Pet Insurance

MetLife

MetLife Pet Insurance1 offers straightforward pricing, group discounts2, customizable limits, deductible savings, and a hassle-free claims process. Our quick 3-step enrollment process and supportive team of pet professionals are here to help.

- ✓ No breed exclusions
- ✓ No upper age limits
- ✓ No initial exam or previous vet records needed to enroll
- ✓ No per-incident or lifetime limits
- ✓ Group discounts[2] and deductible savings[3]
- ✓ Among the shortest wait periods[4] with most claims processed within 10 days[5]
- ✓ Multichannel support options with caring, knowledgeable representatives
- ✓ Trusted benefits partner with more than 100+ years of experience

What does it cover[1]?

- Accidental injuries
- illnesses
- exam fees
- surgeries
- medications
- ultrasounds
- hospital stays
- X-rays and diagnostic tests

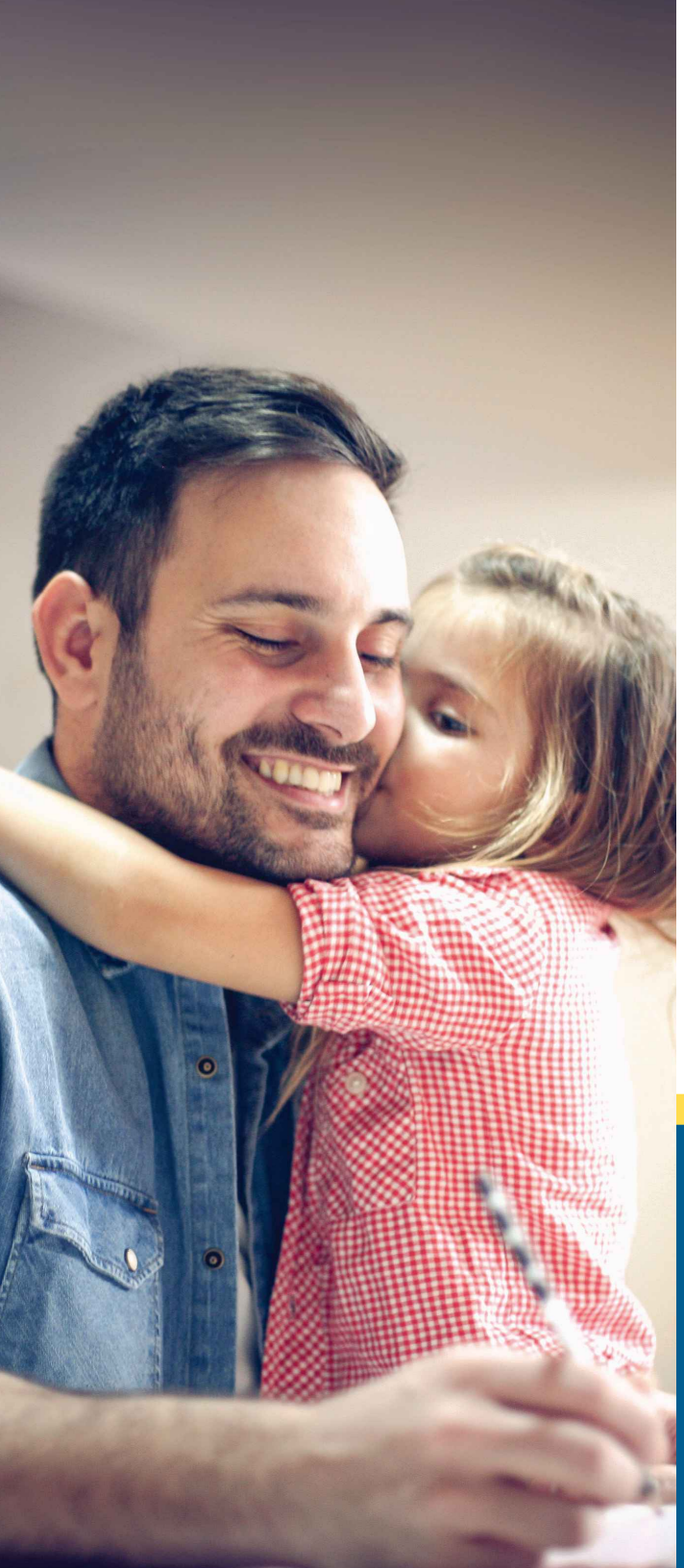
And our coverage[1] also includes

- hip dysplasia
- hereditary conditions
- congenital conditions
- chronic conditions
- alternative therapies
- holistic care
- and much more!

Pre-existing conditions may not be covered.

Insure your pet today.

[1]Provided all terms of the policy are met. Like most insurance policies, insurance policies issued by IAIC contain certain exclusions, exceptions, reductions, limitations, and terms for keeping them in force. For costs, complete details of coverage and exclusions, and a listing of approved states, please contact MetLife Pet Insurance Solutions LLC.



You can add these optional insurance riders for an additional premium:

Accidental Death Benefit (ADB):
The Accidental Death Benefit (ADB) rider can provide an additional death benefit up to $200,000 if you die from an accidental bodily injury. ADB is available for proposed insureds age 1–59 and may be added for your spouse and children too. Accidental Death Benefit expires at age 65. See rider for details.

Premium Waiver (PW):
With the Premium Waiver (PW) Rider, your Group Term life insurance coverage continues if you become totally disabled and can no longer pay premiums. Premiums are waived if the insured (employee, spouse or child) named in the policy becomes totally disabled. Premium Waiver expires at age 65. See rider for details.

This is a solicitation for insurance. The benefits described in this brochure are contained in group policy form GE2 and certificate GE2C, rider forms GEAD and GEPW. This brochure is not an insurance contract. The certificate explains the rights and obligations of both Liberty National and the insured. It is important to read your certificate carefully. Please see your Globe Life Liberty National Division agent for cost and complete details. Underwritten by Liberty National Life Insurance Company, a Globe Life company.

