II. Benefits Highlights

TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

BENEFIT HIGHLIGHTS
PLAN 1200-NGS
(Non-Grandfathered ACA)

BLUECHOICE NETWORK

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Plan Year Deductibles		
Per-admission Deductible	*$0*	*$0*
Deductible *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*	*$1,000 Individual / $3,000 Family*	*$3,000 Individual / $9,000 Family*
Plan Year Out-of-Pocket Maximum		
Deductibles are not applied to the Out-of-Pocket Maximum (OOPM). Copayment Amounts will apply to the OOPM, and they will not be required after the maximum has been satisfied. Your benefit booklet will provide more details.	*$3,000 Individual / $9,000 Family* *Network Deductible & Out-of-Pocket Maximum **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*$6,000 Individual / $18,000 Family* *Out-of-Network Deductible & Out-of Pocket Maximum **do not** apply toward Network Deductible & Out-of-Pocket Maximum*
Copayment Amounts Required		
Physician office visit/consultation *Refer to Medical/Surgical Expenses section for more information*	*$30 Copayment Amount*	*N/A-Refer to Medical/Surgical Expense section for benefits*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*$40 Copayment Amount*	*70% of Allowable Amount after Plan Year Deductible*
MDLIVE (Telemedicine)	*$0 Copayment Amount*	*Not Applicable*
Urgent Care	*$30 / $40 Copayment Amount*	*70% of Allowable Amount*
Outpatient Hospital Emergency Room/Treatment Room *Refer to Emergency Room/Treatment Room section for more information*	*$150 Copayment Amount*	*$150 Copayment Amount*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units	*80% of Allowable Amount*	*60% of Allowable Amount*
Penalty for failure to preauthorize services	*None*	*$250*

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Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
Services performed during the Physician's office visit/consultation, including lab & x-ray *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $30 Copayment*	*70% of Allowable Amount after Plan Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Allergy Injections	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Colonoscopy (All places of treatment and diagnoses)	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Physician surgical services performed in any setting	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Organ Transplants	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
All other outpatient services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Declined*	

Extended Care Expenses		
Extended Care Expenses *All services must be preauthorized*		
	100% of Allowable Amount	*70% of Allowable Amount after Plan Year Deductible*
Skilled Nursing Facility	*25 day maximum each Plan Year**	
Home Health Care	*60 visit maximum each Plan Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses		
Serious Mental Illness *All services must be preauthorized*		
Inpatient Services		
-Hospital services (facility)	*80% of Allowable Amount*	*60% of Allowable Amount*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*100% of Allowable Amount after $30 Copayment*	*70% of Allowable Amount after Plan Year Deductible*
-All outpatient services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits shown

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Mental Health Care/Chemical Dependency		
All services must be preauthorized. Inpatient treatment must be provided in a Chemical Dependency Treatment Center.		
Inpatient Services -Hospital services (facility)	*80% of Allowable Amount*	*60% of Allowable Amount*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Outpatient Services -Services performed during Physician office visit/consultation *(does not include psychological testing)*	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Plan Year Deductible*
-Emergency Room/Treatment Room	*80% of Allowable Amount after $150 Copayment Amount* *(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $150 Copayment Amount & Plan Year Deductible* *(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Other Outpatient Services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care -Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after $150 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	
Non-Emergency Care -Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after $150 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $150 Copayment Amount & Plan Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Plan Year Deductible*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits shown

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Chiropractic Care-Office Services	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Airrosti Rehab Centers	*$30 Copayment Amount*	*Not Applicable*
Plan Year Maximum	*35 visit maximum each Plan Year**	
	All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits shown

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

MDLive (Telemedicine) is part of your benefit plan design. Access to an independently contracted board-certified doctor is available 24 hours a day, seven days a week to speak to immediately or schedule an appointment based on your availability. Please refer to your benefit booklet for other details.

The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, the covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

PRESCRIPTION DRUG PLAN
OPTION 4A-NG NO DEDUCTIBLE

Prescription Drug Program

Up to a 30-day Supply at Participating Navitus Health Solutions Network Retail Pharmacy

Plan Year Deductible	*$0 Individual / $0 Family*
Tier 3 Drug	*$40 Copayment Amount*
Tier 2 Drug	*$25 Copayment Amount*
Tier 1 Drug	*Lesser of $10 Copayment Amount OR Actual Cost*

ATTENTION: Please note the following guidelines regarding your Prescription benefits:

1) Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.
2) Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.

