
Enrollment	Annual Open Enrollment	
Takeover	No	
Covered Conditions	Benefit Percentages	Recurrence Benefit Percentages
Heart Attack	100%	25%
Stroke	100%	25%
Major organ failure	100%	25%
End-stage heart failure	100%	25%
End-stage kidney disease	100%	25%
Occupational infectious disease	100%	N/A
Coronary artery bypass	25%	25%
Angioplasty	5%	5%
Cancer	100%	100%
Cancer In Situ	25%	25%
Skin Cancer	5%	5%
Benign Brain Tumor	100%	25%
Coma	100%	25%
Blindness	100%	N/A
Paralysis	100%	N/A
Loss Of Speech	100%	N/A
Complete Loss of Hearing	100%	N/A
Advanced ALS/Lou Gehrig's Disease	100%	N/A
Advanced Alzheimer's Disease	25%	N/A
Advanced Parkinson's Disease	25%	N/A
Severe Burns	100%	25%
Wellness Benefit		
Annual benefit for covered wellness exams & screenings	\$50	



Critical Illness

Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Minimum of 3 employees participating	
Employee Cost Summary	Monthly Rate per \$1,000	
Based on Employee's Age at Effective Date	Non-Smoker	Smoker
<39	\$0.50	\$0.59
40-49	\$1.44	\$2.17
50-59	\$3.00	\$5.40
60+	\$5.60	\$11.25
Cost for included Wellness Benefit	Added to Monthly Premium	
Employee	\$1.04	
Rate Guarantee		
	24 months	
Payable Commissions		
Flat	20%	

Non-Smoking Monthly Premium Illustration for Employee Benefit				
Benefit	<39	40-49	50-59	60+
\$5,000	\$3.54	\$8.24	\$16.04	\$29.04
\$10,000	\$6.04	\$15.44	\$31.04	\$57.04
\$15,000	\$8.54	\$22.64	\$46.04	\$85.04
\$20,000	\$11.04	\$29.84	\$61.04	\$113.04



Critical Illness Spouse

Eligibility		
Spouse Coverage	Requires Employee Coverage	
Maximum Percentage of Employee Benefit	50%	
Benefit Plan and Features		
Plan Schedule	\$2,500 to \$10,000 in \$2,500 Increments	
Benefit Minimum	\$2,500	
Benefit Maximum	\$10,000	
Guarantee Issue	\$10,000	
Additional Occurrence	Included	
Recurrence	Unlimited	
Lifetime Maximum	Unlimited	
Portability	To age 70	
Premium Rate Basis	Attained Age Rating	
Enrollment	Annual Open Enrollment	
Premium Contribution		
Employer Contribution	0%	
Spouse Cost Summary	Monthly Rate per \$1,000	
Based on Spouse's Age at Effective Date	Non-Smoker	Smoker
<39	\$0.50	\$0.59
40-49	\$1.44	\$2.17
50-59	\$3.00	\$5.40
60+	\$5.60	\$11.25
Cost for included Wellness Benefit	Added to Monthly Premium	
Spouse	\$1.04	

Non-Smoking Monthly Premium Illustration for Spouse Benefit				
Benefit	<39	40-49	50-59	60+
\$2,500	\$2.29	\$4.64	\$8.54	\$15.04
\$5,000	\$3.54	\$8.24	\$16.04	\$29.04
\$7,500	\$4.79	\$11.84	\$23.54	\$43.04
\$10,000	\$6.04	\$15.44	\$31.04	\$57.04



Critical Illness Child

Eligibility	
Child(ren) Coverage	Requires Employee Coverage
Maximum Percentage of Employee Benefit	50%
Benefit Plan and Features	
Plan Schedule	\$2,500 to \$5,000 in \$2,500 Increments
Benefit Minimum	\$2,500
Benefit Maximum	\$5,000
Guarantee Issue	\$5,000
Additional Occurrence	Included
Recurrence	Unlimited
Lifetime Maximum	Unlimited
Portability	To age 70
Premium Rate Basis	Attained Age Rating
Enrollment	Annual Open Enrollment
Premium Contribution	
Employer Contribution	0%
Child Cost Summary	Monthly Rate per \$1,000
	\$0.77
Cost for included Wellness Benefit	Added to Monthly Premium
Child(ren)	No added cost