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3700 S Stonebridge Dr | McKinney, TX 75070

Group Term Life to 100

Insurance for You and Your Family

323300

LND0956 **0520**

Group Term Life to 100

Insurance coverage for you or other members of your family. Features of this plan include:

- Guaranteed Rates – once you purchase the plan your rates will not increase
- Your coverage can never be reduced or cancelled as long as you pay premiums
- Coverage for you, your spouse and dependents (where available)
- You can continue your coverage after you leave employment
- You may continue your coverage to age 100
- Up to $150,000 of insurance coverage available*
- Available in the workplace

*Employees are eligible for coverage up to $150,000 (varies by age). The amount of dependent coverage is limited to $50,000 and cannot exceed:

100% of employee coverage in Arizona, Florida, Hawaii, Illinois, Maryland, Texas, Virginia, and West Virginia for spouse or children – not to exceed $50,000. Coverage is only available if the employee is insured.

50% of employee coverage in Nebraska for spouse or children – not to exceed $50,000. Coverage is only available if the employee is insured.

In Pennsylvania coverage is only available for spouse and children if the employee is insured.

Employee Savings with the Worksite Advantage**

Because Worksite Advantage allows you to pay insurance premiums on a pre-tax basis, you pay less tax on your income. In other words, through Worksite Advantage you receive an IRS-approved tax break to pay for insurance benefits. Choose from a variety of supplemental insurance coverage options such as:

- Accident
- Critical Illness
- Dental
- Cancer
- Group Term Life Insurance

Based on $2,000 Monthly Income	Without Premium Only Plan	With Premium Only Plan
Gross Monthly Income	$2,000	$2,000
Pre-tax Insurance Premium	– $0	– $200
Total Taxable Income	$2,000	$1,800
Federal Income Tax (25%)	– $500	– $450
Total	$1,500	$1,350
Insurance Premium (**taxed**)	– $200	– $0
Take-Home Net Pay	**$1,300**	**$1,350**
Additional Monthly Take-home Pay	0	+ $50
Additional Annual Take-home Pay	0	+ $600

**For illustrative purposes only. These tax savings are simply an example. Individual tax savings will vary from employee to employee.

