Employee Benefits

Plan Year: July 1, 2016 - June 30, 2017

Arranged and Enrolled by Mark III Brokerage, Inc.
Cabarrus County Government is offering all full-time employees a comprehensive Benefits plan. The Benefits plan is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. This plan allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay.

- The Plan Year begins July 1, 2016 and ends June 30, 2017

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This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premium are subject to change. All policy descriptions are for informational purposes only.
PAY DATE
• The first July pay date is: July 1, 2016.

TO ENROLL
• If you need to enroll or make changes to the following benefits, you MUST see a Mark III Benefits Counselor: Allstate Benefits Cancer, Aflac Accident, Aflac Critical Illness, AUL Short Term Disability, AUL Long Term Disability, Term Life, Texas Life.

ANNUAL ENROLLMENT & MIDYEAR BENEFIT CHANGES
• Remember that elections made during annual enrollment cannot be changed once the enrollment period ends unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.

• This also applies if you wish to make a change to your benefits mid-plan year. You must have a qualifying event to make changes. If you should have a qualifying event, you will have 30 days from the date of the qualifying event to request a change. Certain stipulations do apply and documentation is required. Please visit the Human Resources Department to make a change.

CIGNA HEALTH COVERAGE FOR SAME SEX COUPLES
• Legally married same sex couples are now recognized in North Carolina. If you are currently legally married, you are eligible to enroll in the Cabarrus County Cigna Health Plan. You must make your election during the annual enrollment period if you want to add a same sex, legally married spouse.

If you do not elect coverage during annual enrollment, you will not be able to add coverage or make a change without a qualifying event until annual enrollment next year.

CHANGE IN TEXAS LIFE WHOLE LIFE
• Texas Life has replaced the current Whole Life plan. If you have Texas Life coverage now, you may keep it. If you apply for additional coverage on yourself or dependents, you will receive the Solutions 121 plan. With the Solutions 121 plan all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You may also apply for coverage on your spouse, children and grandchildren with limited underwriting requirements.

GILSBAR FLEXIBLE SPENDING ACCOUNTS
• You must re-elect your Health and or Dependent Care Flexible Spending Accounts each year. These accounts do not automatically carry-over to the next year. If you do not re-elect the spending account(s), you will not have the benefit on July 1st.
Accountability Improvement Measures (AIM)

Because of escalating health care costs and health care reform, the cost of operating Cabarrus County’s health insurance program has risen. You can avoid these monthly premiums by participating in the AIM program or meeting or improving AIM requirements.

With AIM, employees have the opportunity to receive a $50 monthly discount for being tobacco free and a $50 monthly discount for participating in the biometrics screening, meeting or improving AIM requirements. In addition to generating savings on your monthly premiums, AIM helps you assess and monitor your health, identify risks and it provides guidance on how to achieve realistic health goals over the next two years.

Your guide to understanding AIM requirements
Cabarrus County’s strength comes from our skilled and experienced workforce. Through the AIM program, you can generate savings on your monthly premiums, monitor your health, identify risks and receive guidance on how to achieve realistic health goals.

By completing a health risk assessment (employees and spouses on County health plan) and meeting biometric screening goals (employees only), you can save $50 in monthly premiums, with the possibility of saving an additional $50 if you live tobacco free.

• If you were hired between March 1, 2015 and February 29, 2016, you are a year-one participant.
• If you were hired on or before February 28, 2015, you are a year-two participant.

This booklet includes information on:
2. Program procedures
3. Biometric measures
4. Biometric screening registration

AIM program procedures

1. Spouses of all year-one AND year-two or greater participants who receive health coverage through Cabarrus County will need to complete the Carolinas HealthCare System online health risk assessment by Thursday, March 24, 2016. If the spouse does not complete the HRA by the deadline, the employee will not qualify for the monthly discount. Please direct your spouse to complete the process at http://tinyurl.com/SpouseHRAOnly2016.

2. All year-one AND year-two or greater participants must complete the annual biometric screening at a County-sponsored site.

To qualify, participants must schedule a screening at a County-sponsored location. Screenings include a simple finger stick to obtain a lipid profile, blood glucose and Hemoglobin A1c; blood pressure check; height and weight
check; and waist circumference measurement. Personal data collected from the screening is secure, kept strictly confidential and maintained by Carolinas HealthCare System.

**To prepare**, participants need to fast for 12 hours prior to their scheduled screening. Take medications as prescribed, but do not eat. You can drink water and black coffee. To schedule a screening, continue to the bottom of this post.

3. **All year-one AND year-two or greater participants must complete the Carolinas HealthCare System health risk assessment.**

   Carolinas HealthCare System will administer the online health risk assessment. You must complete the assessment by Thursday, March 24, 2016. Participants will receive a prompt to complete the health risk assessment when you register for your screening. You will need to allow 20 minutes to complete the information.

**AIM biometric measures**

**Year-two or greater** participants will need to meet three of four biometric measures, show improvement over year-one (2015) baseline results OR meet alternative guidelines designed by you and your physician in order to maintain your AIM discount.

**Year-one** participants will need to take biometric measures. Because this is the baseline measurement, your participation in the screening, not the screening results, is what counts toward future savings. To maintain the discount in your second AIM program year (July 2017-June 2018), you will need to repeat the three-step process next spring and meet three of four biometric measures, show improvement OR meet alternative guidelines designed by you and your physician.

1. **Waist Circumference (WC): <40" male or 35" female**
   If you WC is greater than above measurements, but you lose 5% of your WC you also qualify.

2. **Blood Pressure: Below 140/90 at the screening**
   If your Blood Pressure is greater than 140/90 but you lose 10/5 mmHg you will also qualify.

3. **Cholesterol Ratio: Less than 5.5 at the screening**
   If your Ratio is 5.5 or greater and improve by 10% you will also qualify.

4. **Hemoglobin A1c: Less than 7.0**
   All **year-one AND year-two or greater** participants will receive an email notification of their current year (2016) results in mid-April.

**AIM resources**

If you have any questions about the AIM program, please contact Johanna Ray at 704-920-2885 or JRRay@cabarruscounty.us.
Non-Tobacco Self Insured Policy and Procedure

Definition of Tobacco User
A person who has smoked a cigarette, cigar, or used a pipe or chewing tobacco, snuff or other tobacco product during the 6 months prior to the date he or she applies for health insurance.

Application
Because of escalating health care costs, Cabarrus County’s health insurance premium has risen to $643.50 per month for each qualified employee and retiree. July 1, 2016, Cabarrus County employees will be required to pay a portion of the health care benefit premium of $50 a month, or $25 semi-monthly. Cabarrus County’s employee health insurance plan will offer a $50 discount to non-tobacco users and tobacco users participating in a qualified smoking cessation program making their monthly contribution to their health insurance premium $0.

Employees and retirees who enroll in Cabarrus County plans during open enrollment will enroll as either a tobacco user or a non-tobacco user by certifying their status in the Health Plan Participation Certificate. To receive the non-tobacco use discount, employees must complete the Health Plan Participation Certificate. Current tobacco users may receive the non-tobacco use discount only if they enroll in the Health Coach program at the Employee Health and Wellness Center or local CHS Quit Smart program. To qualify for the discount, employees and retirees must submit proof of participation to Human Resources.

Each year during open enrollment and new hire orientation, employees will be asked to affirm whether they are a tobacco user or non-tobacco user. The employee contribution toward the health insurance premium will be determined each year prior to open enrollment or when benefits begin.

If a Cabarrus County employee is married to another County employee, then both employees will need to complete the, “Employee Health Plan Participation Certificate 2016”.

Employees who falsify the tobacco use Health Plan Participation Certificate, will be subject to disciplinary action up to and including dismissal under Article VII of the Cabarrus County Personnel Ordinance. Stated action(s) may also result in immediate loss of eligibility to participate in the Cabarrus County employee health plan.
### Cabarrus County Government: Open Access Plus

**Coverage Period:** 07/01/2016 - 06/30/2017

**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---

**What is the overall deductible?**<br>For in-network providers $1,000 person / $3,000 family<br>For out-of-network providers $2,000 person / $6,000 family<br>Does not apply to in-network preventive care & immunizations, in-network office visits, prescription drugs<br>Co-payments don’t count toward the deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |  |

**Are there other deductibles for specific services?**<br>No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |  |

**Is there an out-of-pocket limit on my expenses?**<br>Yes. For in-network providers $4,150 person / $9,300 family<br>For out-of-network providers $8,300 person / $18,600 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |  |

**What is not included in the out-of-pocket limit?**<br>Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |  |

**Is there an overall annual limit on what the plan pays?**<br>No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |  |

**Does this plan use a network of providers?**<br>Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24 | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |  |

**Do I need a referral to see a specialist?**<br>No. You don’t need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |  |

**Are there services this plan doesn’t cover?**<br>Yes. | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services. |  |

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Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount of the service. For example, if the health plan’s allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>30 co-pay/visit</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% co-insurance for chiropractor</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not Covered/visit 40% co-insurance/screening Not Covered/immunizations</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost if you use an In-Network Provider</td>
<td>Your Cost if you use an Out-of-Network Provider</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$5 co-pay/prescription (retail), $10 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$45 co-pay/prescription (retail), $90 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 co-pay/prescription (retail), $120 co-pay/prescription (home delivery)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>25% co-insurance/prescription (retail), Min $50 - Max $100 25% co-insurance/prescription (home delivery) Min $100 - Max $200</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
</tbody>
</table>


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<th>Your Cost if you use an</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% co-insurance/office visit and /other outpatient services</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% co-insurance/office visit and /other outpatient services</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Dental care (Children)</td>
</tr>
<tr>
<td>• Eye care (Children)</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Hearing aids (Children)</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan’s situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state’s consumer assistance program refer to www.healthcare.gov.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 1-800-244-6224.

----------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.--------
Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $5,340</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $2,200</td>
</tr>
</tbody>
</table>

Sample care costs:

- Hospital charges (mother) $2,700
- Routine Obstetric Care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**

- Deductible $1,000
- Co-pays $60
- Co-insurance $1,110
- Limits or exclusions $30

**Total** $2,200

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $4,530</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $870</td>
</tr>
</tbody>
</table>

Sample care costs:

- Prescriptions $2,900
- Medical equipment and supplies $1,300
- Office visits & procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**

- Deductible $0
- Co-pays $590
- Co-insurance $0
- Limits or exclusions $280

**Total** $870

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 4869057 BenefitVersion: 6
Plan Name: Cabarrus County 2015 Copay Plan
KitTrak Number: SBM21482
Cigna Open Access Plus Co-pay Health Plan  (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$50.00*</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$241.00*</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$200.50*</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$386.00*</td>
</tr>
</tbody>
</table>

*Before Non-tobacco use discount of $50

Tobacco User or Non-AIM Participant  (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$25</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$216.00</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$175.50</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$361.00</td>
</tr>
</tbody>
</table>

*Non-Tobacco User & AIM Participant  (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$191.00</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$150.50</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$336.00</td>
</tr>
</tbody>
</table>

CIGNA HealthCare of North Carolina, Inc.

CIGNA CUSTOMER CARE LINE
1.800.244.6224
### Important Questions | Answers | Why this Matters:
--- | --- | ---
**What is the overall deductible?** | For in-network providers $1,500 person / $3,000 family For out-of-network providers $3,000 person / $6,000 family Deductible per person applies when the employee is the only person covered under the plan. Does not apply to in-network preventive care & immunizations. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

**Are there other deductibles for specific services?** | No. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

**Is there an out-of-pocket limit on my expenses?** | Yes. For in-network providers $3,500 person / $5,000 family For out-of-network providers $7,000 person / $10,000 family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

**What is not included in the out-of-pocket limit?** Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

**Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.

**Does this plan use a network of providers?** | Yes. For a list of participating providers, see [www.myCigna.com](http://www.myCigna.com) or call 1-800-Cigna24 | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

**Do I need a referral to see a specialist?** | No. You don’t need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan.

**Are there services this plan doesn’t cover?** | Yes. | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

---

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan’s **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% co-insurance for chiropractor</td>
<td>40% co-insurance</td>
<td>Coverage for chiropractic care and rehabilitation services is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not Covered/visit</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery)</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.myCigna.com">www.myCigna.com</a></td>
<td>Preferred brand drugs</td>
<td>20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% co-insurance</td>
<td>20% co-insurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification. Coverage is limited to 120 days annual max. Maximums cross-accumulate.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification. Coverage is limited to 120 days annual max</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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### Excluded Services & Other Covered Services

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

<table>
<thead>
<tr>
<th>Uncovered Services</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Habilitation services</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Long-term care</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Dental care (Children)</td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Eye care (Children)</td>
<td>Routine eye care (Adult)</td>
</tr>
<tr>
<td></td>
<td>Routine foot care</td>
</tr>
<tr>
<td></td>
<td>Weight loss programs</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Hearing aids (Children)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan’s situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state’s consumer assistance program refer to www.healthcare.gov.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika a'tohwol ninesisó, kwijigo holne’ 1-800-244-6224.