Monthly Premium Illustration for Child(ren) Benefit	
Benefit	All eligible Child(ren)
\$2,500	\$1.93
\$5,000	\$3.85



Accident

Eligibility	
Class Description	Class 1: All Active Full Time Employees
Minimum Hours Requirement	30 Hours per week
Eligibility Waiting Period	TBD
Benefit Plan and Features	
Coverage Basis	24-Hour
Age Reduction	No Age Reductions
Annual Maximum Payout	Unlimited
Lifetime Maximum Payout	Unlimited
Portability	To age 70
Enrollment	Annual Open Enrollment
Takeover	No
Wellness Benefit	
Annual benefit for covered wellness exams & screenings	\$50
Premium Contribution	
Employer Contribution	0%
Participation Requirement	Minimum of 3 employees participating.
Employee Cost Summary	
Monthly Rate	
Employee	\$8.45
Employee and Spouse	\$14.56
Employee and Child(ren)	\$15.94
Employee and Family	\$22.05
Rate Guarantee	
	24 months
Payable Commissions	
Flat	20%



Accident

What your benefits cover:

Life and Dismemberment Losses	Employee	Spouse	Child
Accidental Death	\$25,000	\$25,000	\$12,500
Accidental Death Common Carrier	\$50,000	\$50,000	\$25,000
Catastrophic Loss: Loss of Arm or Loss of Hand- both arms or both hands, Loss of Leg or Loss of Foot-both legs or both feet, Loss of Hand and Loss of Foot or Loss of Arm and Loss of Leg - one hand and one foot or one arm and one leg, Loss of an Ear- both ears, irrecoverable Loss of Hearing- both ears, Loss of an Eye- both eyes, irrecoverable Loss of Speech or ability to speak, or any combination equaling two or more losses from: Loss of Arm, Loss of Hand, Loss of Leg, Loss of Foot, Loss of an Ear or Loss of an Eye	\$7,500	\$7,500	\$3,750
Loss of Hand-one hand, Loss of Foot-one foot, Loss of leg-one leg or Loss of Arm-one arm	\$3,750	\$3,750	\$1,875
Loss of a Finger or Loss of a Toe-two or more fingers or toes	\$750	\$750	\$375
Loss of a Finger or Loss of a Toe-one finger or one toe	\$375	\$375	\$190
Loss of Hearing or Loss of an Ear-one ear	\$3,750	\$3,750	\$1,875
Loss of Sight or Loss of an Eye-one eye	\$3,750	\$3,750	\$1,875
Dislocations	Surgical / Non-Surgical Repair		
Hip	\$2,000 / \$1,000		
Knee, ankle or bones of the foot	\$1,000 / \$500		
Elbow or wrist	\$400 / \$200		
Shoulder	\$500 / \$250		
Collarbone or bones of the hand	\$800 / \$400		
Finger(s) or toe(s)	\$100 / \$50		
Lower jaw	\$400 / \$200		
Incomplete Dislocation	25% of the applicable Non-Surgical Repair		
Fractures	Surgical / Non-Surgical Repair		
Hip or thigh	\$2,000 / \$1,000		
Skull-depressed	\$3,000 / \$1,500		
Skull-simple	\$1,500 / \$750		
Vertebral processes	\$350 / \$175		
Bones of face or nose	\$350 / \$175		
Leg (tibia or fibula)	\$1,000 / \$500		
Vertebrae (body of) or sternum	\$800 / \$400		
Pelvis (excluding coccyx)	\$800 / \$400		
Upper jaw or upper arm	\$375 / \$190		