NOTE: Products described in this brochure can be purchased through a Section 125 cafeteria plan or a conventional payroll deduction program made available by your employer.

Available only through your worksite. Your employer is providing this voluntary group plan as a benefit to full-time employees.

Level death benefit coverage. Your coverage will not decrease so long as your certificate remains in force.

No increase in premiums. They are locked in at your present age. No increase as you get older and no increase if you leave employment.

Payroll deduction makes premium payment easy. Your premiums are deducted each payday, so you don't have to write a check.

You are covered when you sign the enrollment form, provided underwriting requirements are met.

You can take this coverage with you. If you leave employment, you may pay the premiums through bank draft. Your coverage and premiums remain the same, even if you change jobs or retire.

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Intensive Care Protector™ Insurance Policy

We can help relieve some of the pressure of being in intensive care.

A study from academic researchers found that 66.5 percent of all bankruptcies were tied to medical issues — either because of high costs for care or time out of work.* An estimated 530,000 families turn to bankruptcy each year because of medical issues and bills, the research found. That's why Globe Life Liberty National Division developed specific coverage for intensive care.

*Source: CNBC, This is the reason most Americans file for bankruptcy 2019 https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html

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Liberty National Division's Intensive Care Protector™ Insurance Policy

Issue Ages: 0–60 for individuals | 15–60 for family* or single parent

Benefit for:	We pay:
Daily Intensive Care	**$1,000 per day** up to 30 days for each ICU† confinement (other than automobile and travel accidents) beginning the first day for accidental bodily injury and the second day for sickness.
Automobile and Travel Accident	**$1,000 per day** up to 30 days for each ICU confinement for treatment of an accidental bodily injury resulting from an automobile or travel accident. This benefit pays for confinements that begin within 48 hours of the accident, and pays in addition to Daily Intensive Care Benefit.
Regular Hospital Room	**$200 per day** for confinement in a regular hospital room up to the same number of covered days of ICU confinement. For example, if you are in ICU for two covered days, you would receive $200 per day for up to two days of regular room confinement occurring during the same hospitalization. Both regular room and ICU benefits are not payable for the same day of confinement.
Blood	**$200** for whole blood or blood components administered during a hospital stay involving an ICU confinement.
Ambulance	**$200** for a professional ambulance or air ambulance when a covered insured is transported to the hospital for an ICU confinement.

* On Family policies, older spouse is Proposed Insured. | † ICU: Intensive Care Unit as defined by the policy. See policy definition for details.
Note: Benefit amounts shown above are based on two units of coverage. For one unit of coverage, the benefits will be one-half the amount shown.

Plus you get these extra features:

- Benefits will be paid to you unless you direct otherwise in writing. Under some governmental plans (such as Medicaid), some benefits have already been assigned by law.
- There is no maximum limit for total benefits paid on this policy.
- Your coverage is guaranteed renewable until you are 65 or eligible for Medicare due to age, as long as you pay premiums.
- Insured children remain covered until the earliest of: the date the child ceases to be dependent on you, ceases to live in your household (if not a full or part-time student), ceases to be a full-time or part-time student (if not living with you), or age 25. Coverage on mentally or physically incapacitated children may continue even longer.
- This policy is available to individuals, single parents, families, and children.
- Benefits are paid when you are confined to a U.S. government hospital.

Limitations and Exclusions: No benefits will be paid for medical treatment (1) Caused by mental or emotional disorders (2) Resulting from war or act of war, not including acts of terrorism (3) Involving preexisting conditions for two years after the effective date of the policy (4) For which no charge is normally made in the absence of insurance, except for U.S. government hospitals, Medicare, Medicaid, and TRICARE (formerly CHAMPUS) (5) For the first day of confinement in an ICU due to sickness (6)Occurring or beginning within the first 30 days of life for children born, or adopted newborn, within 10 months of the effective date of the policy.