---------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.---------------------

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Coverage Examples
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(normal delivery)</td>
<td>(routine maintenance of a well-controlled condition)</td>
</tr>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $4,830</td>
<td><strong>Plan pays:</strong> $2,910</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $2,710</td>
<td><strong>Patient pays:</strong> $2,490</td>
</tr>
</tbody>
</table>

**Sample care costs:**

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$1,500</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$0</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$1,180</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,710</strong></td>
</tr>
</tbody>
</table>

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- Costs don't include premiums.
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- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

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Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 4869061
BenefitVersion: 6
Plan Name: Cabarrus County 2016 Qualified HDHP - Open Access
KitTrak Number: SBM21483
Cigna Consumer Driven Health Plan *(with Health Savings Account)* (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$50.00*</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$225.00*</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$170.00*</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$345.00*</td>
</tr>
</tbody>
</table>

*Before Non-tobacco use discount of $50

Tobacco User or Non-AIM Participant (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$25</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$200.00</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$145.00</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$320.00</td>
</tr>
</tbody>
</table>

*Non-Tobacco User & AIM Participant (Semi-Monthly Rates)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$175.00</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$120.00</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$295.00</td>
</tr>
</tbody>
</table>

Health Savings Account (HSA) Employer sponsored annual participation amount is $750.
Gilsbar Health & Dependent Care
Flexible Spending Accounts

• Plan Year: July 1, 2016 - June 30, 2017
• Health Care Spending Account Minimum: $0
• Waiting Period: First of the month following a full month of employment

Medical Reimbursement Plan Maximum: $2,550
Dependent Care Account Maximum: $5,000

Claims Filing Limit: All claims for reimbursement must be submitted within three months following the end of the plan year, or if earlier, three months following the date you cease to participate in the Plan, or the claims will be denied.

Thank you for choosing to participate in the Health Care or Dependent Care FSA or HRA. Your plans are administered by Gilsbar, LLC. Your group number is S2584.

MANAGE YOUR ACCOUNT ONLINE 24/7 AT WWW.MYGILSBAR.COM!

• View plan year balance
• Set up or edit ACH/Bank Draft information
• Check claim status
• View claim/receipt images within 24 hours of submission
• Obtain forms
• Set up email messaging
• View processed payments and payment dates
• File appeals to denied claims

IT’S EASY TO GET STARTED:

STEP 1: After your effective date, go to www.myGilsbar.com and register as a new participant. You will complete a brief registration form, and you will need a valid email address and your group number, S2584.

STEP 2: Once logged in, choose the FSAs and HRAs link in the left navigation bar. If you are a first time user, you will be prompted to enter your email address to sign up for our Reimbursement Account Center email service. This is an important step to ensure you will receive email updates each time:

• A claim is received
• The claim/receipt images are ready to view online
• The claim is processed and posted for payment

STEP 3: Click the Accounts tab at the top to confirm that your address and annual election(s) are accurate. If there are any discrepancies in your account information, please contact us at (800) 445-7227 ext. 1883.

STEP 4: Confirm that your ACH/Auto Bank Draft Information is entered and accurate. To set up direct deposits into your bank account, click the Profile tab at the top and select Edit under the Your ACH section. To update your email address, select Edit under the View/Edit Your Profile section.

SUBMIT YOUR CLAIMS:

For fastest processing, fax claims and receipts to: (866) 635-1329

Mail claims and receipts to:
Claims Processing Center
P.O. Box 965
Covington, LA 70434

(Please keep the original documents for your records.)

CONTACT US:

Customer Contact Center
Phone: (800) 445-7227 ext. 1883
Email: flex@gilsbar.com

7:00 a.m.-7:00 p.m. CST
(Please do not email claims/receipts.)
WHAT IS A HEALTHCARE FSA?

Provided by your employer, a Healthcare FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck, pre-tax, to help pay for out-of-pocket medical expenses for you and your family. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses, you can save an additional 20-30% on healthcare expenses.

Any employee who has eligible out-of-pocket expenses beyond what their health plan covers should enroll in the Healthcare FSA. Eligible out-of-pocket expenses are determined by the IRS and include deductibles, co-insurance, co-payments, and other non-covered expenses in excess of the maximum amounts allowed under your plan.

HOW DOES THE HEALTHCARE FSA WORK?

With an FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided among pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visits, and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet is provided to help you determine the amount of money to allocate to your Healthcare FSA.

The IRS requires that all money in the account be used during the plan year. Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your election amount. To help avoid this situation, you will receive a notice of your balance prior to the end of the plan year, so you can use that balance on qualified expenses prior to the last day of the current plan year.

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur expenses, you may fax a claim form and receipts to Gilsbar for reimbursement.

HOW DOES THE HEALTHCARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of “single” with one exemption:

<table>
<thead>
<tr>
<th>Salary:</th>
<th>$1000.00</th>
<th>$1000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Pre-Taxed Dollars:</td>
<td>-$100.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Healthcare Reimbursement</td>
<td>$900.00</td>
<td>$1000.00</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$900.00</td>
<td></td>
</tr>
<tr>
<td>Less:</td>
<td>$900.00</td>
<td></td>
</tr>
<tr>
<td>Federal Income Tax (15%*)</td>
<td>-$135.00</td>
<td>-$150.00</td>
</tr>
<tr>
<td>State Income Tax (5%*)</td>
<td>-$45.00</td>
<td>-$50.00</td>
</tr>
<tr>
<td>Social Security (7.65%*)</td>
<td>-$68.85</td>
<td>-$76.50</td>
</tr>
<tr>
<td>Net Take Home Pay:</td>
<td>$651.15</td>
<td>$723.50</td>
</tr>
<tr>
<td>Less Healthcare Expenses</td>
<td>-$50.00</td>
<td>-$100.00</td>
</tr>
<tr>
<td>Net After Expenses:</td>
<td>$601.15</td>
<td>$623.50</td>
</tr>
</tbody>
</table>

*Your income tax rates may vary based on your income and the state in which you reside.

HOW EASY IS IT TO USE MY HEALTHCARE FSA?

Very easy! Visit www.myGilsbar.com and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the Reimbursement Account Center link to view your personalized FSA dashboard. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number (found on your ID card), Social Security number, and a valid e-mail address to complete this section. As a registered user, you can:

- Access balance information.
- View images of receipts and claim forms online within 24 hours of receipt.
- Receive an email when the claim is received and is viewable online, and again when it is processed and posted for payment.
- View account elections, account deposits, reimbursement payments, claim status details, receipt images, and denials.
- File online appeals to denied claims.
- Receive end-of-year reminders about available account balances, and much more!

Gilsbar
2100 Covington Centre • Covington, LA • 70433
800.445.7227 • www.gilsbar.com
CAN I CHANGE MY CONTRIBUTION AMOUNT?

Generally, you may not change your FSA election during the plan year. However, you may make changes during the annual enrollment period for the coming plan year. There is one exception to this rule: you may change your contribution amount during the plan year if you have a qualifying status change. Examples include:

- Change in legal marital status
- Change in number of tax dependents
- Termination or commencement of employment
- Dependent satisfies or ceases to satisfy dependent eligibility requirements, judgment decree, or order

HEALTHCARE EXPENSE WORKSHEET

The below worksheet has been prepared to help you determine the amount of money you wish to allocate to your Healthcare FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Healthcare FSA (keeping in mind to only budget for those expenses specifically eligible under your Healthcare FSA).

HOW WILL HEALTHCARE REFORM AFFECT MY FSA?

Healthcare reform imposes stricter reimbursement rules for qualified medical expenses. The definition of qualified medical expense, for purposes of reimbursement from an FSA, has been modified to include amounts paid for medicine or a drug only if the medicine or drug is insulin or prescribed by a physician. **AS A RESULT OF THIS CHANGE, EFFECTIVE JANUARY 1, 2011, OVER-THE-COUNTER (OTC) MEDICINES (EXCEPT THOSE PRESCRIBED BY A DOCTOR) ARE NO LONGER ELIGIBLE FOR REIMBURSEMENT BY AN FSA ACCOUNT.**

### MOST COMMON ELIGIBLE EXPENSES

- Dental Services
- Orthodontia/Braces
- Copay Amounts
- Deductibles
- Hospital Services
- Physical Therapy
- Well Baby Care
- Contact Lenses
- Lab Exams/Tests
- Insulin
- Nicotine Gum or Patches
- Prescription Drugs
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries

### HEALTHCARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles (medical and dental)</td>
<td>$ __________</td>
</tr>
<tr>
<td>Benefit percentage/co-insurance (The amount NOT paid by your insurance)</td>
<td>$ __________</td>
</tr>
<tr>
<td>Amounts paid over plan limits</td>
<td></td>
</tr>
<tr>
<td>Over reasonable and customary allowance</td>
<td>$ __________</td>
</tr>
<tr>
<td>Over psychiatric limits</td>
<td>$ __________</td>
</tr>
<tr>
<td>Over private room allowance</td>
<td>$ __________</td>
</tr>
<tr>
<td>Expenses NOT covered by your insurance plan</td>
<td></td>
</tr>
<tr>
<td>Physicals</td>
<td>$ __________</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$ __________</td>
</tr>
<tr>
<td>Vision Care</td>
<td>$ __________</td>
</tr>
<tr>
<td>Hearing Expenses</td>
<td>$ __________</td>
</tr>
<tr>
<td>Psychiatric Care</td>
<td>$ __________</td>
</tr>
<tr>
<td>Dental and Orthodontic Care</td>
<td>$ __________</td>
</tr>
<tr>
<td>Assistance for the Handicapped</td>
<td>$ __________</td>
</tr>
<tr>
<td>Therapy / Treatments</td>
<td>$ __________</td>
</tr>
<tr>
<td>Physician’s Fees / Services</td>
<td>$ __________</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>$ __________</td>
</tr>
<tr>
<td>Miscellaneous Charges</td>
<td>$ __________</td>
</tr>
<tr>
<td>My out-of-pocket healthcare expenses last year</td>
<td>TOTAL $ __________</td>
</tr>
</tbody>
</table>

Compare last year’s typical expenses to those eligible under your Healthcare FSA and budget accordingly for the upcoming year.
HOW DOES THE FSA DEBIT CARD WORK?

Shortly after enrolling in a Healthcare Flexible Spending Account (FSA), you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don’t have to pay with cash out of pocket.

IF I USE MY FSA DEBIT CARD, IS VERIFICATION OF CLAIMS STILL REQUIRED?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transactions can be verified using one of the IRS’s approved electronic methods; however, not all transactions can be verified this way. For any expense that cannot be verified electronically you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost, and patient liability. If Gilsbar does not receive verification of transactions within 30 days of the date requested, you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

HOW CAN I PROVIDE SUPPORTING DOCUMENTATION?

If you receive a substantiation request letter, please go to www.myGilsbar.com to electronically upload any required receipts. For each claim requiring a receipt, click “Upload Receipt” on the far right of the Accounts Page under your Home Page and follow the instructions. (Your receipt must be in .doc, PDF, BMP, or GIF format.) Upon successful upload, the Receipt Uploaded confirmation appears: “Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved.” After uploading, you may also click “View Confirmation” and print the form for your records. NOTE: If you see a “Receipts Needed” link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

WHERE CAN I USE MY FSA DEBIT CARD?

Your FSA Debit Card will only be accepted at authorized vendors who have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers, and pharmacies.

WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

Effective January 1, 2011, OTC medications and drugs (other than insulin) will no longer be reimbursed by an FSA unless they are accompanied by a doctor’s prescription. Medications or drugs must meet one of the following criteria to be eligible for reimbursement:
1) The medicine or drug requires a prescription.
2) The medicine or drug is available without a prescription and the individual obtains a prescription.
3) The medicine or drug is insulin.

CAN I USE MY FSA DEBIT CARD FOR ELIGIBLE DEPENDENT CARE EXPENSES?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors who have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers, and pharmacies.

WHAT HAPPENS IF THE FSA DEBIT CARD IS USED FOR AN INELIGIBLE EXPENSE?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

WHAT SHOULD I DO TO PAY FOR AN EXPENSE THAT IS MORE THAN MY ACCOUNT BALANCE?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.
WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses, you save 20-30% on dependent care expenses.

HOW DOES THE DEPENDENT CARE FSA WORK?

With a Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from you each pay period. To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided for you to help you determine the amount of money to allocate to your Dependent Care FSA.