Accident

Fractures	Surgical / Non-Surgical Repair
Lower jaw	\$325 / \$170
Knee cap	\$325 / \$170
Ankle	\$325 / \$170
Foot	\$325 / \$170
Collarbone	\$325 / \$170
Shoulder	\$325 / \$170
Forearm	\$325 / \$170
Hand	\$325 / \$170
Wrist	\$325 / \$170
Elbow	\$325 / \$170
Heel	\$325 / \$170
Rib, finger, toe or coccyx	\$175 / \$90
Multiple ribs	\$500 / \$250
Chip Fractures and other Fractures not resolved by Surgical or Non-Surgical Repair	25% of the applicable Non-Surgical Repair
Additional Injuries	
Eye Injury	\$125
Gunshot wound	\$250
Brain Injury	\$75
Paralysis - monoplegia	\$500
Paralysis - diplegia	\$2,500
Paralysis - hemiplegia	\$2,500
Paralysis - paraplegia	\$12,500
Paralysis - quadriplegia	\$25,000
Coma	\$7,500
Concussion	\$150
Concussion Lifetime Maximum Benefit	\$1,500
Lacerations	
Lacerations(s) with no sutures and treated by Physician	\$20
Single lacerations under 5 centimeters with sutures	\$35
Lacerations 5 - 15 centimeters with sutures (total of all lacerations)	\$125
Lacerations greater than 15 centimeters with sutures (total of all lacerations)	\$250
Burns	
21 - 40 square centimeters 2nd degree	\$200
21 - 40 square centimeters 3rd degree	\$500
41 - 65 square centimeters 2nd degree	\$400
41 - 65 square centimeters 3rd degree	\$1,000
66 - 160 square centimeters 2nd degree	\$600
66 - 160 square centimeters 3rd degree	\$3,000
161 - 225 square centimeters 2nd degree	\$800



Accident

Burns	
161 - 225 square centimeters 3rd degree	\$7,000
More than 225 square centimeters 2nd degree	\$1,000
More than 225 square centimeters 3rd degree	\$10,000
Skin graft	\$50% of the applicable Burn Benefit
Medical Services	
Diagnostic Exam (1 time per Benefit Year):	
Arteriogram, angiogram, CT, CAT, EKG, EEG, or MRI	\$100
X-ray	\$25
Accident Emergency Treatment (non-Emergency Room or non-Urgent Care Facility) (1 time per Covered Accident)	\$50
Physician's follow-up Treatment office visit (per visit, up to 10 times per Covered Accident)	\$25
Physical and occupational therapy (per visit up to 10 visits per Covered Accident)	\$25
Medical Devices	\$100
Epidural Pain Management (up to 2 times per Covered Accident)	\$25
Prescription drug	\$15
Prosthesis (one)	\$250
Prosthesis (two)	\$500
Anesthesia	\$25
Blood, plasma or platelet transfusion	\$100
Hospital	
Hospital admission (once per Benefit Year)	\$1,000
Hospital Confinement (per day up to 365 days per Covered Accident)	\$200
Intensive Care Unit admission (once per Benefit Year; payable instead of Hospital admission benefit if Confined immediately to ICU)	\$1,500
Intensive Care Unit Confinement (per day up to 15 days; payable in addition to any Hospital Confinement benefit)	\$400
Ambulance (Ground)	\$400
Ambulance (Air)	\$2,000
Emergency Room admission or Urgent Care Facility	\$100
Rehabilitation Unit (per day up to 30 days per Covered Accident)	\$50
Transportation (100 or more miles up to 3 times per Covered Accident)	\$250
Family lodging	\$50
Maximum Lodging Night Stays: 1 benefit per day, 30 days per Benefit Year	



Accident

Surgery

Miscellaneous Surgery requiring general anesthesia that is not otherwise listed (once per 24 hour period even though multiple surgical procedures may be performed)	\$150
Open Surgery	\$625
Exploratory Surgery or debridement	\$125
Laparoscopic Surgery or hernia repair	\$150
Tendon/Ligament/Rotator cuff tear	\$300
Torn Knee Cartilage	\$300
Ruptured / herniated disc	\$300
Emergency Dental	
Emergency dental extraction	\$30
Emergency dental crown	\$100