This is a solicitation for insurance. The benefits described in this brochure are contained in policy forms 5JP, 5JQ, 5JR. Forms and benefits may vary by state. This brochure is not an insurance contract. The policy explains the rights and obligations of both Liberty National and the insured. It is important to read your policy carefully. Please see your Globe Life Liberty National Division agent for cost and complete details.

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Accident Protector Max

Individual | Two-Parent Family | Single-Parent Family Coverage

Accidents can happen anytime, anyplace, 24 hours a day.

You need around-the-clock protection. You need Accident Protector Max.

The Problem:

There are more than **47 million accidental injuries** in the U.S. every year.

Every hour **4,589 injuries** require emergency room visits.

Accidental injuries cost the U.S. **$1,034 billion** every year.

The Solution: Liberty National Division's Accident Protector Max

- Accidental death and dismemberment benefits
- Protection on and off the job
- Guaranteed Renewable to age 65
- Benefits paid directly to you unless you direct otherwise in writing*
- Initial and daily hospital benefits
- Intensive care unit benefit
- Emergency treatment benefit
- Coverage for dislocations and fractures
- Ambulance benefit
- Transportation benefit
- Blood and plasma benefit
- Waiver of premiums for extended confinement
- Pays in addition to workers' compensation

QUICK CLAIMS™

Source: National Safety Council, Injury Facts, 2019 Edition
*Under some governmental plans, such as Medicaid, benefits have already been assigned by the insured.

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Liberty National Division's Accident Protector Max

Individual | Two-Parent Family | Single-Parent Family Plans (with reduced benefits for Spouse and each Child)

We pay for death of, or loss involving (with reduced benefits for Spouse and each Child):

		Insured	Spouse (if applicable)	Each Child* (if applicable)
Accidental Death	If death is accidental;	**$25,000**	**$10,000**	**$1,000**
	Or if death by automobile accident;	**$50,000**	**$20,000**	**$2,000**
	Or if death by travel accident.	**$250,000**	**$100,000**	**$4,000**
Dismemberment	For loss of eyesight	**$20,000**	**$20,000**	**$2,000**
	For loss of one limb	**$10,000**	**$10,000**	**$1,000**
	For loss of two or more limbs	**$20,000**	**$20,000**	**$2,000**

Also For			**We pay**
Emergency Treatment	Actual expenses up to a maximum amount of $500. Treatment must be received within 48 hours of the injury (72 hours in Georgia).		**Up to $500**
Initial Hospitalization Benefit	Lump sum benefit after the first 24 hours of hospital confinement as a result of accidental bodily injury (payable one time per covered person per calendar year).		**$1,000**
Daily Hospital Confinement	If policy has been in force at date of the accident:	Daily Hospital Benefit is payable for a maximum of 26 weeks of hospital confinement due to any one accident.	**Daily Hospital Benefit**
	Less than one year		**$150**
	One year but less than two years		**$250**
	Two years but less than three years		**$350**
	Three years or more		**$500**
Intensive Care Unit Confinement	Two times the Daily Hospital Benefit up to a maximum of 30 days. This is paid in addition to the Daily Hospital Benefit.		**Two times the Daily Hospital Benefit**
Specified Injuries	$200 maximum. See policy for details on specific injuries.		**Up to $200**
Blood and Plasma	If whole blood or blood components are administered during the hospital confinement resulting from accidental bodily injury (benefit payable one time per accident).		**$200**
Ambulance	If an ambulance or air ambulance is used for transportation to an emergency center or hospital within 100 miles of an accident that results in bodily injury (Benefit is payable one time per accident).		**$300**
Transportation	We will pay a benefit for transportation to and from any hospital located more than 100 miles from the site of the accident or the residence of a covered person for special treatment and hospital confinement as the result of accidental bodily injury. (This benefit is payable one time per accident and is payable only if your attending physician prescribes treatment not locally available).		**$300**
Waiver of Premium	If you have received benefits for continuous hospital confinement for 30 days or more, we will waive the payment of each premium that becomes due while hospital benefits continue to be paid.		