The IRS requires that all money in your account be used during the plan year. An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who is:

• A child under 13 years of age
• A child over the age of 13 who is physically or mentally incapable of self-care
• Your spouse and is physically or mentally incapable of self-care
• An elderly parent who resides with you and is physically or mentally incapable of self-care

HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of “single” with one exemption:

<table>
<thead>
<tr>
<th>Salary</th>
<th>$1000.00</th>
<th>$1000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Pre-Taxed Dollars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Day Care Reimbursement</td>
<td>-$192.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$808.00</td>
<td>$1000.00</td>
</tr>
<tr>
<td>Less:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Income Tax (15%)*</td>
<td>-$121.20</td>
<td>-$150.00</td>
</tr>
<tr>
<td>State Income Tax (5%)*</td>
<td>-$40.40</td>
<td>-$50.00</td>
</tr>
<tr>
<td>Social Security (7.65%)*</td>
<td>-$61.81</td>
<td>-$76.50</td>
</tr>
<tr>
<td>Net Take Home Pay</td>
<td>$584.59</td>
<td>$723.50</td>
</tr>
<tr>
<td>Less Dependent Care Expenses</td>
<td>-$0.00</td>
<td>-$192</td>
</tr>
<tr>
<td>Net After Expenses</td>
<td>$584.59</td>
<td>$531.50</td>
</tr>
</tbody>
</table>

*Your income tax rates may vary based on your income and the state in which you reside.

HOW EASY IS IT TO USE THE DEPENDENT CARE FSA?

Very easy! Visit www.myGilsbar.com and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the FSA and HRA link to view your personalized FSA Home Page. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number, Social Security number, and a valid email address to complete this section. As a registered user, you can:

• Review Action Alerts that enable you to keep current on your accounts.
• File a claim online and upload receipts and other documentation
• View account balances and history
• View payments and next payment dates
• Report lost or stolen debit cards
• Review instructions to download Gilsbar’s FSA Mobile App
WHAT EXPENSES ARE COVERED?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attend school full time. Private school tuition (K4 and above) is not eligible for reimbursement. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before / after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider

HOW DO I GET REIMBURSED?

As you incur eligible expenses, you must complete a Dependent Care FSA claim form and attach proof of payment from your day care provider or from the individual who provides the care. The claim form and documentation of expense can be submitted online at www.myGilsbar.com or my using the Gilsabr FSA Mobile App. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name, and address of the provider, dates of service, type of service rendered, and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19. With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in “pending” status until funds are received through payroll deduction, at which time you will receive reimbursement.

CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?

Generally, you may not change your FSA elections during the plan year unless you have a change in family status that change the benefit eligibility during the plan year. Otherwise, you may change during the annual enrollment period for the coming plan year. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement for adoption of a child
- Death of a dependent or spouse
- Change in your or your spouse’s employment status
- A significant change caused by a third party in the cost of your dependent care coverage

DEPENDENT CARE FSA EXPENSE WORKSHEET

The worksheet below has been prepared to help you determine the amount of money you wish to allocate to your Dependent Care FSA. You may want to review your checkbook register or credit card statements from last year to identify expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Dependent Care FSA (keeping in mind to only budget for those expenses specifically eligible for your Dependent Care FSA).

<table>
<thead>
<tr>
<th>DEPENDENT CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of Child or Adult Care Facilities*</td>
</tr>
<tr>
<td>Day Care Center / Nursery School</td>
</tr>
<tr>
<td>Family Day Care / Adult Day Care Centers**</td>
</tr>
<tr>
<td>Wages paid to a nanny or in home care provider***</td>
</tr>
<tr>
<td>Other dependent care expenses considered eligible by the IRS</td>
</tr>
<tr>
<td>TOTAL ESTIMATED DEPENDENT CARE EXPENSES</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* The facility must follow all local and state laws.

** These costs are eligible only if the adult dependent spends at least eight hours per day at your home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.
IRS REGULATIONS ON FSA DEBIT CARDS
The IRS sets regulations regarding how debit cards operate in conjunction with a Flexible Spending Account (FSA). According to these rules, there are five basic requirements that must be met for you to use an FSA debit card.

Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.

- The participant must retain all receipts for all transactions.
- 100% of debit card transactions must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee “self-certification” is not allowed.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, the IRS defines several Auto-Substantiation (electronic substantiation) methods that we can use to help with the adjudication process.

These methods are:

- **Co-pay Match** - If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- **Recurring Expense** - For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- **Real-Time or Merchant Substantiation** - If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

WHY DOES THE IRS HAVE THESE RULES? ISN’T IT MY MONEY?
Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

WHAT SHOULD I DO IF I RECEIVE A SUBSTANTIATION REQUEST?
You may receive requests for Manual Substantiation in the event that the charges do not qualify for Auto-Substantiation. If you receive a substantiation request, please go to www.myGilsbar.com to electronically upload any required receipts.

For each claim that requires a receipt, click “Upload Receipt” on the far right of the Accounts Page under your Home Page, and follow the instructions. (Your receipt must be in .doc, .pdf, .bmp, or .gif format.) Upon successful upload, the Receipt Uploaded confirmation appears: “Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved.” After uploading, you may also click “View Confirmation” and print the form for your records.

NOTE: If you see a “Receipts Needed” link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?
Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register/provider receipts showing the name and address of the merchant or provider, date of service, items purchased, and dollar amount charged. Credit card receipts are not an acceptable form because they are not itemized; Gilsbar cannot verify that the expense was an FSA eligible item.

ARE PROVIDERS, PHARMACIES, HOSPITALS, ETC. REQUIRED TO PROVIDE A RECEIPT WITH SERVICE?
No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

SHOULD I KEEP COPIES OF MY RECEIPTS?
Yes, because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending them to Gilsbar.
Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA). If applicable, it enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims and payment (reimbursement) details
- Report a lost/stolen card and request a new one
- Download forms and notifications
- Access your wellness center

ACCESSING YOUR PORTAL

2. If you have an existing myGilsbar account, log in with your user ID and password.
3. If you are new to myGilsbar, complete the brief registration to log in. You will need your Gilsbar group number, Social Security number, and a valid email address to complete this section.
4. Once logged in, click the “FSAs and HRAs” link on the left navigation panel to access your information.
NAVIGATING THE HOME PAGE

The top section of the home page has a drop-down menu with useful links for managing your accounts.

Just below the Welcome, there are links to file a claim and to manage your expenses. Your Available Balance for each of your accounts will display towards the left side of the page. Click Available Balance to view a detailed account summary.

Your account information can also be accessed through the Accounts tab. Click on each account name to view that account’s details (you may need to set your browser to allow pop-ups from the site).

The Message Center displays helpful information, alerts, and relevant links. If you see a Receipts Needed link in your Message Center, click on it. A listing of any claims requiring receipts will appear.

In the Quick View section, you will see a helpful graphical summary of paid claims, elections for the current plan year, and your contributions to date.

HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

1. On the Home Page under the Accounts tab, click File Claims on the drop-down menu.

2. Enter your claim information and upload the receipt. You may also enter your mileage reimbursement information at this time. Once you have completed the form, click Add Claim.

3. You will be directed to your Claims Basket. You may choose to Add Another Claim or submit the claim(s) listed.

4. When all of your claims are added to the Claims Basket, check the box to confirm that you have read and agree to the Terms and Conditions.

5. Click Submit to send your claims for processing. The Claim Confirmation page will display. You may print the Claim Confirmation Form as a record of your submission.
Gilsbar is pleased to announce the release of our FSA & HRA mobile app for your iPhone, Android, and tablet devices.

With the mobile app, you can:

• Check your FSA and HRA account balances
• View account activity and receive alerts via text message
• File new claims with receipt images
• Enter a new expense and review expense information
• Upload receipts using your mobile device’s camera
• Manage expense receipts
• Report a lost or stolen ID card

DOWNLOADING THE APP

For Apple Devices:

• Open the App Store and search for “Gilsbar FSA HRA.”
• Tap “Get” and then “Install.” You will be prompted for your Apple ID log in information. Once entered, select “OK.”
• Once the app is downloaded, tap its icon to open it on your device.

For Android Devices:

• Open the Google Play Store or Market and search for “Gilsbar FSA HRA.”
• Tap the Gilsbar app icon.
• Tap “Install” and then “OK.”
• Once the app is downloaded, tap its icon in your app list to open it on your device.
LOGGING INTO THE MOBILE APP

• Before you log in for the first time, you will need your participant ID number.

Your participant ID can be found in the FSA/HRA section of myGilsbar.com by clicking the arrow to the right of your name.

• Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).

• After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

If you would like assistance installing or logging in to the mobile app, please contact our Customer Contact Center!
1-800-445-7227, ext 1883 • flex@gilsbar.com

INSIDE THE MOBILE APP

Once logged in to the app, you are seconds away from managing your FSA & HRA accounts from your phone.

view account balances & activity  file new claims  upload & manage receipts

Gilsbar 2100 Covington Centre • Covington, LA • 70433
800.445.7227 • www.gilsbar.com
Plan Year: July 1, 2016 - June 30, 2017

• **Health Reimbursement Arrangement Annual Employer Contribution:** $225  
  (To be used with the Open Access Plus Health plan only)

• **Waiting Period:** When health insurance becomes effective
• **Run Off Period:** 90 days following the end of the plan year to file for services rendered during the plan year

A Health Reimbursement Arrangement (HRA) is a type of health plan that uses only **Employer** contributions to pay for Employee and Dependent health care expenses. Cabarrus County will allow the HRA funds to be used for **deductibles, primary care physician co-pays and coinsurance**. This account may never be used for anything but reimbursements on the designated expenses.

The good news is that you do not pay federal income taxes or employment taxes on amounts your Employer contributes to the HRA.

You will not be able to rollover any balance that remains at the end of the plan year. Your Employer is not permitted to refund any part of the balance to you.

If you also have the Gilsbar Health Care Flexible Spending Account (FSA), you will receive one debit card and Gilsbar will **pull funds from the HRA first to pay for eligible expenses**. After you have spent the funds in the HRA account, your FSA account will begin paying for your expenses.

If you terminate your employment with Cabarrus County, you will be able to spend down the balance in your account **IF** you elect COBRA. You have 90 days after termination to submit claims to Gilsbar.
Ameritas Dental Non-PPO

Effective Date: July 1, 2016

COMBINED CALENDAR YEAR DEDUCTIBLE

• $50.00 per individual for TYPE II- BASIC PROCEDURES and TYPE III - MAJOR PROCEDURES

• 3 times family limit- After the date that 3 covered family members have each satisfied their individual deductible ($150.00), the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

• The $50.00 deductible does not apply to TYPE I PREVENTIVE AND DIAGNOSTIC procedures and ORTHODONTIA.

TYPE I - PREVENTIVE AND DIAGNOSTIC - Type I benefits are payable at 100%. U & C*. No deductible applies.

• Evaluations (Two per benefit period)
• Cleanings (Two per benefit period)
• Fluoride for Children (Under age 19)
• Space Maintainers
• Radiographs (X-rays)
• Bitewings x-rays (Two per benefit period)

TYPE II - BASIC PROCEDURES - Type II benefits are payable at 80% U & C*. $50.00 deductible applies.

• Sealants (under 17)
• Limited Exams
• Restorative Amalgam & Resin
• Denture Repair
• Oral Surgery - Complex Extractions
• Anesthesia
• Oral Surgery - Simple Extractions

TYPE III - MAJOR PROCEDURES - Type III benefits are payable at 50% U & C*. $50.00 deductible applies.

• Endodontics (Root Canal)
• Periodontics (Gum Disease)
• Prosthodontics (Removable Dentures, Partial)
• Restorative - Crowns
• Prosthodontics - Fixed Pontics or Abutment
• Crown Repair

ORTHODONTIA - ADULT & CHILDREN - Paid at 50% U &C* with a $1,250 lifetime maximum. No deductible applies.

*Usual & Customary
ANNUAL MAXIMUM BENEFIT
• Type I, II, and Type III Procedures - $1,250 per calendar year per person.
• Orthodontia Procedures - $1,250 Lifetime per person.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)
During the first 36 months following your or your dependent’s Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES
You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

ELIGIBLE DEPENDENTS
Provides Coverage On:
• Your Spouse
• Children up to age 26

PREDETERMINATION OF BENEFITS
A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

COORDINATION OF BENEFITS
If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

CERTIFICATE OF INSURANCE
The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

SECTION 125
This policy is provided as part of the Policyholder’s Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period,
except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

ORTHODONTIA LIMITATIONS
(This is not a complete list)
No benefit is payable for expenses incurred:
• In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
• During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
• After the individual’s insurance for orthodontic benefits terminates.