Up to a 90-day supply at In-Network Retail or Mail Service Pharmacy

Tier 3 Drug	*$80 Copayment Amount*
Tier 2 Drug	*$50 Copayment Amount*
Tier 1 Drug	*$20 Copayment Amount*

Note: Prescription Drug Benefits are provided by Navitus Health Solutions through a master contract with the Texas Association of Counties Health and Employee Benefits Pool. Prescription Drugs are not administered by Blue Cross and Blue Shield of Texas

DENTAL PLAN III WITHOUT ORTHODONTIA

BLUECARE DENTAL PPO

Type of Service	Benefit**
General Provisions Plan Year Deductible Plan Year Maximum per Participant	*$75 Individual / $225 Family* *$1,000*
Diagnostic and Preventive Care Benefits (deductible waived) ***(Benefits do not apply to Plan Year Maximum)*** Oral Examinations (twice per Plan Year) Problem-Focused and non-routine exams limited to 1 per plan year Consultations Prophylaxis (two cleanings per Plan Year) Dental X-rays -Full Mouth/Panoramic X-rays (once every 60 months) Bitewing X-ray Series (once per Plan Year) Fluoride Treatment (to age 19; twice per Plan Year) Sealants up to age 19, permanent molars, one per tooth every 36 months Space Maintainers up to age 19; 1 per arch per lifetime on posterior teeth only Labs and Tests Periodontal Maintenance 2 per plan year; not combined with Preventive Prophylaxis Full Mouth Debridement once per lifetime	*80%*
Miscellaneous Services Palliative Care	*80%*
Restorative Services Amalgams and Composite (once per surface on the indicated tooth per 24 months) Simple Extractions Pin Retention	*80%*
General Services Diagnostic Casts (once per Plan Year) Prefabricated Stainless Steel Crowns	*80%*
Endodontic Services Root canal therapy Direct pulp cap Apicoectomy/Apexification Retrograde filling Root amputation/hemisection Therapeutic pulpotomy	*80%*
Periodontal Services Periodontal scaling and root planing	*80%*
Oral Surgery Services Surgical tooth extractions Full Bony impacted tooth extractions General Anesthesia/IV Sedation Alveoloplasty, Vestibuloplasty Gingivectomy/gingivoplasty Gingival flap procedure / Osseous surgery and grafts / Soft tissue grafts	*50%*
Crowns, Inlays/Onlays Services Crowns, Inlays, Onlays, Labial Veneers	*50%*

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Prosthodontic Services Bridges and dentures Denture reline/rebase, Denture adjustments, Re-cementation and repair of bridges/dentures, Re-cementation and repair of crowns, inlays/onlays, Occlusal Guard Implants	*50%*
Orthodontia Benefits Orthodontic Diagnostic Procedures and Treatment for Adults	*Not Covered*

**Each time you need dental care, you can choose to:

SEE A CONTRACTING DENTIST	SEE A NON-CONTRACTING DENTIST
• Your out-of-pocket cost will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses • You are not required to file claim forms • You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists	• Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses • You are required to file claim forms • You are balance billed for costs exceeding the BCBSTX Allowable Amount

EMPLOYEE INFORMATION

This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions. The following eligibility provisions apply:

- Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
- Retirees may be eligible, depending on employer contract.
- Employees may enroll dependent children up to age 5, on the first of the month following application with no late enrollment penalty.

When the course of treatment will be in excess of $300, a predetermination request should be submitted to BCBSTX in advance of treatment.

Summary of Vision Benefits

Texas Association of Counties

PREMIUM PLAN

INSIGHT NETWORK		
Frequency		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 12 months	
Contact lens eval/fitting	N/A	

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam with dilation as necessary	$0 copay	Up to $30
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium	N/A
Frames		
Any available frame at provider location	$0 copay, $180 allowance, 20% off balance over $180	Up to $65
Standard Lenses		
Single vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Standard progressive lens	$65 copay	Up to $40
Premium progressive lens	See table on page 2.	Up to $40
Lens Options		
Tint (solid and gradient)	$15	N/A
Scratch resistant coating	$0	Up to $5
Polycarbonate lenses	$0 kids; $40 adults	Up to $5 kids
Ultraviolet coating	$15	N/A
Anti-reflective coating	See table on page 2.	N/A
High index lenses	20% off retail	N/A
Polarized lenses	20% off retail	N/A
Photochromic/transitions plastic	$75	N/A
Contact Lenses (in lieu of spectacle lenses)		
Conventional	$0 copay, $180 allowance, 15% off balance over $180	Up to $104
Disposable	$0 copay, $180 allowance, plus balance over $180	Up to $104
Medically necessary	$0 copay, paid-in-full	Up to $210
Other		
Laser vision correction	15% off retail price or 5% off promotional price	N/A
Additional pairs benefit	40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used	N/A
Amplifon hearing discount	40% off hearing exams and low price guarantee on discounted hearing aids	N/A
Additional discounts	20% off non-covered items with limitations	N/A

Eligibility: All active full-time employees as defined by your employer.
Dependent coverage is available to age 26.