* No benefit for accidental death and dismemberment will be payable for a covered child less than 1 year old. Not applicable in TN and VA.

The policy is designed to provide coverage for certain losses resulting from a covered accident only, subject to any limitations contained in the policy. Coverage is not provided for any loss resulting wholly or partially from sickness.

Exceptions The policy does not cover death, injury, or other loss caused or contributed to by: (1) any disease, illness or infirmity, or medical or surgical treatment therefor; (2) participation in an assault, felony, riot, or insurrection; (3) mental or emotional disorders; (4) self-destruction or any attempt thereat whether sane or insane or injuries intentionally inflicted upon oneself whether sane or insane; (5) operating or riding or descending from any kind of aircraft of which a covered person is an officer, pilot, or member of the crew; or in which a covered person is receiving training or giving instructions or has any duty; (6) war or act of war (declared or undeclared) whether or not the covered person is in military service; or (7) any covered person being under the influence of alcohol or other intoxicant, or under the influence of any drug or narcotic unless taken on the advice of a physician.

This is a solicitation for insurance. The benefits described in this brochure are contained in policy [forms HAJ, HAK, HAL]. Forms and benefits may vary by state. This brochure is not an insurance contract. The policy explains the rights and obligations of both Liberty National and the insured. It is important to read your policy carefully. Please see your Globe Life Liberty National Division agent for cost and complete details.

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Cancer Endurance Plan™

You don't have to endure the financial strain of cancer alone.

Lifetime Chance of Developing Cancer

1 in 3 People in the U.S.*

Cancer shows no favoritism. Everyone is at risk.

Cancer isn't just a devastating disease. Cancer can also be devastating to your family's finances. But if you are diagnosed with cancer, you don't have to endure the financial strain of cancer alone.

The Cancer Endurance Plan's benefits do not reduce as you age. And, most benefits do not have lifetime maximums, meaning our policy can be with you or your family member for the entirety of treatment, providing help when it is needed most.

Features

- Pays in addition to any other insurance you have
- Benefits will be paid to you unless you direct otherwise in writing. Under some governmental plans (such as Medicaid) benefits have already been assigned by the insured
- Choice of individual, family, or single parent coverage
- Policy can be converted to different type (individual, family, single parent) if your family status changes (adoption, birth, death, divorce)
- Guaranteed renewable for life
- Cannot be canceled as long as premiums are paid on time
- Rates cannot be increased on an individual basis, but may increase on a class basis by state