LIMITATIONS/EXCLUSIONS
(This is not a complete List)
• For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspids are considered cosmetic.
• Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
• Services which are not recommended by a dentist or which are not required for necessary care and treatment.
• Expenses incurred to replace lost or stolen appliances.
• Expenses incurred by an insured because of a sickness for which he/she is eligible for benefits under Worker’s Compensation Act or similar laws.

LATE ENTRANT
If you do not elect to participate in the dental plan when first eligible, you will be considered a Late Entrant and you must wait 12 months for most benefits. For a Late Entrant, benefits will be limited to exams, cleanings, and child fluoride treatments. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event. This applies to dependents as well.

SEMI-MONTHLY RATES
   Employee         $16.42
   Employee + Spouse $33.66
   Employee + Children  $40.26
   Employee + Family    $57.50

For Claims/Customer Service call Ameritas: 1.800.487.5553
Website: www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.
Ameritas Dental PPO

Effective Date: July 1, 2016

To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced. Out-of-Network benefits will be paid based on the maximum allowable charge.

COMBINED CALENDAR YEAR DEDUCTIBLE

• $50.00 per individual for **TYPE II- BASIC PROCEDURES** and **TYPE III - MAJOR PROCEDURES**

• 3 times family limit- After the date that 3 covered family members have each satisfied their individual deductible ($150.00), the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

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SEMI-MONTHLY RATES

Employee $13.19
Employee + Spouse $27.05
Employee + Children $32.35
Employee + Family $46.21

For Claims/Customer Service call Ameritas: 1.800.487.5553
Website: www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.
Commonly Asked PPO Questions

Cabarrus County Government wants employees to have options regarding their dental benefits. You have a choice of enrolling in the PPO plan or the Non-PPO plan. Both plans are administered by Ameritas and the benefits in each plan are very similar. The key difference in the PPO and Non-PPO option is the decision of utilizing one of the many participating network providers or choosing to use a non-network provider when seeking dental services. Utilizing a network provider will allow greater cost savings opportunities in terms of your premium dollars as well as out of pocket costs.

Do I have to use an Ameritas PPO provider?

No, you and your covered dependents can choose to visit any licensed dental provider. However, if you choose to enroll in the PPO option - having lower premium rates - you are strongly encouraged to utilize a participating network provider in order to realize the true benefits of the plan including lower out of pocket costs. While the benefits of the Non-PPO and PPO plan are very similar, the reimbursement allowances are different between the two options.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas’ plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.

- As part of their contractual agreement with Ameritas, the PPO provider cannot “back-bill” the patient for the difference between the dentists’ normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.

- PPO providers are required to file the claim for the patient.

- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don’t use an Ameritas PPO provider?

As noted above, you have a choice of enrolling in the PPO plan or the Non-PPO plan.

If you elect to enroll in the PPO option, it is strongly advised that you and your covered dependents utilize one of the many available network providers when seeking dental services. Members enrolling in the PPO plan should absolutely utilize a participating provider for all procedures and services in order to benefit from the plan and the Maximum Allowable Charge (MAC) reimbursement tied to the PPO option.
For members enrolling in the Non-PPO option, you can choose to visit any provider. Non-panel providers will charge their standard fees and Ameritas will reimburse based on the 90th U&C. The 90th U&C reimbursement means that 9 out of 10 dentists in an area are within our reimbursement allowance. The 90th U&C is the highest in the industry and does provide a strong reimbursement. That said, unlike the Ameritas PPO providers: Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient’s behalf, the patient can simply attach the dentist’s bill to a claim form that includes the patient’s name and identification number, and fax or mail the claim to Ameritas for processing.

Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas’ claim forms which are available in the Benefit’s Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800.487.5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com
Ameritas PPO Dental Plan

PLAN HIGHLIGHTS

LOWER PREMIUMS
- Compared to the Standard Plan, the PPO Plan can save you $43 - $151 per year depending on your level of coverage.

<table>
<thead>
<tr>
<th>Procedure (Code)</th>
<th>% covered under plan</th>
<th>Out-of-Network Cost</th>
<th>Your Cost</th>
<th>In-Network Cost</th>
<th>Your Cost</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam (D120)</td>
<td>100%</td>
<td>$49</td>
<td>$0</td>
<td>$28</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Cleaning (D1110)</td>
<td>100%</td>
<td>$87</td>
<td>$0</td>
<td>$64</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Filling (D2330)</td>
<td>80%</td>
<td>$161</td>
<td>$32.20</td>
<td>$95</td>
<td>$19.00</td>
<td>$13.20</td>
</tr>
<tr>
<td>Simple Extraction</td>
<td>80%</td>
<td>$170</td>
<td>$34.00</td>
<td>$91</td>
<td>$18.20</td>
<td>$15.80</td>
</tr>
<tr>
<td>(D7140)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Crown (D6750)</td>
<td>50%</td>
<td>$1,081</td>
<td>$540.50</td>
<td>$702</td>
<td>$351</td>
<td>$189.50</td>
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<tr>
<td>Endodontics (D3330)</td>
<td>50%</td>
<td>$1,114</td>
<td>$557</td>
<td>$740</td>
<td>$370</td>
<td>$187</td>
</tr>
</tbody>
</table>

1 - $50 deductible per covered individual per calendar year applies for Type 2 (Basic) and Type 3 (Major) Procedures.
2 - Cost represents Usual & Customary Charges in the Concord area.
3 - Cost represents the Maximum Allowable Benefit for In-Network Providers.
4 - Savings is your total out-of-pocket savings. You are also saving on dollars applied toward your Annual Maximum Allowance.

LOWER PROCEDURE COSTS
- To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not sign up for the PPO Plan or your Out-of-Network benefits will be significantly reduced.
- All In-Network Providers have a lower negotiated rate for procedures. This not only saves you money out-of-pocket, but also allows you to get more out of your Annual Maximum Allowance.
- Please see below for examples of cost savings.
Community Eye Care Vision

**Effective Date: July 1, 2016**

The County is pleased to provide you with the following summary of the vision benefit that includes a voluntary (optional) eyewear plan. The eyewear plan enables employees and their family members to significantly reduce their expenditures for glasses and contact lenses. In addition, the County will continue to pay for an annual routine eye examination for all eligible employees and dependents covered by the health plan. Both the annual eye examination and the voluntary eyewear plan are administered by Community Eye Care.

**EXAM BENEFIT**

- An eye examination every 12 months ($10 co-pay)
- A contact lens fitting, re-fit or evaluation every 12 months (no co-pay)

Premiums for the exam benefit are 100% employer-paid. There is no cost to *eligible* employees or dependents, other than the applicable co-payment.

*Eligible* employees and dependents are those currently covered on the County’s health plan. Although exam coverage is limited to eligible individuals, the eyewear benefit can be selected by any employee, regardless of eligibility.

**EYEWEAR PLAN**

- $150 Annual Allowance for Eyewear every 12 months ($20 co-pay)

The eyewear allowance is completely flexible. It can be applied to frames, eyeglass lenses, contact lenses, special lens options, or any combination. As long as you select eyewear having a retail price that’s less than or equal to your allowance, your only out-of-pocket expense for the eyewear is the $20 co-pay. If the eyewear you choose is more expensive than $150, you are eligible for attractive discounts on the overage amount from most network providers: 20% for frames and lenses, and 10% for contact lenses.

Members are also eligible for discounts of up to 15% on LASIK refractive surgery performed by participating providers.

Note that maximum coverage for contact lens examinations is $100 for fittings and $80 for annual evaluations. Members are responsible for any charges exceeding these amounts.
How to Use Your Benefit

1) Select a provider from the Community Eye Care provider network.

2) Call the provider to make an appointment, and let them know that you have Community Eye Care coverage.

3) See the provider and select your eyewear.

4) Pay the provider your co-pays, plus any discounted amount that exceeds the $150 eyewear allowance.

*Note that premiums for the optional Eyewear Plan are handled through payroll deduction.*

To locate a provider in your area, go to www.communityeyecare.net and search by any of the following categories:

- county
- doctor’s last name
- practice name
- zip code

There are no claims to file when you see an in-network provider. Network providers file claims on your behalf.

Members who obtain exams and eyewear from a non-network provider still receive their full benefit. The member simply submits a claim form to Community Eye Care and is reimbursed for the full cost of their exam (minus the co-pay) and for the cost of their eyewear, up to the amount of the allowance. Note that a claim form can be printed from the member benefit page of the Community Eye Care website. Alternatively, members can contact Community Eye Care to obtain a form.

**Semi-monthly Rates (24 deductions)**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$3.70</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$7.21</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$10.92</td>
</tr>
</tbody>
</table>

**Customer Service and Claims Administration**

1-888-254-4290  ~ Fax: 704-426-6044

www.communityeyecare.net

2359 Perimeter Pointe Parkway, Suite 150, Charlotte, NC 28208
# CEC Retail Optical Chains

<table>
<thead>
<tr>
<th>Lenscrafters</th>
<th>America's Best Visionworks</th>
<th>Nationwide Vision MyEyedr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wal-Mart Vision Center</td>
<td>Sears Optical</td>
<td>Optical Shop in Meijer</td>
</tr>
<tr>
<td>Target Optical</td>
<td>20/20 Vision Center</td>
<td>Henry Ford Optimeyes</td>
</tr>
<tr>
<td>Pearle Vision Optical</td>
<td>Vision Center in Wal-Mart</td>
<td>Fred Meyer</td>
</tr>
<tr>
<td>JCPenney Optical</td>
<td>Bosco's Optical</td>
<td>Vista Optical</td>
</tr>
<tr>
<td>Sam's Club Vision Center</td>
<td>20/20 Express</td>
<td>Coastal.com</td>
</tr>
<tr>
<td>Vision World</td>
<td>See Eyewear</td>
<td></td>
</tr>
<tr>
<td>Eyeglass World</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Logos of various optical chains]
Effective Date (pending underwriting approval if a health statement is submitted)

PLAN SPONSORED BY: Cabarrus County Government, PO Box 707, Concord, NC 28026-0707 / 704.920.2200

EMPLOYER PAID - $20,000 DEATH BENEFIT (no cost to you)
This insurance is payable for death from any cause to any person you name as beneficiary.

OPTIONAL EMPLOYEE LIFE INSURANCE
Your employer-sponsored Basic life coverage provides important protection for you, but you may need to add to that protection. To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your plan.

ACCIDENTAL DEATH AND DISMEMBERMENT
Benefits under this coverage are payable as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage. Matching Accidental Death and Dismemberment amounts also apply to employees electing Optional Life coverage.

AD&D Exclusions:
AD&D benefits will not be paid for accidental losses caused by, contributed to by, or resulting from:
• Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane
• Active participation in a riot
• Attempt to commit or commission of a crime
• War, declared or undeclared, or any act of war
• Use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of the employee’s physician. This exclusion does not apply if the chemical substance is ethanol.
• Disease of the body, or diagnostic, medical or surgical treatment, or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders
• Being intoxicated

DEPENDENT LIFE INSURANCE - EMPLOYEE PAID
Provides coverage on:
• Your lawful spouse
• Your unmarried children from live birth but less than age 19, or less than age 23 if a full-time student. Handicapped children can continue to be covered with no age limit, as long as the child is covered prior to age 19 or to age 23 if a full-time student.

*It is your responsibility to notify the Human Resources Department in writing when a dependent is ineligible for coverage.
Examples of ineligible dependent status are divorce, death or a child graduates from college.

ELIGIBILITY
Regular active full-time employees working at least 40 hours per week. For employees who are absent from work on the date their coverage would normally begin (due to injury, sickness, layoff or leave of absence), coverage will begin on the date they return to active employment. For newly eligible dependents that are totally disabled on the date their coverage would normally begin, coverage will begin on the first of the month coincident with or next following the date they are no longer totally disabled. This does not apply to a newborn child while dependent insurance is in effect.

ENROLLMENT
Enrollment is simple - just fill out the election card provided by your employer. You have 31 days to enroll yourself and dependents without evidence of insurability.

STATEMENT OF HEALTH
Increases in coverage, a re-entry in the plan and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to Unum Life Insurance Company of America.

BENEFICIARY
You have the right to designate the beneficiary of your choice. The beneficiary elected on your life enrollment form designates your beneficiary for Basic and Optional coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update one’s beneficiary designation as necessary.

WHEN YOUR BASIC INSURANCE STARTS
If you enroll on or before the day you become eligible, your insurance becomes effective on the first day of the policy month following one complete month of continuous employment, if you are then actively at work; otherwise on the day you return to active work.

WHEN YOUR OPTIONAL INSURANCE STARTS
If you enroll for Optional and/or Dependent Life Insurance and proof of good health is accepted, the additional amount of insurance will take effect on the date that coverage is approved by Unum Life Insurance Company of America.