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- For a complete list of in-network providers near you, visit eyemedvisioncare.com/bcbstxvis or call 1.855.556.8796.
- For LASIK providers, call 1.877.5LASER6.

BlueCross BlueShield of Texas

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Summary of Benefits Continued

Progressive Price List[1]	Member Cost In-Network
Standard progressive	$65 copay
Premium progressives[2] as follows:	
Tier 1	$85 copay
Tier 2	$95 copay
Tier 3	$110 copay
Tier 4	$65 copay 80% of charge less $120 allowance

Anti-Reflective Coating Price List[1]	Member Cost In-Network
Standard anti-reflective coating	$45
Premium anti-reflective[2] coatings as follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
Photochromic	$75
Polarized	80% of charge

Plan Exclusions

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses
2. Medical and/or surgical treatment of the eye, eyes or supporting structures
3. Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear
4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
5. Plano (non-prescription) lenses and/or contact lenses
6. Non-prescription sunglasses
7. Two pair of glasses in lieu of bifocals
8. Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order
9. Services or materials provided by any other group benefit plan providing vision care
10. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Target Optical

[1]Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states, members may be required to pay the full retail rate. [2]Blue Cross and Blue Shield of Texas Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. [3]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

For employee use. This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy provides the actual terms of coverage, including any exclusions, conditions and limitations to coverage.

Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

750187.0423 TAC High

Group Benefit Program Summary for

Refugio County

Group Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Texas' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All active employees working at least 120 hours per month and elected or appointed officials
Basic Group Term Life Benefit: Employee	$10,000
Guarantee Issue Amount: Employee	$10,000
Age Reduction Schedule: Employee	Benefits do not reduce due to age.
Waiver of Premium	Waiver of Premium is available for your Life insurance. In order to apply, you must be under age 60 and continuously totally disabled from any occupation for 6 months. If approved, Life insurance premiums may be waived until your 65th birthday or until you are no longer disabled, whichever occurs first.
Accelerated Death Benefit (ADB)	Your coverage includes an accelerated death benefit (ADB) for Employee Life insurance. The ADB is an advance payment of 50% your Life insurance up to $100,000 while you are still alive and have been diagnosed with a terminal illness with a life expectancy of 6 months or less.
Portability Privilege (Life Insurance)	Not Included
Conversion	The Conversion privilege allows you to convert Life insurance to an individual whole life policy if coverage, or any portion of it, terminates for any reason.
Beneficiary Resource Services[SM1]	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Services[SM2]	Helps travelers deal with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance, and access to other critical services and resources available via the internet.

[1] Beneficiary Resource Services is provided by Morneau Shepell. Morneau Shepell is an independent organization that does not provide Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn Life Insurance Company products or services. Legal services will not be provided for court proceedings or for the preparation of briefs for legal appearances or actions or for any action against any party providing Beneficiary Resource Services. Legal services provided under Beneficiary Resource Services are not intended for adversarial matters. Neither Morneau Shepell, BCBSTX nor Dearborn Life Insurance Company are responsible or liable for care or advice rendered by any referral resources. May include face-to-face sessions, over-the-phone sessions or time taken for research or document preparation.

[2] Travel Resource Services is administered by Assist America, Inc. Assist America is an independent organization that does not provide Blue Cross and Blue Shield of Texas or Dearborn Life Insurance Company products or services. Assist America is solely responsible for the products and services associated with Travel Resource Services. Usage of the Assist America mobile app may be subject to additional terms and conditions.

This piece is for illustrative purposes only. The policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

AD&D Benefit: Employee	Same as Basic Life Insurance
Age Reduction Schedule	Same as Basic Life Insurance

AD&D Schedule of Loss *	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of same hand	25%
Uniplegia	25%

** Loss must occur within 365 days of accident*

AD&D Plan for Employees includes:

- Seat Belt Benefit
- Airbag Benefit
- Repatriation Benefit
- Child Education Benefit
- Day Care Benefit
- Coma Benefit
- Felonious Assault Benefit
- In the Line of Duty Benefit