Group Hospital Indemnity

Eligibility	
Class Description	Class 1: All Active Full Time Employees
Minimum Hours Requirement	30 Hours per week
Eligibility Waiting Period	TBD
Benefit Plan and Features	
Single Product Bundle	Hospital Indemnity
Coverage Basis	24-Hour
Age Reduction	None
Maternity Waiting Period	No Waiting Period
Pre-Existing Condition Limitation	12/12
Annual Maximum Payout	Unlimited
Lifetime Maximum Payout	Unlimited
Portability	To age 70
Takeover	No
Enrollment	Annual Open Enrollment
Premium Contribution	
Employer Contribution	0%
Participation Requirement	Minimum of 3 employees participating.
Cost Summary	
	Monthly Rate
Employee	\$13.84
Employee and Spouse	\$29.19
Employee and Child(ren)	\$22.92
Employee and Family	\$38.27
Rate Guarantee	
	24 months
Payable Commissions	
Flat	20%

What your benefits cover:

Included Benefits	Benefit Amount
First Day Hospital Confinement	\$500, once per year
First Day Intensive Care Unit (ICU) Confinement	\$1,000, once per year
Daily Hospital Confinement	\$100, up to 365 days per year
Daily ICU Confinement	\$200, up to 60 days per year
Daily Rehabilitation Unit Confinement	\$50, up to 60 days per year
Annual Wellness Screening	\$50, once per year for each insured

Admission and Confinement benefits are not additive.

Qualifying exams and screenings for Wellness Screening Benefit

- CA15-3 (blood test for breast cancer)
- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA 125 (blood test for ovarian cancer)
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CEA (blood test for colon cancer)
- Lipid panel(cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Cardiac exercise stress test
- Electrocardiogram (ECG)-resting or stress
- Chest x-ray
- Hemoccult stool analysis
- Serum protein electrophoresis
- Carotid Doppler
- Echocardiogram
- Immunizations
- Interscholastic Sports Physical Exam

General Assumptions

- Final terms and rates are based on Equitable's standard policy language unless otherwise specifically indicated in this proposal. It is recommended that existing coverage be kept in force until Equitable has accepted any requested non-standard language and reviewed the final census. State filings or specially drafted contract language is not assumed in the quoted rates in this proposal.
- This proposal is intended to explain certain portions of the group plan being considered and does not constitute a contract.
- Any discrepancies between this proposal and the contract will be resolved by the wording in the contract.
- Quote assumes a situs state of [REDACTED]
- The employer's assumed primary business is classified as an SIC Code of [REDACTED].
- Equitable reserves the right to re-evaluate and adjust the rates:
 - For any change of 10% or more to the amount of lives or coverage (volume) since the effective date.
 - If the sold plan design differs from the proposed/quoted plan design.
 - For changes in State or Federal Insurance regulations.
 - If a material misstatement of the information provided in the RFP, bid specifications, claim experience or plan of benefits is discovered post-sale, final rates will be calculated on the effective date of the plan based on the actual participants, volume and benefits elected.
- Equitable reserves the right to change the plan to comply with any state mandated benefits, including charging additional premium for such changes, if applicable.
- Claims incurred prior to the effective date of the contract will be the liability of the prior carrier, unless as stated in the Work in Progress Upon Transfer of Carriers in the Group Dental Insurance Certificate.
- If required product participation requirements are not met, Equitable reserves the right to either re-price or to decline to accept the risk if the minimum participation threshold is not met. Evidence of Insurability may also be required.
- This proposal assumes an employer/employee relationship for all eligible classes of employees. 1099 employees are not eligible for coverage.
- Quote does not include temporary or seasonal employees.
- Quote assumes all eligible employees are U.S. citizens or U.S. residents working in U.S. locations who have met the eligibility requirements.
- Quote assumes employees must be Actively at Work on the effective date. The deferred effective date provision applies unless the employer's contract is currently in force with Equitable.
- Quote assumes that the proposed plans are subject to ERISA regulations.
- The agent certifies that he/she is appropriately licensed and appointed to solicit insurance business in accordance with applicable state law requirements.
- A current billing statement or census will be required at time of sale to verify current enrollees and insurance amounts.
- Proposal is not subject to Collective Bargaining Agreements.