APPROVED LEAVE OF ABSENCE
If you are temporarily laid off, on FMLA (Family Medical Leave), or have been granted a leave of absence for other than military service (off the payroll) you may continue your group term life insurance for up to 90 days.

REDUCTIONS AT AGE 65 & OVER
If you remain in active service beyond age 65 your combined amount of Basic and Optional Employee Life Insurance will reduce as follows:

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Percent of Original Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>65%</td>
</tr>
</tbody>
</table>
TERMINATION OF COVERAGE
All insurance under this plan will terminate upon the earlier of the date you retire, or the date your employment terminates. Nevertheless, if you or a covered dependent should die within 31 days thereafter, the life insurance will still be paid to the beneficiary under the conversion privilege.

DISABILITY (Waiver of Premium)
If you become totally disabled for 9 months before your 60th birthday, your insurance will continue as long as you are disabled, but not past SSNRA. If you become disabled on or after your 60th birthday, you will not be eligible for waiver of premium.

ACCELERATED BENEFIT OPTION (ABO)
Unum Life Insurance Company of America has included an Accelerated Benefit Option (ABO) as part of your Group Life benefits. Under this option, if you are diagnosed as having a terminal illness with less than 12 months to live, you will be eligible to receive a maximum of $500,000 or 75% (whichever is less) of your insurance coverage. Any payout would reduce the death benefit. Please refer to your Group Certificate for details.

SUICIDE EXCLUSION
The Optional Life & AD&D Insurance on any Insured Person will not be payable if the Person dies as a result of suicide within two years of the date his insurance becomes effective with this Company, or prior insurer, and or after an election to increase the amount of insurance under the policy. The Company's liability for that portion of insurance shall be limited to the return of premiums paid for the life insurance without interest. This does not apply to the Basic Life.

GROUP POLICY
The insurance briefly described is subject to the terms and conditions of the Unum Term Life Group Policy.

CONVERSION (applies to Optional and Basic coverage)
You must apply and pay the premium for the converted policy within 31 days of your group life insurance ending. If the policy ends or is changed to reduce or end your life insurance, and if you have been insured for at least 5 years under the policy, you may convert up to the lesser of: $10,000 or the amount of life insurance that ended minus the amount of any group life insurance for which you become eligible within 31 days.

PORTABILITY (applies to Optional and Basic coverage)
This applies to any Personal Life insurance, Dependent Life Insurance, and Accidental Death and Dismemberment Insurance provided by the policy. Such insurance may be continued by paying the required premiums when:
• You are covered under the life policy and your employment with your Employer ends.

To continue insurance, written application and the first premium payment must be made to the company, within 31 days of the date insurance would otherwise end.
SCHEDULE OF BENEFITS
BASIC EMPLOYEE LIFE INSURANCE & AD&D
All Class 1 Full-Time Employees - $20,000 (At no cost to you)

OPTIONAL EMPLOYEE LIFE INSURANCE & AD&D (pre-tax benefit)

<table>
<thead>
<tr>
<th>Optional Employee Life Insurance &amp; AD&amp;D</th>
<th>Semi-Monthly Premium (24 pay periods)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$1.00</td>
</tr>
<tr>
<td>$20,000</td>
<td>$2.00</td>
</tr>
<tr>
<td>$30,000</td>
<td>$3.00</td>
</tr>
<tr>
<td>$40,000</td>
<td>$4.00</td>
</tr>
<tr>
<td>$50,000</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

Optional Dependent Life Insurance* (post-tax benefit)
- $2,000 on your spouse
- $2,000 on each of your eligible children (from live birth to 6 months of age, the face amount of coverage is $2,000)
- Family Coverage - $.27 (semi-monthly premium)

(no matter how many children)

*Optional Dependent coverage is not a pre-tax item per IRS Section 125 regulations.

NOTE: If you are an existing employee and you are increasing your current coverage amount or if you are applying for coverage the very first time (did not apply when first hired) you are required to complete an Evidence of Insurability. This applies to your dependents as well.

CLAIMS PROCEDURE
Claim forms needed to file for benefits under the group insurance plan can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information. Your claim can also be submitted online at the following address: www.unum.com/claims

This summary has been prepared to give you the highlights of coverage now being offered by your employer to meet your insurance needs. For further information, please contact your Human Resources Office, and refer to your certificate booklet.

Life/AD&D Policy Form Number: C.FP-2
Underwritten by Unum Life Insurance Company of America, Portland, Maine
Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.
CE-14373
Humana Group Cancer & Specified Disease

Effective Date: July 1, 2016 (subject to underwriting)

Group Cancer and Specified Disease Insurance
POLICY FORM HIC-GP-CAN-POL-NC 6/09
Underwritten by Humana Insurance Company

Plan Features

- Donor Benefits
- Wellness Benefits
- Many Benefits have No Lifetime Maximum
- Covers Certain Lodging and Transportation
- Portable (take it with You)
- In and Out of Hospital benefits
- Pays regardless of other coverage

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Benefit</td>
<td>$100 per calendar year</td>
<td>$100 per calendar year</td>
</tr>
<tr>
<td>Positive Diagnosis Test</td>
<td>Up to $300 per calendar year</td>
<td>Up to $300 per calendar year</td>
</tr>
<tr>
<td>First Diagnosis Benefit</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Actual Charges</td>
<td>Actual Charges</td>
<td>Actual Charges</td>
</tr>
<tr>
<td>Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.</td>
<td>Up to $75 per day for lodging, 50 cents per mile if a personal vehicle is used.</td>
<td>Up to $75 per day for lodging, 50 cents per mile if a personal vehicle is used.</td>
</tr>
<tr>
<td>Actual Charges</td>
<td>Actual Charges</td>
<td>Actual Charges</td>
</tr>
<tr>
<td>Up to $3,000</td>
<td>Up to $3,000</td>
<td></td>
</tr>
<tr>
<td>(a) $200 per day</td>
<td>(a) $200 per day</td>
<td></td>
</tr>
<tr>
<td>(b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile.</td>
<td>(b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile.</td>
<td></td>
</tr>
<tr>
<td>(c) Actual charges up to $50 per day</td>
<td>(c) Actual charges up to $50 per day</td>
<td></td>
</tr>
<tr>
<td>Actual charges to a combined lifetime maximum of $15,000</td>
<td>Actual charges to a combined lifetime maximum of $15,000</td>
<td></td>
</tr>
</tbody>
</table>

Effective Date: July 1, 2016  (subject to underwriting)

Donor Benefit Bone Marrow and Stem Cell Transplant.
We will pay the following expenses incurred by the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual Charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.

Bone Marrow and Stem Cell Transplant. We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant.

Form Number: HIC-GP-CAN-SB-NC
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia. For services of an anesthesiologist during a Covered Person’s surgery. No Lifetime Maximum</td>
<td>Up to 25% of surgical benefit paid.</td>
<td>Up to 25% of surgical benefit paid.</td>
</tr>
<tr>
<td>For anesthesia in connection with the treatment of skin Cancer. No Lifetime Maximum</td>
<td>$100 maximum per Covered Person</td>
<td>$100 maximum per Covered Person</td>
</tr>
<tr>
<td>Ambulatory Surgical Center. We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum</td>
<td>$250 Per Day</td>
<td>$250 Per Day</td>
</tr>
<tr>
<td>Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum</td>
<td>Up to $25 per day, $600 per calendar year</td>
<td>Up to $25 per day, $600 per calendar year</td>
</tr>
<tr>
<td>Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum</td>
<td>Up to $250 per calendar year</td>
<td>Up to $250 per calendar year</td>
</tr>
<tr>
<td>Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum</td>
<td>Actual charges up to $2,500 per month</td>
<td>Actual charges up to $5,000 per month</td>
</tr>
<tr>
<td>Miscellaneous Therapy Charges. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Item 15 or within 30 days following a covered treatment.</td>
<td>Actual charges up to a lifetime maximum of $10,000</td>
<td>Actual charges up to a lifetime maximum of $10,000</td>
</tr>
<tr>
<td>Self-Administered Drugs. We will pay the actual expenses incurred for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum</td>
<td>Actual charges up to $4,000 per month</td>
<td>Actual charges up to $4,000 per month</td>
</tr>
<tr>
<td>Colony Stimulating Factors. We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum</td>
<td>Actual charges up to $500 per month</td>
<td>Actual charges up to $500 per month</td>
</tr>
<tr>
<td>Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum</td>
<td>Actual charges up to $200 per day</td>
<td>Actual charges up to $200 per day</td>
</tr>
<tr>
<td>Physician’s Attendance. For one visit per day while Hospital confined. No Lifetime Maximum</td>
<td>Up to $35 per day</td>
<td>Up to $35 per day</td>
</tr>
<tr>
<td>Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum</td>
<td>Up to $100 per day</td>
<td>Up to $100 per day</td>
</tr>
<tr>
<td>National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the expense incurred if an Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person’s place of residence, We will also pay the transportation and lodging expenses incurred. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation Benefits of the policy.</td>
<td>Expenses incurred limited to a lifetime maximum of $750 for evaluation. Expenses incurred limited to a lifetime maximum up to $350 for transportation and lodging.</td>
<td>Expenses incurred limited to a lifetime maximum up to $750 for evaluation. Expenses incurred limited to a lifetime maximum up to $350 for transportation and lodging.</td>
</tr>
<tr>
<td>Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum</td>
<td>Actual Charges</td>
<td>Actual Charges</td>
</tr>
<tr>
<td>Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.</td>
<td>$1,500 lifetime maximum per amputation.</td>
<td>$1,500 lifetime maximum per amputation.</td>
</tr>
<tr>
<td>Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum</td>
<td>Up to $35 per session</td>
<td>Up to $35 per session</td>
</tr>
<tr>
<td>Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay a Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum</td>
<td>$300 per day</td>
<td>$300 per day</td>
</tr>
<tr>
<td>Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum</td>
<td>Up to $50 per day</td>
<td>Up to $50 per day</td>
</tr>
<tr>
<td>At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum</td>
<td>Up to $100 per day</td>
<td>Up to $100 per day</td>
</tr>
<tr>
<td>New or Experimental Treatment. We will pay the expenses incurred by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum</td>
<td>Up to $7,500 per calendar year</td>
<td>Up to $7,500 per calendar year</td>
</tr>
<tr>
<td>Hospice Care. If a Covered Person elects to receive hospice care, We will pay the expenses incurred for care received in a Free Standing Hospice Care Center. No Lifetime Maximum</td>
<td>Up to $50 per day</td>
<td>Up to $50 per day</td>
</tr>
<tr>
<td>Government or Charity Hospital. Payable if the Covered Person is confined in a U.S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum</td>
<td>$200 per day</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Hairpiece. We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.</td>
<td>Actual charge up to a lifetime maximum of $150</td>
<td>Actual charge up to a lifetime maximum of $150</td>
</tr>
</tbody>
</table>
Other Specified Diseases Covered:

- Addison’s Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen’s Disease
- Legionnaire’s Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Rey’s Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple’s Disease

Payment of Benefits
Benefits are payable for a Covered Person’s Positive Diagnosis of a Cancer or Specified Disease that begins after the Certificate Effective Date and while this Certificate has remained in force.

Pre-Existing Condition Limitation
No benefits will be provided during the first 12 months of the policy for cancer diagnosed before the 30th day after the effective date shown in the policy schedule. During the first 12 months of a Covered Person’s insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

Pre-Existing Condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions and Other Limitations
The Policy pays benefits only for diagnoses resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:
1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
   a. Specified Disease or Specified Disease treatment; or
   b. Cancer or Cancer treatment, or unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary;
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Termination of Coverage
A Covered Person’s insurance under the Policy will automatically terminate on the earliest of the following dates:
1. the date that the Policy terminates.
2. the date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the date the Policy is amended to terminate the eligibility of the Employee class.
4. any premium due date, if premium remains unpaid by the end of the grace period.
5. the premium due date coinciding with or next following the date the Covered Person ceases to be a member of an eligible class.
6. the date the Policyholder no longer meets participation requirements.

Portability
On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.
Covered Persons
Covered Person means any of the following:
a. the Named Insured; or
b. any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective; or
c. any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
d. a newborn child (as described in the Eligibility Section).

Child (Children)
means the Named Insured’s unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is:

a. not yet age 25; or
b. not yet age 26 if a full time student at an accredited school.

Option to Add Additional Benefits
Hospital Intensive Care Insurance Rider
Form Number HIC-GP-ICR 6/09

In consideration of additional premium, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits
Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit
You may choose the benefit of $325 or $625 per day. It is reduced by one-half at age 75.

Double Benefits
We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the named insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU
We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU, if you are admitted on an emergency basis, and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit
We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step Down Unit.