*Source: American Cancer Society, *Cancer Facts & Figures, 2020.*

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Benefit	Pays
First Occurrence	**$10,000** upon the first written diagnosis of cancer. Payable only once. For this benefit only, skin cancer (except for melanoma) is not covered.
Hospital Confinement	Days 1-90: **$750** per day of continuous confinement. And **$1,200** per day thereafter for continuous confinement. No maximum number of days. **No lifetime limit.**
Surgical	Maximum payment for any one operation is **250%** of the amount shown in the surgical schedule of the policy, **up to $5,000** per surgical procedure. **No lifetime limit.**
Anesthetist	**Up to 25%** of the amount payable for surgery. **No lifetime limit.**
Outpatient Surgery	**Up to $250 for each day** of a surgical procedure for cancer treatment as outpatient in hospital or ambulatory surgical center. **No lifetime limit.**
Attending Physician	**Up to $35 per day** for one attending physician charges for cancer treatment, in or out of hospital. Charges by physician for surgery, radiation, chemotherapy, or office visit for chemotherapy and/or radiation not covered under this benefit. **No lifetime limit.**
Private Duty Nursing	**Up to $75 per day** for graduate RN or LPN care recommended by physician, in or out of hospital. **No lifetime limit.**
Hospice	**Up to $75 per day** for visit from Hospice representative or visiting a Hospice facility for treatment or services related to cancer as determined by physician. Does not pay if person is confined to hospital or U.S. government hospital. **No lifetime limit.**
Radiation and Chemotherapy*	**Up to $500 per day**, for radiation or chemotherapy administered in person by a physician or nurse. **No lifetime limit.**
Prescription Chemotherapy Drug*	**Up to $10,000 per year** for prescription cancer-fighting chemotherapy drugs prescribed to be self-administered. **No lifetime limit.**
Blood Transfusion	**Up to $500 per day** for blood or blood components and administration of blood or plasma for blood transfusion for cancer treatment. Does not pay for cross matching, lab tests, supplies, or blood replaced by donors. **No lifetime limit.**
New or Experimental Treatment	Covered person's charges for new or experimental cancer treatment under policy's regular schedule of benefits. Treatment must be approved by AMA and FDA and administered in United States by licensed physician. State specific provisions may apply.
Transportation	**All charges** covered person and one attendant incurs for commercial transportation by aircraft, railroad, bus, or ambulance to and from **ANY** hospital or clinic in U.S. to receive specialized treatment for cancer. Or, 25¢ per mile if personal car is used and destination is more than 100 miles away, one way. This benefit is payable only when traveling to another city because similar physician advised services are not available within 100 miles of the city where you live. Maximum limit of 6 trips in a consecutive 12-month period.
Income Replacement	**$100 per week**, if disabled due to cancer, up to a lifetime maximum of 26 weeks. All insured persons gainfully employed when the disability begins are covered. A 14-day elimination period applies.
Prosthesis	**Up to $750** for prosthesis used as a result of cancer. Lifetime limit of 2 prostheses.
Government Hospital Confinement	**$3,500** First Occurrence Benefit upon the first diagnosis of cancer (if not already paid). **$250 per day** for the first 90 days of hospital confinement and **$600 per day** thereafter for continuous confinement in lieu of all other hospital benefits.
Dread Disease	Pays Hospital Confinement Benefit in lieu of all other benefits for treatment of cystic fibrosis, diphtheria, encephalitis, Lou Gehrig's disease, meningitis, multiple sclerosis, muscular dystrophy, osteomyelitis, poliomyelitis, rabies, scarlet fever, sickle cell anemia, smallpox, tetanus, tuberculosis, tularemia, typhoid fever.

*In no event will charges for chemotherapy drugs be covered under both the "Radiation and Chemotherapy" benefit and the "Prescription Chemotherapy Drug" benefit. See policy and Benefit Enhancement Endorsement R3724 for full details and coverage amounts.

Limitations and Exclusions This policy contains a 30-day waiting period that begins with the policy's effective date. If a covered person has cancer manifested during the waiting period, coverage for that cancer will apply only to expenses incurred after two years from the policy's effective date, and no First Occurrence Benefit will be paid. No benefits are payable to anyone who has cancer manifested before the effective date of this policy. If a covered person has one of the specified dread diseases manifested before the policy's effective date or waiting period, coverage for the specified disease will apply only to expenses incurred after two years from the policy effective date. The policy does not cover treatment for any disease or sickness or incapacity other than cancer or one of the specified dread diseases; treatment or services where no charge is normally made in the absence of insurance, except U.S. government hospitals; treatment or services outside the continental United States; treatments that are not accepted or approved by the American Medical Association as an effective cancer treatment; or drugs or substances not approved by the Federal Drug Administration for use in the treatment of cancer. These Limitations and Exclusions may vary by state.

This is a cancer policy. This is **NOT** major medical insurance or a Medicare Supplement policy. This is a solicitation for insurance. The benefits described in this brochure are contained in policy forms 5KM, 5KN, 5KO. Forms and benefits may vary by state. This brochure is not an insurance contract. The policy explains the rights and obligations of both Liberty National and the insured. It is important to read your policy carefully. Please see your Globe Life Liberty National Division agent for cost and complete details.