Equitable policy strictly prohibits doing business with any person or entity involved with marijuana production, distribution or other ancillary operations. Marijuana related businesses also include the marketing of marijuana related products and services, persons and businesses that service and receive income from the marijuana industry, and business involving hemp and hemp related ingredients.

Life Coverage

- An employee must be approved for Basic Life Insurance in order to be eligible for Supplemental Life Insurance.
- Insured benefit amounts from the previous carrier will be grandfathered up to the class benefit maximum illustrated in the benefit summary section. All future amounts are subject to the guarantee issue limit and actively at work provision.
- Evidence of Insurability is required for all late entrants or coverage amounts in excess of any specified Guarantee Issue amount.
- AD&D coverage is packaged with the Life.
- We will not pay any Supplemental Life benefit, or increase in benefit, for a loss caused by suicide within the first two years from the Certificate Effective Date or the effective date of the increase. Credit will be given for time covered under a prior plan.
- Spouse age reduction is based on employee age, unless otherwise noted.

Dental

- If actual enrollment averages more than 3 children per family unit, we reserve the right to re-evaluate the quoted rates.
- Out of Network benefits will be calculated by applying the coinsurance percentage to the dentist's charge, capped at the reasonable and customary limit, less any deductible amount.
- The dental network is administered by Careington International and NovaNet Inc.
- Quote does not include retirees.

Vision

- For group sizes 5-9, 70% enrollment is required. For group sizes 2-4, 100% enrollment is required.
- The vision network is administered by VSP.
- Quote does not include retirees.

Short-Term Disability Coverage

- Quote assumes the employer participates in Workers' Compensation, Social Security and statutory disability plans where mandated for all eligible employees.
- Evidence of Insurability is required for all late entrants or coverage amounts in excess of any specified Guarantee Issue amount.
- The employer must be in business for at least 2 years and be in good financial standing. If otherwise, additional underwriting approval will be required prior to sale.

Long-Term Disability Coverage

- Quote assumes the employer participates in Workers' Compensation, Social Security and statutory disability where mandated for all eligible employees.
- Evidence of Insurability is required for all late entrants or coverage amounts in excess of any specified Guarantee Issue amount.
- A new pre-existing condition limitation period will apply on the date of any increase in coverage.
- The employer must be in business for at least 2 years and be in good financial standing. If otherwise, additional underwriting approval will be required prior to sale.

Travel Assistance Program:

Travel assistance services are considered non-insurance services and are provided by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance Program are underwritten by a licensed third-party insurance company. The Travel Assistance Program and services provided are separate and apart from the insurance provided by Equitable. Equitable is not affiliated with AXA Assistance USA, Inc.

AD&D Limitations and Exclusions (State variations may apply)

We will not pay any Accidental Death and Dismemberment Benefit for a loss:

1. caused or contributed to by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity;
2. caused or contributed to by an infection not occurring as a direct result or consequence of the accidental bodily injury;
3. caused or contributed to by suicide, attempted suicide, or intentionally self-inflicted injury, while sane or insane;
4. caused or contributed to by travel in or descent from an aircraft, if the Insured Person acted in a capacity other than as a passenger;
5. caused or contributed to by travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, used for travel beyond the earth's atmosphere;
6. declared or undeclared war, or any act of war, or any conflict involving the armed forces of one or more countries;
7. caused or contributed to by active participation in a riot, insurrection, or terrorist activity;
8. while the Insured Person is incarcerated;
9. caused or contributed to by the Insured Person's participation in a felony or illegal activity ("felony" is defined by the law of the jurisdiction in which the activity takes place);
10. caused or contributed to by voluntary intake or use of any drug, unless prescribed or administered by a Physician and taken in accordance with the Physician's instructions, an over the counter drug taken in accordance with the manufacturer's instructions, or the voluntary inhalation of poison, gas, or fumes except as the direct result of an occupational accident;
11. caused or contributed to by intoxication as defined by the jurisdiction where the accident occurred;
12. caused or contributed to by riding or driving an air, land or water vehicle in a race, speed or endurance contest;
13. caused or contributed to by bungee jumping, rock climbing, mountain climbing, hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing.