Exceptions and Other Limitations
Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable: if you go into an ICU before the Certificate Effective Date; if you go into an ICU for intentionally self-inflicted injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician’s instructions. The term “intoxicated” refers to that condition as defined by law in the jurisdiction where the accident or cause of loss occurred.

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer’s Guide available from the Company. This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected.

Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact:

Bay Bridge Administrators
P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519

HUMANA
• Toll Free: 800.845.7519
• Fax: 512.275.9350
• Mailing Address: Bay Bridge Administrators, LLC
  P.O. Box 161690, Austin, Texas 78716
• Website: www.bbadmin.com
### Humana Base Cancer Plan - Low & High Options

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Option 1 - Low</th>
<th>Option 2 - High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room Rate</td>
<td>$100 per day</td>
<td>$100 per day</td>
</tr>
<tr>
<td>Surgical Schedule</td>
<td>$3,000 per schedule</td>
<td>$3,000 per schedule</td>
</tr>
<tr>
<td>Radiation, Chemotherapy, Immunotherapy Benefit</td>
<td>Actual charges up to $2,500 per month</td>
<td>Actual charges up to $5,000 per month</td>
</tr>
<tr>
<td>First Diagnosis Benefit</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Colony Stimulating Factors Benefit</td>
<td>$500 per month</td>
<td>$500 per month</td>
</tr>
<tr>
<td>Wellness Benefit</td>
<td>Actual charges up to $100 per calendar year</td>
<td>Actual charges up to $100 per calendar year</td>
</tr>
<tr>
<td>Intensive Care Rider</td>
<td>$325</td>
<td>$625</td>
</tr>
</tbody>
</table>

### Semi- Monthly Premium (24 pay periods)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Option 1- Low</th>
<th>Option 2- High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$11.69</td>
<td>$15.45</td>
</tr>
<tr>
<td>Employee &amp; Children</td>
<td>$16.60</td>
<td>$21.68</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$23.80</td>
<td>$31.44</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$28.72</td>
<td>$37.67</td>
</tr>
</tbody>
</table>
Effective Date: July 1, 2016

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series 7700.

What is Aflac accident insurance? Why should I consider it?

Aflac accident insurance provides benefits for the treatment of injuries suffered as the result of a covered accident. These benefits are payable regardless of any other insurance you may have.

Many families don’t budget for the out-of-pocket costs associated with accidents. While we all hope to steer clear of accidents, at some point most of us will probably take a trip to the local emergency room. When you (or a covered family member) are injured in an accident, the last things on your mind are the charges that may be accumulating for services like the following:

- Ambulance ride
- Emergency room use
- Surgery and anesthesia
- Crutches
- Wheelchairs
- Stitches
- Casts

These costs add up—fast. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered accident? Aflac accident insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

What are some of the highlights of the Aflac accident plan?

- There’s no limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Spouse and dependent child coverage is available.
• The plan provides 24-hour protection.

• There are benefits for inpatient and outpatient treatment of covered accidents.

• Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).

• Your premiums are paid through the convenience of payroll deduction.

• Coverage will be effective the date you sign the enrollment form.

• Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

**What is guaranteed-issue coverage? Am I eligible?**

Guaranteed-issue refers to certain types of coverage that may be issued without your having to answer health questions. Guaranteed-issue coverage is offered during your employer’s initial enrollment period (and for new hires after the enrollment period).

**Am I eligible for Aflac accident coverage? What about my family?**

You are eligible to apply for Aflac accident coverage if you:

• Are between the ages of 18 and 69;

• Are a full-time, benefit-eligible employee;

• Are working at least 30 hours per week;

• Have been employed for at least 30 continuous days by the enrollment date; and

• Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 64 to be eligible for coverage, and dependent children must be younger than age 26.

**What core benefits does the Aflac accident plan feature?**

• Accident Benefits

You may receive benefits if you incur one of the following covered events:

<table>
<thead>
<tr>
<th>Benefit Event</th>
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<tbody>
<tr>
<td>Fractures</td>
<td>Injuries requiring surgery</td>
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<td>Dislocations</td>
<td>Eye injuries</td>
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<td>Paralysis</td>
<td>Removal of foreign body</td>
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<td>Lacerations</td>
<td>Ruptured disc</td>
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<td>Burns (second- and third-degree)</td>
<td>Torn knee cartilage</td>
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<tr>
<td>Concussion</td>
<td>Internal injuries</td>
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<tr>
<td>Coma</td>
<td>Exploratory surgery</td>
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<tr>
<td>Emergency dental work</td>
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</table>
• **Medical Fees Benefit**  
You may receive this benefit per covered accident for physician charges, emergency room services and supplies, and X-rays.

• **Accident Follow-Up Treatment Benefit**  
You may receive this benefit for up to six treatments per covered accident for follow-up treatment.

• **Physical Therapy Benefit**  
You may receive this benefit for up to six treatments per covered accident for physical therapy.

• **Ambulance Benefit**  
You may receive this benefit if you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident.

• **Transportation Benefit**  
You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn’t available in your hometown).

• **Blood/Plasma Benefit**  
You may receive this benefit if you receive blood and plasma within 90 days after a covered accident.

• **Prosthesis Benefit**  
You may receive this benefit if a covered accident requires the use of a prosthetic device (hearing aids, wigs, or dental aids—including (but not limited to) false teeth—are not covered).

• **Appliance Benefit**  
You may receive this benefit for use of a medical appliance due to injuries received in a covered accident (payable for crutches, wheelchairs, leg braces, back braces, and walkers).

• **Family Lodging Benefit**  
If you are required to travel more than 100 miles for inpatient treatment of injuries suffered in a covered accident, you may receive this benefit for an immediate family member’s lodging (payable up to 30 days per accident while the insured is confined to the hospital).

• **Wellness Benefit - $60.00**  
You may receive this benefit for one routine examination or other preventive testing once each 12-month period (payable for one covered person annually). Benefits are payable for the following:

  o Annual physical exams
  o Mammograms
  o Pap smears
  o Eye examinations
  o Immunizations
  o Flexible sigmoidoscopies
  o PSAs
  o Ultrasounds
  o Blood screenings
• **Hospital Admission Benefit**
You may receive this benefit if you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the accident.

• **Hospital Confinement Benefit (per day)**
You may receive this benefit on the first day of hospital confinement for up to 365 days. The confinement must begin within 90 days after the date of the accident (payable once per confinement).

• **Hospital Intensive Care (per day)**
You may receive this benefit up to 30 days per covered accident (payable in addition to the Hospital Confinement Benefit).

• **Accidental-Death and-Dismemberment Benefit**
  o Accidental Death
  o Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)
  o Dismemberment
  o Loss of One or More Fingers and Toes
  o Partial Amputation of Fingers or Toes

**What else do I need to know about the Aflac accident plan?**
You should know that the plan includes:

• **A pre-existing condition limitation.** Aflac will not pay benefits for a loss that is caused by, that is contributed to, or that results from a pre-existing condition for 12 months after the effective date of coverage. Pre-Existing Condition means within the 12-month period prior to the effective date of this certificate and attached riders, as applicable. A claim for benefits for loss starting after 12-months from the effective date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

• **Certain exclusions.** No benefits are payable for loss resulting from:
  o Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
  o Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
  o Participating or attempting to participate in an illegal activity or working at an illegal job.
  o Committing or attempting to commit suicide, while sane or insane.
  o Injuring or attempting to injure yourself intentionally.
  o Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica (except under the Accidental Common Carrier Death Benefit).
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participating in any organized sport, professional or semi-professional.
- Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
- Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.
- Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.
- Having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

**What will my payroll deduction be for the accident plan?**

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<td>Employee and Dependent Child(ren)</td>
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<td>Employee &amp; Family</td>
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Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

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Columbia, South Carolina
800.433.3036 ~ aflacgroupinsurance.com

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan. As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

**Notice to Consumer:** The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.
Effective Date: July 1, 2016

• Guaranteed Issue Amounts: Employee- $20,000         Spouse- $10,000

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI2800.

What is Aflac critical illness insurance? Why should I consider it?
Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

• Major Organ Transplant
• End-Stage Renal Failure
• Stroke
• Coma
• Paralysis
• Burns
• Loss of Sight
• Loss of Hearing
• Loss of Speech
• Heart Attack
• (Coronary Artery Bypass Surgery)
• Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

What are some of the highlights of the Aflac critical illness plan?
• An annual Health Screening Benefit is included.
• Spouse coverage is available.
• Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
• Each dependent child is covered at 50% of the primary insured’s amount at no additional charge.
• Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
• Your premiums are paid through the convenience of payroll deduction.

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers
Am I eligible for Aflac critical illness coverage? What about my family?
You are eligible to apply for Aflac critical illness coverage if you:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does the Aflac critical illness plan feature?

• **First Occurrence Benefit**
  After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

• **Additional Occurrence Benefit**
  After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

• **Reoccurrence Benefit**
  You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months.

• **Heart Benefit**
  After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:
  - Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
  - Mitral valve replacement or repair
  - Aortic valve replacement or repair
  - Surgical treatment of abdominal aortic aneurysm
  - AnjioJet clot busting*
  - Balloon angioplasty (or balloon valvuloplasty)*
  - Laser angioplasty*
  - Atherectomy*
  - Stent implantation*
  - Cardiac catheterization*
  - Automatic implantable (or internal) cardioverter defibrillator (AICD)*
  - Pacemaker insertion*

*Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.
• Health Screening Benefit
After the waiting period, you may receive a maximum of $100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray

- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

What else do I need to know about the Aflac critical illness plan?
You should know that the plan includes:

• A 30-day waiting period. This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.

• A pre-existing condition limitation. A Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date. Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment free for that cancer for 12 consecutive months.
• **Certain exclusions.** No benefits are payable for loss resulting from:
  
  o Intentionally self-inflicted injury or action;
  
  o Suicide or attempted suicide while sane or insane;
  
  o Illegal activities or participation in an illegal occupation;
  
  o War - *whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence*;
  
  o Substance abuse; or
  
  o Diagnosis and/or treatment received outside the United States

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

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CAIC Group Critical Illness Plan (without Cancer)
Employee and Spouse - Semi-Monthly Rates

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Rates do not include cancer benefit.
Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

No benefit reduction at age 70.

Please Note: Premiums shown are accurate as of publication. They are subject to change.
**Aflac Critical Illness Insurance (with cancer)**

**Effective Date: July 1, 2016**

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI2800.

- **Guaranteed Issue Amounts: Employee- $20,000  Spouse- $10,000**

**What is Aflac critical illness insurance? Why should I consider it?**

Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Cancer (internal or invasive)  (Carcinoma in Situ)
- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack
- (Coronary Artery Bypass Surgery)
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

**What are some of the highlights of the Aflac critical illness plan?**

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
- Each dependent child is covered at 50% of the primary insured’s amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.

**Underwritten by Continental American Insurance Company**

*A proud member of the Aflac family of insurers*
• Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

Am I eligible for Aflac critical illness coverage? What about my family?
You are eligible to apply for Aflac critical illness coverage if you:
  o Are between the ages of 18 and 69;
  o Are a full-time, benefit-eligible employee;
  o Are working at least 30 hours per week;
  o Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does the Aflac critical illness plan feature?

• First Occurrence Benefit
After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

• Additional Occurrence Benefit
After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

• Reoccurrence Benefit
You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months. Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid.

• Heart Benefit
After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:
  o Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
  o Mitral valve replacement or repair
  o Aortic valve replacement or repair
  o Surgical treatment of abdominal aortic aneurysm
  o AnjioJet clot busting*
  o Balloon angioplasty (or balloon valvuloplasty)*
  o Laser angioplasty*
  o Atherectomy*
  o Stent implantation*
  o Cardiac catheterization*
  o Automatic implantable (or internal) cardioverter defibrillator (AICD)*
  o Pacemaker insertion*

*Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.
• **Health Screening Benefit**

After the waiting period, you may receive a maximum of $100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Breast ultrasound
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

**What else do I need to know about the Aflac critical illness plan?**

You should know that the plan includes:

- **A 30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.

- **A pre-existing condition limitation.** A Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date. Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment free for that cancer for 12 consecutive months.
• **Certain exclusions.** No benefits are payable for loss resulting from:
  
  o Intentionally self-inflicted injury or action;
  
  o Suicide or attempted suicide while sane or insane;
  
  o Illegal activities or participation in an illegal occupation;
  
  o War - whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
  
  o Substance abuse; or
  
  o Diagnosis and/or treatment received outside the United States.

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

Continental American Insurance Company

Columbia, South Carolina

800.433.3036 | aflacgroupinsurance.com

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

**Notice to Consumer:** The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.
## Aflac Critical Illness Plan (with cancer)
### Employee and Spouse Semi-Monthly Rates

### NONTOBACCO - Employee

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Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

No benefit reduction at age 70.