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Critical Illness Protector Insurance Policy

The risk of a Critical Illness is real.
You need affordable protection you can count on.

357709

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LND0622 **0621**

Every 40 seconds...

Someone in the U.S. suffers a **heart attack.***

Someone in the U.S. suffers a **stroke.***

Will you be able to beat the odds?

The risks of developing a critical illness are high. So is the cost of surviving.

The Problem:

You need immediate financial help.

The Expenses:

- Loss of Income
- Child Care
- Lifestyle Change
- Money to "Tide a Family Over"
- Special Medical Needs
- Less Savings and Retirement
- Insurance Deductibles
- Coinsurance Payments

The Solution:

Critical illness protection that pays a lump sum benefit directly to you upon first diagnosis of a critical illness.

- Major Organ Transplant
- Total Loss of Eyesight
- Total Loss of Hearing
- Heart Attack
- Stroke
- End Stage Renal Failure

Be prepared with Liberty National Division's Critical Illness Protector.

Even though a person's chances of survival have increased, surviving a critical illness comes with a cost! Be prepared financially with Liberty National Division's Critical Illness Protector. The risks are real!

*Source: American Heart Association/American Stroke Association's Heart Disease and Stroke Statistics, 2019

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Policy Features

- Premiums paid through the convenience of payroll deduction or bank draft
- Guaranteed renewable to age 65
- Portable coverage, take your policy with you if you leave your employer
- Issue ages 18 to 60
- Unisex rates
- Choose your benefit amount
- Lump sum payment paid directly to you in addition to any other life, major medical, or hospital coverage you already have (unless you direct otherwise in writing)
- This is a one time payable benefit. Policy terminates upon payment of any such benefit
- Policy covers heart attack, stroke, end stage renal failure, major organ transplant, total loss of eyesight, and total loss of hearing
- Lump sum benefits* of $11,000, $16,500, $27,500, $38,500, $44,000, or $55,000.

Critical Illness Rates

Individual Plan 5M7

Benefit	Age	Weekly	Bi-Weekly	Semi-Monthly	Monthly
$11,000*	18–35	$0.67	$1.34	$1.44	$2.88
	36–50	1.58	3.16	3.42	6.84
	51–60	2.62	5.24	5.67	11.34
$16,500*	18–35	0.88	1.76	1.89	3.78
	36–50	2.25	4.50	4.86	9.72
	51–60	3.81	7.62	8.24	16.47
$27,500*	18–35	1.29	2.58	2.79	5.58
	36–50	3.58	7.16	7.74	15.48
	51–60	6.17	12.34	13.37	26.73
$38,500*	18–35	1.71	3.42	3.69	7.38
	36–50	4.91	9.82	10.62	21.24
	51–60	8.54	17.08	18.50	36.99
$44,000*	18–35	1.92	3.84	4.14	8.28
	36–50	5.57	11.14	12.06	24.12
	51–60	9.72	19.44	21.06	42.12
$55,000*	18–35	2.33	4.66	5.04	10.08
	36–50	6.90	13.80	14.94	29.88
	51–60	12.09	24.18	26.19	52.38

*Benefit amounts shown above include the policy benefit amount plus the endorsement rider R3719 increase of 10%.
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Critical Illness Coverage
We will pay you the Benefit Amount as shown on the policy when we receive due proof of the Insured's First Diagnosis of a Covered Critical Illness as defined below, while the policy is in force. No benefit is payable if the Covered Critical Illness first manifests itself during the 30-day Waiting Period. In such case, you may void the policy from the beginning and receive a full refund of premium. The Insured is limited to only one First Diagnosis benefit. The policy terminates upon payment of a benefit or at the policy anniversary immediately following the insured's 65th birthday, whichever is earlier.