Dental Limitations and Exclusions (State variations may apply)

Limitations: Payment of benefits is limited under this certificate as follows: Refer to the Group Dental Insurance Certificate for full limitations and exclusions

1. Services must begin after the end of any applicable Waiting Period. Waiting Periods for each category of service show in the Benefit Plan and Features section .
2. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.
3. Alternate Benefit: If we determine that a service, less costly than the covered service the dentist performed, could have been performed to treat a dental condition, we will pay benefits based upon the less costly service if such service:
 - a. would produce an equivalent therapeutic or diagnostic result as to the diagnosis or treatment of the individual's dental condition; and
 - b. would qualify as a covered service. For example, if a high noble metal crown and a predominantly base metal crown are both professionally acceptable methods for restoring a tooth, we may base our determination on the less costly predominantly base metal material.If we pay benefits based upon a less costly service in accordance with this subsection, the dentist may charge for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an in-network dentist.
4. Basic restorative services are limited as follows:
 - a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a covered service.
 - b. Micro filled resin restorations which are non-cosmetic.
 - c. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Any procedures not specifically listed as a Covered Service in the Schedule of Benefits and Benefits We Pay sections of the Group Dental Insurance Certificate .
2. Services which are not deemed to be dentally necessary care or treatment and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
3. Services for which the insured person would not be required to pay in the absence of dental insurance.
4. Services or supplies received by an insured person before the dental insurance starts for that person.
5. Treatment or services received outside of the United States and Canada.
6. Services which are primarily cosmetic, except for services covered under the Teeth Whitening Benefit if Teeth Whitening is shown as a covered service under the Benefit Plan and Features section.
7. Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
 - a. scaling and polishing of teeth; or
 - b. fluoride treatments.
8. Services or appliances which restore or alter occlusion or vertical dimension.
9. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease or unless TMJ is listed as a covered service under the Plan Benefit and Features section .
10. Restorations or appliances used for the purpose of periodontal splinting.

11. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
12. Personal supplies or devices including , but not limited to : water piks, toothbrushes, or dental floss.
13. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
14. Charges for missed appointments.
15. Services:
 - a. covered under any workers' compensation or occupational disease law;
 - b. covered under any employer liability law;
 - c. for which the employer of the person receiving such services is required to pay; or
 - d. received at a facility maintained by Your employer, labor union, mutual benefit association, or VA hospital.
16. Services covered under other coverage provided by Your employer.
17. Temporary or provisional restorations.
18. Temporary or provisional appliances.
19. Prescription drugs.
20. Services for which the submitted documentation indicates a poor prognosis.
21. Fixed and removable appliances for correction of harmful habits , unless Orthodontics is listed as a covered service under the Benefit Plan and Features section .
22. Application of desensitizing agents.
23. Repair or replacement of an orthodontic device.
24. The following, when charged by the dentist on a separate basis:
 - a. claim form completion;
 - b. infection control, such as gloves, masks, and sterilization of supplies; or
 - c. local anesthesia or non-intravenous conscious sedation.
25. Caries susceptibility tests.
26. Appliances or treatment for bruxism (grinding teeth), including , but not limited to occlusal guards and night guards, unless Occlusal Guards is listed as a covered service under the Benefit Plan and Features section, then only the occlusal guards is covered .
27. Precision attachments associated with fixed and removable prostheses.
28. Adjustment of a denture made within 6 months after installation by the same Dentist who installed it.
29. Duplicate prosthetic devices or appliances.
30. Replacement of a lost or stolen appliance, cast restoration or denture.
31. Extra-oral photographic images, unless TMJ is listed as a covered service under the Benefit Plan and Features section.
32. Cone beam imaging.
33. Diagnostic casts, unless part of overall treatment plan allowance for orthodontia, if Orthodontia is listed as a covered service under the Benefit Plan and Features section .
34. Labial veneers.
35. Modification of removable prosthodontic and other removable prosthetic services.
36. Occlusal adjustments.
37. The following services are not covered services:
 - a. a connector bar;
 - b. a stress breaker;
 - c. coping;
 - d. pediatric partial dentures.