Please Note: Premiums shown are accurate as of publication. They are subject to change.
We've enhanced your plan without adding cost.

Now, if you have Aflac Group Critical Illness, Group Accident or Group Hospital Indemnity policies, you also have access to three new services that make it easier to access care, reduce out-of-pocket medical expenses and navigate the healthcare system with greater ease:

- Get answers and expert help with Health Advocacy from Health Advocate.
- Let advocates negotiate your medical bills with Medical Bill Saver™, also from Health Advocate.
- Connect with health providers via phone, app or online with MeMD.

These three services are now embedded in your group plan — at no extra charge. Best of all, you can start using them as soon as your Aflac coverage starts.

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD January 1, 2016.

Questions? Call 855-423-8585

You can also use Health Advocate’s Health Advocacy and Medical Bill Saver™ services for your spouse, dependent children, parents and parents-in-law, while Telemedicine is available for you and your family.
Get more without spending more.

More than just peace of mind.
Health Advocacy from Health Advocate

You have 24/7 access to Personal Health Advocates who start helping from the first call:

- Find doctors, dentists, specialists, hospitals and other providers
- Schedule appointments, treatments and tests
- Resolve benefits issues and coordinate benefits
- Assist with eldercare issues, Medicare and more
- Help transfer medical records, lab results and X-rays
- Work with insurance companies to obtain approvals and clarify coverage

More than just cash benefits.
Medical Bill Saver™ from Health Advocate

Aflac already pays claims quickly. Now, with Medical Bill Saver™, Health Advocate professionals also help you negotiate medical bills not covered by health insurance:

- Just send in your medical and dental bills of $400 or more
- They contact the provider to negotiate a discount
- Negotiations can lead to a reduction in out-of-pocket costs
- Once an agreement is made, the provider approves payment terms and conditions
- You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms

More than just care.
Telemedicine from MeMD

You can quickly connect with board-certified, U.S. licensed health providers online for 24/7/365 access to medical care — fast:

- Create your account at www.MeMD.me
- When you have a health issue, log on and request a provider consultation
- You can request consultations via webcam, app or phone
- Get ePrescriptions,* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- $35.00 per visit!

Questions? Call 855-423-8585

*When medically necessary, MeMD providers can submit a prescription electronically for purchase and pick-up at your local pharmacy.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Continental American Insurance Company | Columbia, South Carolina
Effective Date: July 1, 2016

Why do you need Disability Insurance? Consider this . . .

Statistics show you are much more likely to be injured in an accident than to die from one.

• A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.¹

• There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.¹

• In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.¹

While many people survive accidental injuries, many others live with serious illnesses.

• In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.²

• One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.³

• More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.⁴

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

• In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three are up dramatically! Things that used to kill now disable.⁵

You have life insurance, home insurance, and automobile insurance. But is your income insured?

² American Cancer Society, Cancer Facts & Figures 2004
³ American Heart Association, Heart Disease and Stroke Statistics – 2004 Update
⁴ American Lung Association, Lung Disease Data 2003
⁵ National Underwriter, May 2002
Class Description
All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability
You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit
You can choose to **insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum benefit is $500.**

Elimination Period
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Benefit Duration
This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks.

Basis of Coverage
24 hour coverage, on or off the job.

Maternity Coverage
Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date.
Recurrent Disability

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to port your coverage.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer’s Retirement Plan as recognition of past services or has concluded his/her working career).

Please refer to the Mark III website (address on the cover of this booklet) for a copy of your certificate, a claim form or application to port form.

Annual Enrollment

Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1000 monthly benefit without medical questions, subject to pre-existing exclusion. Employees may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments. Employees that elect to increase may do so only during the annual enrollment period subject to the pre-existing exclusion.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.
## AUL Life Short-Term Disability
### Semi-Monthly Premium

**Benefit Duration:**

13 Weeks

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**Customer Service**
1.800.553.5318  
Website: www.employeebenefitsaul.com

**Disability Claims**
American United Life Insurance Company  
c/o Custom Disability Solutions  
600 Sable Oaks Drive, Suite 200, South Portland, ME  04106  
Toll Free~ 855.517.6365  Fax~ 844.287.9499  
OneAmerica.claims@customdisability.com
AUL Long Term Disability

**Effective Date:** July 1, 2016

**LTD Class Description**
All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Long-Term Disability.

**LTD Monthly Benefit**
You can choose to **insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000 in $500 increments. The minimum benefit is $500.**

**LTD Elimination Period**
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

**LTD Benefit Duration**
This is the period of time that benefits will be payable for long-term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

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</tbody>
</table>

**LTD Total Disability Definition:** An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefits have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.
LTD Mental & Nervous / Drug & Alcohol:
Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

Special Conditions
Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

Other income Offsets
AUL will not reduce your LTD disability benefit with other disability income benefits that you might be receiving from AUL or external sources such as Social Security or other disability or income benefits you may receive, or be eligible to receive.

Waiver of Premium
AUL will waive the premium payments for your coverage while you are disabled and will continue to be waived during the elimination period and the benefit eligibility period.

Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person’s Individual Effective Date.

This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date Or Continuity of Coverage will apply if the employee was insured under the employers prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan’s or AUL’s benefit.

Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period
This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit IF:
1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and
2. The Person changes from one AUL short-term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period.
The Person’s Individual Effective Date of Insurance under the prior AUL group voluntary short-term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short-term disability plan’s Pre-Existing Condition Limitation.

**Portability**

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to AUL in order to port your coverage. The application to port coverage is located on the Mark III website.

The Portability Privilege is not available to any person that retires (when the person receives payment from any Employer’s Retirement plan as recognition of past services or has concluded his/her working career).

Please refer to the Mark III website (address located on the cover of this booklet) for a copy of your certificate, a claim form or application to port form.

**Annual Enrollment**

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly LTD benefit without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

**Exclusions and Limitations**

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

**Voluntary Long Term Disability**

<table>
<thead>
<tr>
<th>Monthly Benefit Amount</th>
<th>Semi-Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
<td>$3.20</td>
</tr>
<tr>
<td>$1,000</td>
<td>$6.40</td>
</tr>
<tr>
<td>$1,500</td>
<td>$9.60</td>
</tr>
<tr>
<td>$2,000</td>
<td>$12.80</td>
</tr>
</tbody>
</table>
This information is provided as a Benefit Outline. It is not part of the insurance policy and does not change or extend American United Life Insurance Company’s liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverages under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.
Texas Life Whole Life - Solutions 121

Common Issue Date: August 1, 2016 (pending underwriting approval)

An ideal complement to any group term and optional term life insurance your employer might provide, Texas Life’s SOLUTIONS 121 is the life insurance you keep, even when you change jobs or retire as long as you pay the premiums. It will help protect your family, both today and, more importantly, tomorrow. Even better, you won’t even have to pay for it after age 65 (or 20 years if you’re 46 years of age or older), because it’s guaranteed to be paid up.¹

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements.² As an employee, you are eligible to apply once you have satisfied your employer’s eligibility period.

Why Voluntary Coverage?
• Most employees typically depend on group term life insurance.
• Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amounts of coverage.³
• On the other hand, adults with both individual life and group life policies have the most life insurance protection.³
• Most term policies generally expire before paying a death claim.
• When do you want a life insurance policy in force? --Answer: When you die.
• Term is for IF you die, permanent is for WHEN you die.

The SOLUTIONS Advantage
Individual Protection SOLUTIONS 121 is a permanent life insurance policy that you own; it can never be canceled, as long as you pay the guaranteed level premiums due, even if your health changes. Because you own it, you can take SOLUTIONS 121 with you when you change jobs or retire with no change in the premium.

Coverage for Your Family You may also apply for an individual SOLUTIONS 121 policy for your spouse/domestic partner, dependent children ages 15 days-26 years and grandchildren ages 15 days-18 years, even if you do not apply for coverage.²

Paid Up Insurance SOLUTIONS 121 has premiums that are guaranteed to remain level until your age 65, or for 20 years if you purchase the policy after age 45. At that time, the policy becomes fully paid up; no further premiums are due, and the death benefit does not reduce. This gives you the peace of mind that comes with life insurance that’s paid for as your income changes in retirement.

¹5M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11
**Convenience of payroll deduction** Thanks to your employer, SOLUTIONS 121 premiums are paid through convenient payroll deductions and sent to Texas Life by your employer.

**Portable, Permanent** You may continue the peace of mind SOLUTIONS 121 provides, even when you change jobs or retire. Once your policy is issued, the coverage is yours to keep. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to Texas Life by automatic bank draft or monthly bill (for monthly bill we may add a billing fee not to exceed $2.00). Premiums are guaranteed to remain level to your age 65, or for 20 years if you purchase the policy after age 45. At that time, the policy becomes fully paid up; no further premiums are due.

**Accelerated Death Benefit due to Terminal Illness** For no additional premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92.6% (92% in CA, CT, DC, DE, FL, ND & SD) of the face amount, minus a $150 ($100 in Florida) administrative fee in lieu of the insurance proceeds otherwise payable at death. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply)*

**Accelerated Death Benefit for Chronic Illness** Included in the policy at the option of the employer, the Accelerated Death Benefit for Chronic Illness rider covers all applicants. If an insured becomes permanently chronically ill, meaning that he/she is unable to perform two of six Activities of Daily Living (such as bathing, continence, or dressing), or is severely cognitively impaired (such as Alzheimer’s), he/she may elect to claim an accelerated death benefit in lieu of the Face Amount payable at death. The single sum payment is 92% of the Face Amount less an administrative fee of $150 ($100 in FL). The Accelerated Death Benefit for Chronic Illness Rider premiums are 8% of the base policy premium. Conditions and limitations apply. See the SOLUTIONS 121 Pamphlet for details. *(Policy form ULABR-CI-14 or ICC14-ULABR-CI-14.)*

**Waiver of Premium Rider** This benefit to age 65 (issue ages 17-59) waives the premium after six months of the insured’s total disability and will even refund the prior six months’ premium. Benefits continue payable until the earlier of the end of the insured’s total disability or age 65. Cost is an additional 10% of the basic monthly premium. Self-inflicted or war-related disability is excluded. Notice, proof and waiting period provisions apply. Form ICC07-ULCL-WP-07 and Form Series ULCL-WP-07.

**Coverage begins immediately** Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply (one year in ND).

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details. Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11
Sample Rates
The chart below displays examples of SOLUTIONS 121 rates at varying ages for a $50,000 policy. Rates shown below are for both non-tobacco and tobacco users and include the cost for Waiver of Premium and the Accelerated Death for Chronic Illness benefit.

**SOLUTIONS 121**

<table>
<thead>
<tr>
<th>Age</th>
<th>Face Amount</th>
<th>Monthly Premium Non-Tobacco Chronic Illness, &amp; Waiver</th>
<th>Monthly Premium Tobacco Chronic Illness, &amp; Waiver</th>
<th>Paid-up Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>$50,000</td>
<td>$38.11</td>
<td>$46.96</td>
<td>65</td>
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<tr>
<td>25</td>
<td>$50,000</td>
<td>$43.42</td>
<td>$54.63</td>
<td>65</td>
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<tr>
<td>30</td>
<td>$50,000</td>
<td>$53.45</td>
<td>$67.02</td>
<td>65</td>
</tr>
<tr>
<td>35</td>
<td>$50,000</td>
<td>$68.20</td>
<td>$86.49</td>
<td>65</td>
</tr>
<tr>
<td>40</td>
<td>$50,000</td>
<td>$91.80</td>
<td>$115.40</td>
<td>65</td>
</tr>
<tr>
<td>45</td>
<td>$50,000</td>
<td>$125.43</td>
<td>$162.01</td>
<td>65</td>
</tr>
</tbody>
</table>

**SOLUTIONS REVIEW**
- Permanent and yours to keep when you change jobs or retire
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you’re actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness
- Waiver of Premium Rider included for ages 17-59
- If you desire more coverage, you can qualify by answering just four underwriting questions.
- Coverage available for spouse, children and grandchildren

1 Guarantees are subject to product terms, exclusions and limitations and the insurers claims-paying ability and financial strength.
2 Coverage and spouse/domestic partner eligibility may vary by state. Coverage not available for children and grandchildren in Washington. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships and legally recognized familial relationships.