Covered Critical Illnesses:

- Heart Attack
- Stroke
- End Stage Renal Failure
- Major Organ Transplant
- Total Loss of Eyesight
- Total Loss of Hearing

The Policy Does Not Cover:

- Transient Ischemic Attack (TIA)
- Attacks of Vertebrobasilar Ischemia
- Cerebral Symptoms Due to Migraine
- Cerebral Injury Resulting from Trauma or Hypoxia
- Vascular disease affecting the eye or optic nerve

Waiting Period
No benefit is payable if the Covered Critical Illness first manifests itself before the policy has been in force for 30 days from the Effective Date shown on the policy. An illness is manifested when symptoms exist which relate to a Covered Critical Illness and which would cause an ordinary prudent person to seek diagnosis, care, or treatment.

First Diagnosis
The first time you are diagnosed by a physician as having a Covered Critical Illness, which is first manifested after the Waiting Period and while the policy is in force.

Guaranteed Renewable to Age 65; Premiums Subject to Change
Your policy is guaranteed renewable until the policy anniversary immediately following your 65th birthday. On such date, the policy will terminate and cease to be in force. Until such date and subject to the conditions of the policy, we cannot cancel or refuse to renew your policy as long as premiums are paid when due. You may renew the contract before such date by paying each renewal premium as it falls due or during the grace period. Should we accept a premium for any period after the policy is to terminate, coverage will continue until the end of the period for which the premium has been accepted. We reserve the right to change premium rates. A change in the rates will apply to all such polices issued by us and in force in the state where you live. If we change the rates, your premium will be determined by your age on the effective date of the policy. Subject to the terms and conditions of the policy, we will not restrict or limit your policy in any other way while it is in force.

Limitations and Exclusions (1) The policy pays a benefit only for First Diagnosis of a Covered Critical Illness while the policy is in force. Proof of First Diagnosis of a Covered Critical Illness must be provided. The policy does not provide benefits for any other disease, sickness, disability or incapacity. (2) The policy contains a 30-day Waiting Period. No benefit is payable to anyone who has a Covered Critical Illness manifested before the policy has been in force for 30 days from the Effective Date shown on the policy. (3) The policy will not pay benefits if the First Diagnosis of a Covered Critical Illness is made outside the United States of America absent a written, confirming diagnosis of a Covered Critical Illness by a doctor who is duly licensed to practice, and is practicing, medicine in the United States. (4) The policy does not cover any loss caused or contributed to by: participation in an assault, felony, riot, or insurrection; mental or emotional disorders; self-destruction or an attempt thereat whether sane or insane or injuries intentionally inflicted upon yourself whether sane or insane; war or acts of war (declared or undeclared) whether or not you are in military service (the term 'war or act of war' shall not be deemed to include acts of terrorism); or your ingesting or being under the influence of alcohol or other intoxicant, or taking or being under the influence of any drug or narcotic unless taken on the advice of a physician. Being under the influence of alcohol or a drug or narcotic is that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred.

This is a solicitation for insurance. This is a limited benefit policy. The benefits described in this brochure are contained in policy form 5MB, Endorsement R3719. Forms and benefits may vary by state. This brochure is not an insurance contract. The policy explains the rights and obligations of both Liberty National and the insured. It is important to read your policy and endorsement carefully. Please see your Globe Life Liberty National Division agent for cost and complete details.
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Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.
- If you need additional assistance or have questions, please contact the TEL Staffing HR at benefits@telstaffing.com.

Carriers	Website / Email	Phone
TEL Staffing & HR	benefits@telstaffing.com	850-476-9008
Dental MetLife	https://www.metlife.com/	800-638-5433
Vision MetLife	https://www.metlife.com/	800-638-5433
Life / AD&D Insurance Short Term Disability **MetLife**	https://www.metlife.com/	800-638-5433
Voluntary Benefits Liberty National	globelifelibertynational.com	800-333-0637

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usuallycharge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Presented by: The Enterprise Team