Vision Limitations and Exclusions (State variations may apply)

Limitations: Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Insured Persons may obtain details regarding frame brand availability by calling the information number shown in the Certificate Information Page.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Services provided without a Benefit Authorization or after expiration of a Benefit Authorization;
2. Services and/or materials not specifically included in the Schedule of Benefits;
3. Orthoptics or vision training and any associated supplemental testing;
4. Plano lenses (less than a ± 50 diopter power), except as specifically allowed in the frames benefit shown in the Certificate Information page;
5. Two pair of glasses in lieu of bifocals;
6. Medical or surgical treatment of the eyes;
7. Replacement of eyeglass lenses, frames or contact lenses furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available;
8. Plano contact lenses to change eye color cosmetically;
9. Artistically-painted contact lenses;
10. Contact lens insurance policies or service contracts;
11. Additional office visits associated with contact lens pathology;
12. Contact lens modification, polishing or cleaning;
13. Costs for Covered Services and/or materials above In-Network or Out-of-Network benefit allowance;
14. Services or materials of a cosmetic nature;
15. Services and/or materials not indicated in this Certificate as Covered Services;
16. Pathological treatment;
17. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology;
18. Laser or any other form of refractive surgery;
19. Pre- and post-operative services;
20. Local, state and/or federal taxes, except where We are required by law to pay; or
21. Corrective vision treatment of an Experimental Nature.

Short-Term Disability Limitations and Exclusions (State variations may apply)

Exclusions: What Disabilities are not covered?

The Policy does not cover, and We will not pay a benefit for, any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war, whether declared or not;
3. caused by Your commission of or attempt to commit a felony;
4. caused or contributed to by Your being engaged in an illegal occupation;
5. caused or contributed to by an intentionally self-inflicted Injury;
6. for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
7. sustained as a result of doing any work for pay or profit for another employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1. was sponsored by Your Employer; and
2. was terminated before the Effective Date of The Policy;

no benefits will be payable for that Disability under The Policy.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by a Pre existing Condition, unless, at the time You become Disabled You have been continuously covered under The Policy for 365 consecutive days.

Pre-existing Condition means:

1. any Injury, Sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse; for which You received Medical Care during the consecutive days period that ends the day before:
 - a. Your effective date of coverage; or
 - b. the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1. is consulted or gives medical advice; or
2. recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1. medical examinations, tests, attendance or observation; and
2. use of drugs, medicines, medical services, supplies or equipment

Long-Term Disability Limitations and Exclusions (State variations may apply)

Exclusions: What Disabilities are not covered?

The Policy does not cover, and We will not pay a benefit for, any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war, whether declared or not;
3. caused by Your commission of or attempt to commit a felony;
4. caused or contributed to by Your being engaged in an illegal occupation; or
5. caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1. was sponsored by Your Employer; and
2. was terminated before the Effective Date of The Policy;

no benefits will be payable for that Disability under The Policy.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre existing Condition, unless, at the time You become Disabled You have been continuously covered under The Policy for 365 consecutive days.

Pre-existing Condition means:

1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse; for which You received Medical Care during the 90 consecutive days period that ends the day before:
 - a. Your effective date of coverage; or
 - b. the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1. is consulted or gives medical advice; or
2. recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1. medical examinations, tests, attendance or observation; and
2. use of drugs, medicines, medical services, supplies or equipment

Critical Illness Exclusions (State variations may apply)

Exclusions: What is not covered?