**If you have any questions regarding your Texas Life policy, please call 800.283.9233, prompt 2**
Choose a pet health plan to fit your needs

From Nationwide®, the #1 choice in America for pet insurance

| Prices include 5% discount

| Plan Type                  | Starting at | Use any vet | Accidents, including poisoning, cuts and broken bones | Common illnesses, including ear infections, rashes, vomiting and diarrhea | Serious/chronic illnesses, including cancer, diabetes and allergies | Hereditary conditions | Procedures/services, including surgeries, Rx meds and hospitalization | Wellness services, including exams, vaccinations and flea/heartworm preventives | Annual deductible |
|---------------------------|-------------|-------------|------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------|------------------|------------------|
| Major Medical Plan        | $22/ payday | ✓           | ✓                                                    | ✓                                                                     | ✓                                                                   | ✓                     | ✓                                                                     | ✓                                                                  | $250             | $0               |
| Pet Wellness Plan Plus    | $13/ payday | ✓           | ✓                                                    | ✓                                                                     | ✓                                                                   | ✓                     | ✓                                                                     | ✓                                                                  | $250             | $0               |
| everyday care             | $10/ payday | ✓           | ✓                                                    | ✓                                                                     | ✓                                                                   | ✓                     | ✓                                                                     | ✓                                                                  | $0               | $0               |

Sample reimbursement

When Biscuit needed emergency surgery after eating a handful of pebbles, the Major Medical plan reimbursed 100% of her vet bill (less the deductible).

Exam, X-rays, surgery, treatment

Veterinary fee
Reimbursed by Nationwide
Annual deductible

Sample reimbursement for Major Medical Plan with $250 annual deductible. Sample is based on actual claim, but has been edited for clarity.

Enroll now and receive your discount.

PetsNationwide.com • 877-738-7874

*2012 Veterinary AAU. **Premiums vary based on the age of the pet, species, size (as an adult), plan type and state of residence. ***Discount applies to base medical plan only. New illness only. Does not include conditions pre-existing to enrollment. †Limited hereditary condition coverage after the first year of enrollment. ‡Limited hereditary condition coverage after the first year of enrollment.

Wellness plans are not available in all states.

Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declarations pages, which are controlling. Such terms and availability may vary by state and exclusions may apply. Insurance plans are offered and administered by Veterinary Pet Insurance Company in California and DVM Insurance Agency in all other states. Underwritten by Veterinary Pet Insurance Company (VPI), Brea, CA, and M. B. Insurance company (2013), Madison, WI or an M. B. Insurance company (2014). Nationwide, the Nationwide/Nand Eagle, and Nationwide is. On Your Side are service marks of Nationwide Mutual Insurance Company, Brea, CA. ©2015 Nationwide.
Get cash back on the everyday care your pet needs to stay healthy.

**Pet Wellness Plan Plus**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exam: Two exams per policy term</td>
<td>$60</td>
</tr>
<tr>
<td>Behavioral exam and/or treatment</td>
<td>$30</td>
</tr>
<tr>
<td>Vaccination or titer</td>
<td>$75</td>
</tr>
<tr>
<td>Heartworm or FeLV/FIV test</td>
<td>$35</td>
</tr>
<tr>
<td>Fecal test</td>
<td>$25</td>
</tr>
<tr>
<td>Deworming</td>
<td>$25</td>
</tr>
<tr>
<td>Nail trim</td>
<td>$20</td>
</tr>
<tr>
<td>Microchip</td>
<td>$40</td>
</tr>
<tr>
<td>Health certificate</td>
<td>$40</td>
</tr>
<tr>
<td>Flea control or heartworm prevention</td>
<td>$75</td>
</tr>
<tr>
<td>One additional test:</td>
<td></td>
</tr>
<tr>
<td>1. Health screen (blood test) or</td>
<td>$75</td>
</tr>
<tr>
<td>2. Radiograph (X-rays) or</td>
<td></td>
</tr>
<tr>
<td>3. Electrocardiogram (EKG)</td>
<td></td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>$500</td>
</tr>
</tbody>
</table>

**Duke got a clean bill of health**

Wanting to get her new puppy, Duke, up to date with all his shots, Anne took him to the vet for his first wellness visit.

Duke is covered with Pet Wellness Plus, so he's already off to a healthy start. Here's how we reimbursed Anne's claim.

Using your Nationwide policy is quick and easy.

1. **Visit any vet and pay at checkout.**
2. **Send us your claim.**
3. **We'll send you a check.**

**vethelpline™**

Live veterinary guidance about your pet’s health, from general questions to identifying urgent care needs. **Free to all members** ($170 value). Only from Nationwide.
Employee benefits now include savings on auto and home insurance! Cabarrus County Government has teamed up with Liberty Mutual to offer employees Group Savings Plus®. This unique program allows you to purchase high-quality auto, home and renters insurance at **low group rates** through the convenience of bank draft.

**Liberty Guard Auto Insurance**

Liberty Guard Auto Insurance provides coverage from collision to theft, and includes extra benefits to help make insurance easier for you. Here is a brief list of some of the coverages that come with a Liberty Guard Auto Insurance policy.

**Liability coverage**
- If you cause an accident, your policy will pay the damages up to your policy limits.
- We will pay the legal expenses if a suit is brought against you.

**Medical payments coverage**
- In some states, Medical Payments Coverage is required, and is included in your policy. In other states, you may choose to purchase Medical Payments Coverage at an additional cost. This coverage covers anyone injured in your vehicle for reasonable medical and funeral expenses for up to three years after the accident.

**Uninsured motorist coverage**
- In some states, Uninsured Motorist Coverage is required, and is included in your policy. In other states, you may choose to purchase Uninsured Motorist Coverage at an additional cost. If you are in an accident with someone who does not have enough, or any, insurance, this coverage will protect you up to your policy limits.

**You can purchase coverage for damage to your auto that best fits your needs—**
- **Collision** coverage provides protection if your car rolls over, is hit by another car, or hits another car or object
- **Other Than Collision** coverage protects your car when it is damaged by other perils, such as birds, animals, fire, theft, vandalism, windstorm, earthquake, and hail.
- **Towing and Labor** coverage provides for towing each time you need it.

**LibertyGuard® Deluxe Homeowners Insurance**

Your home is not only one of the largest investments you’ll ever make, it is also one of the most important assets you and your family have. You need to feel secure about your home and its contents, and that starts with the right insurance coverage. A Liberty Mutual LibertyGuard® Deluxe Homeowners Insurance policy protects your home and other structures on your premises against direct physical loss on your premises. We’ll protect your **belongings** if they are damaged or stolen, and we’ll even protect your pets against claims for accidental bodily injury or property damage.

Think you need to live near water to need flood insurance? Think again. Floods can be caused by storms, hurricanes and even melting snow. Don’t get caught in rising water – protect your home with flood insurance.
Flood insurance is provided by Liberty Mutual authorized by the Federal Emergency Management Agency for over 18,000 participating communities. Flood coverage must be purchased as a separate policy as flood damage is not covered under homeowner policies.

LibertyGuard® Tenants Insurance
Insurance is not just for homeowners. If you rent your home, you should consider protecting your possessions with a LibertyGuard® Tenants Insurance policy. It covers you for items such as computer equipment, jewelry, stereo equipment, furniture, and clothing if these belongings are stolen or damaged, whether they are at home or anywhere in the world. You will also have protection against claims for accidental bodily injury or property damage, at or away from your home.

Watercraft Insurance can be added to your Tenants policy as well as many other endorsements for an additional cost.

LibertyGuard® Condominium Insurance
Your condominium is more than a place to live; it is a home—filled with memories and your valuable possessions. Should you ever suffer a loss due to fire, robbery, or other circumstances, you want to be sure your belongings are protected. Liberty Mutual’s LibertyGuard® Condominium Insurance will provide you with the coverage you need. The LibertyGuard® Condominium policy also provides coverage for the alterations, appliances, fixtures and improvements which are part of your unit. See for yourself how much money you could save with Liberty Mutual compared to your current insurance provider.

FOR A FREE, NO-OBLIGATION QUOTE, PLEASE CALL: Matt Morrison

- 704.549.8944 x. 55741 (Direct)
- 704.881.2895 (Cell)
- 603.334.8996 (Fax)
- Office Address: 9115 Harris Corners Parkway, Suite 200, Charlotte, NC 28269
- Website: https://www.libertymutual.com/matt-morrison

*Group discounts, other discounts, and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.*
AFLAC GROUP ACCIDENT & CRITICAL ILLNESS INSURANCE
When you leave employment, you may continue your Accident and Critical Illness plans by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. Certain stipulations apply. Please see your certificate of insurance for specific details. You may also contact Aflac toll free at 1.800.433.3036.

AUL SHORT & LONG TERM DISABILITY
Once you have been on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 31 days from your date of termination to apply for portability. Please see the Mark III website for the portability form; www.markiiibrokerage.com/cabarruscountync

ASSURITY CANCER (no longer enrolled, but remains on payroll deduction)
When you leave employment you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may arrange that by contacting Assurity at 1.866.289.7337.

CIGNA HEALTH & AMERITAS DENTAL
Under the CIGNA Health & Ameritas Dental plans, you and your covered dependents are eligible to continue coverage through COBRA according to the “qualifying events”. If you and your dependents are enrolled in either plan, you will be eligible to continue coverage through COBRA after you leave your employment, for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact IMS (Interactive Medical Systems, COBRA administrator) at 1.800.426.8739 or your Benefits Department at 704.920.2200.

COMMUNITY EYE CARE VISION
Under the Community Eye Care plan, you may continue the Vision coverage once you leave employment by calling Community Eye Care and set up your deduction to be bank drafted or paid by Visa and or Mastercard. The premium will remain the same even though you have ceased employment. You may contact Community Eye Care at 1.888.254.4290.
GILSBAR HEALTH CARE SPENDING ACCOUNT
If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Spending Account when you leave employment, you may continue participation in the Plan for the remainder of the Plan year.
If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call IMS (Interactive Medical Systems, COBRA administrator) at 1.800.426.8739 or your Benefits Department at 704.920.2200.

HUMANA CANCER
When you leave employment you may continue your Humana Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Humana will send you a letter explaining your options or you may arrange for payment by contacting Humana at 1.800.845.7519.

LIBERTY MUTUAL AUTO & HOMEOWNERS
When you leave employment, you may continue the coverage that you have with Liberty Mutual. The coverage will continue to be drafted from your bank account. If you have questions you may contact Liberty Mutual at 704.596.4045.

METLIFE WHOLE LIFE
When you leave employment, you may continue your MetLife Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may contact MetLife at 1.800.634.5007.

TEXAS LIFE WHOLE LIFE SOLUTIONS 121
When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting Texas Life at 1.800.283.9233 prompt #2.

USERRA (Uniformed Services Employment and Reemployment Rights Act)
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing exclusions) except for service-connected illnesses or injuries. If you have questions you may contact your Benefits Department at 704.920.2200.

UNUM TERM LIFE
Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates.
This applies to Optional Life and Dependent Life as well as the Basic coverage. To get information for converting to an individual life plan, please contact your Benefits Department at 704.920.2200 or Unum Life Benefits Department at 800.445.0402.

**Portability: (applies to Optional Employee coverage only)**
Such insurance may be continued by paying the required premiums when:
• your employment with your Employer ends for a reason other than total disability or retirement;
• the insurance has been in force for at least 12 months in a row just prior to the date employment ends.

To continue insurance, written application and the first premium payment must be made to the company, within 31 days of the date insurance would otherwise end. To get information for porting your life plan, please contact your Benefits Department at 704.920.2200 or Unum Life Benefits Department at 800.445.0402.

**VPI-NATIONWIDE PET INSURANCE**
When you leave employment, you may continue your Pet Insurance by having the premiums that are currently deducted from your paycheck drafted from your bank account. To set up bank draft, contact VPI-Nationwide at 1.877.738.7874.

**PHONE DIRECTORY**
• Aflac Accident & Critical Illness - 1.800.433.3036
• Ameritas Dental - 1.800.487.5553
• Assurity Cancer - 1.800.869.0355
• AUL/OneAmerica Short & Long Term Disability - 1.800.553.5318
• Cabarrus County Government Benefits Department - 704.920.2200
• Cigna Health - 1.800.244.6224
• Community Eye Care - 1.888.254.4290
• Gilsbar Flexible Spending Accounts - 1.800.445.7227, ext.883
• Humana Cancer - 1.800.845.7519
• Interactive Medical Systems (Cobra) - 1.800.426.8739
• Liberty Mutual Auto & Homeowners - 1.800.835.0894
• Mark III Brokerage, Inc.- 1.800.532.1044
• MetLife Whole Life - 1.800.634.5007
• Texas Life Whole Life Solutions 121- 1.800.283.9233 prompt #2
• Unum Term Life - 704.920.2200 (Cabarrus County Human Resources)
• Unum Life Benefits Department - 800.445.0402
• VPI-Nationwide Pet Insurance - 877.738.7874
View Benefit Information & Download Forms at:
www.markiiibrokerage.com/cabarruscounync

or scan:

Mark III
Employee Benefits
211 Greenwich Road
Charlotte, NC 28211
(800) 532-1044
(704) 365-4280