We will not pay a benefit for any Critical Illness that is due to or results from:

- services or Treatment not included in the Benefit Highlights;
- services or Treatment for which an Insured is not charged, unless there is no charge because the facility is a United States government facility;
- services or Treatment provided by a Family Member;
- Treatment or complications of Treatment not related to a Critical Illness ;
- an autologous bone marrow transplant, one in which Your own bone marrow is used;
- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- war or any act of war or Your active duty in any armed service during a time of war (this does not include acts of terrorism);
- Your active Participation in a Riot, Rebellion or Insurrection;
- committing of or attempting to commit an assault, felony or other criminal act;
- Your engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious Injury;
- committing or attempting to commit suicide, whether sane or insane;
- incarceration in a penal institution of any kind;
- being legally Intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or
- improper or illegal use of inhalents or huffing.

Accident Exclusions (State variations may apply)

Exclusions: What is not covered?

No benefits will be payable for any loss that is the result of a Covered Accident that is due to or results from:

- war or any act of war or Your active duty in any armed service during a time of war (this does not include acts of terrorism);
- active participation in a war (declared or undeclared);
- active military duty;
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated;
- Intoxication;
- operating, learning to operate, serving as a crew member of, jumping or falling from any aircraft, including those which are not motor-driven. This does not include:
 1. flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
 2. flying as a passenger with no duties on board an aircraft operated by a private business to transport its personnel or guests;
 3. flying in Your Employer's corporate aircraft as a passenger or crew member; or
 4. flying in a life-saving medevac or similar medical air transport service;
- Injuries sustained from any aviation activities, other than riding as a fare paying passenger;
- operating a taxi or any other delivery service for any kind of compensation or profit;
- engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering;
- participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating;
- committing of or attempting to commit an assault, felony or other criminal act;
- active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally;
- voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician and used as directed;
- improper or illegal use of inhalants or huffing;
- a Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- incarceration in a penal institution of any kind;
- for Non-Occupational plans, an Injury arising out of or in the course of any work for pay or profit.

No benefits will be payable relating to or resulting from services or Treatment rendered or Confinement outside the United States.

The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Hospital Indemnity Exclusions (State variations may apply)

Exclusions: What is not covered?

No benefits will be payable for any loss that is the result of, or is caused or contributed to by:

- war or any act of war or Your active duty in any armed service during a time of war (this does not include acts of terrorism);
- active military duty;
- active participation in a war (declared or undeclared);
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated (where the blood alcohol level meets the legal presumption of intoxication in the jurisdiction where the Accident or Injury occurred);
- intoxication;
- committing of or attempting to commit an assault, felony or other criminal act;
- participation in a riot, rebellion, insurrection, civil commotion, civil disobedience, or unlawful assembly; (For purposes of this exclusion, "Participation" means to take an active part in common with others. "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law. This does not include a loss that occurs while acting in a lawful manner within the scope of authority.)
- committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally;
- incarceration in a penal institution of any kind;
- elective abortion or complications thereof;
- elective or cosmetic surgery or procedures, except for reconstructive surgery or unless due to congenital anomaly or disease of a Child which has resulted in a defect;
- artificial insemination, in vitro fertilization, test tube fertilization;
- sterilization, tubal ligation or vasectomy, and reversal thereof, unless recommended by a Physician;
- gender change, unless recommended by a Physician;
- Treatment, supplies or services provided by, through or, behalf of any government agency or program or program for which there is not normally any charge except for Treatment provided by or through a Veteran's Home or Hospital;
- operating, learning to operate, serving as a crew member of, jumping or falling from any aircraft, including those which are not motor-driven. This does not include:
 1. flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
 2. flying as a passenger with no duties on board an aircraft operated by a private business to transport its personnel or guests;
 3. flying in your employer's corporate aircraft as a passenger or crew member; or
 4. flying in a life-saving medevac or similar medical air transport service;
- Injuries sustained from any aviation activities, other than riding as a fare paying passenger;
- operating a taxi or any other delivery service for any kind of compensation or profit;
- engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering;
- participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating;
- voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician and used as directed;
- Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
- any Mental and Nervous Disorder; or
- Substance Abuse.

No benefits will be payable relating to or resulting from services or Treatment rendered or Confinement outside the United States.

The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.