City of Asheboro offers a comprehensive benefits package specifically designed to protect your income and assets. The benefits package is arranged and enrolled by Mark III Brokerage, an Employee Benefits firm that has worked in the public sector since 1973. During annual enrollment, you may purchase coverage through pre-tax and after-tax payroll deductions.

To learn more about your benefits package, you must attend a group meeting and meet with a Mark III Benefits Counselor during this year's Annual Enrollment period.

- The Plan Year is from July 1, 2017 to June 30, 2018.

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This overview of benefits is only intended to offer an outline of options. All details and contract obligations of plans are stated in the actual benefit booklets provided by the Insurance Companies represented. You may contact your Benefits Administrator for additional information.

Key Points to Remember

- Plan Year ~ July 1, 2017 through June 30, 2018.

- Everyone **must** see an enroller.

- The Voluntary benefits with the exception of the Lincoln Term Life benefits are new offerings. **If you want these benefits in place for the 2017- 2018 plan year, you must enroll. Even if you choose not to select these benefits, you must see an enroller to decline coverage.**

- **Your current Voluntary benefits will not rollover.** Most of these benefits are guarantee issue. If you have had a challenge when applying for benefits in the past, now is your time to apply. There are pre-existing stipulations, but the coverage will still be afforded to you.

- The Annual Benefits Enrollment will occur **Tuesday, April 25th through Friday, April 28th** with Mark III Benefits Counselors onsite. The enrollment will officially end on **Tuesday, May 2nd at 5pm**. No changes will be allowed after this date.

- Payroll deductions for this year's enrollment will start ***the month of June.***

- 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.***

- If you should have a qualifying event, you will have 30 days from the date of the qualifying event to request a change to your benefits. ***All requests must be made to your Human Resources Department.***

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premiums) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **call 1-800-795-1023 or visit us at www.medcost.com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-795-1023 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$2,000 / person $6,000 / family	$4,000 / person $12,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes: most In-Network office visits, preventive care and prescription drugs.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,500 / person $11,000 / family	There is no out-of-pocket limit for Out-of-Network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing, health care this plan doesn't cover, and penalties for failure to meet certain plan requirements.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.medcost.com or call 1-800-795-1023 for a list of network providers		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146. Released on April 6, 2016

All **co-payment** and **co-insurance** costs shown in this chart are as noted, *either before or after,* your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible Out-of-Network.
	Specialist visit	$50 copay up to $250 / visit, then 30% co-insurance	50% co-insurance	Deductible does not apply to $50 co-pay. Co-insurance applies after deductible has been met.
	Preventive care/screening/ immunization	No charge	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to $500 / visit, then 30% co-insurance	50% co-insurance	Deductible does not apply to $500 co-pay. Co-insurance applies after deductible has been met.
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medcost.com.	Generic drugs	$4 co-pay Retail $8 co-pay Mail Order		Each co-pay covers up to a 30 day supply (retail prescription) or a 90 day supply (mail order prescription). $4 co-pay for OTC Prilosec. FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription) are covered at 100%.
	Preferred brand drugs	$35 co-pay Retail $70 co-pay Mail Order		
	Non-preferred brand drugs	$50 co-pay $100 co-pay		
	Specialty drugs	$50 co-pay		Each co-pay covers a 30 day supply. Certain high cost specialty injectable drugs must be purchased and dispensed by the Plan's Specialty Pharmacy program. Contact the Prescription Drug administrator at the telephone number on ID Card for more information. These drugs will not be covered by the Medical Plan.

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay, then 30% co-insurance	$500 co-pay, then 50% co-insurance	Deductible does not apply to co-pays. Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room care	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible.
	Emergency medical transportation	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible.
	Urgent care	$50 co-pay	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible. Charges for other services may apply, such as for lab or x-ray.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co-pay, then 30% co-insurance	$500 co-pay, then 50% co-insurance	Deductible does not apply to co-pays. Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician	30% co-insurance $25 co-pay	50% co-insurance 50% co-insurance	Co-insurance applies after deductible. Deductible does not apply to the $25 co-pay; co-insurance applies after deductible.
	Inpatient services	$250 co-pay, then 30% co-insurance	$500 co-pay, then 50% co-insurance	Deductible does not apply to co-pays. Co-insurance applies after deductible. Precertification required.*
If you are pregnant	Office visits	$150 co-pay	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible Out-of-Network. The $150 co-pay applies to the global fee charged by the physician.
	Childbirth/delivery professional services	$150 co-pay	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible Out-of-Network. Professional services are generally included in the global fee charged by the physician for pregnancy & delivery.
	Childbirth/delivery facility services	$250 co-pay, then 30% co-insurance	$500 co-pay, then 50% co-insurance	Deductible does not apply to co-pays. Co-insurance applies after deductible. Includes birthing centers.

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Limited to 60 visits / benefit year.
	Rehabilitation services – cardiac	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Habilitation services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes physical, occupational and speech therapies. Limited to 30 visits / benefit year for each type of therapy.
	Skilled nursing care	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible. Limited to 100 days / benefit year.
	Durable medical equipment	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Hospice services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage. Coverage available by separate election.
	Children's glasses	Not covered	Not covered	No coverage
	Children's dental check-up	Not covered	Not covered	No coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care (Adult) – employee only
- Infertility treatment (testing only)
- Private duty nursing

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov. For more information on how to continue coverage under this Plan, you may contact the Plan at 252-475-5823. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Claims Administrator, MedCost Benefit Services at 1-800-795-1023 or at www.medcost.com. Additionally, a consumer assistance program can help you file your appeal: contact Health Insurance Smart NC at 1-855-408-1212 or at http://www.ncdoi.com/Smart/.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-1023

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-1023

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-795-1023

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-795-1023

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

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$2,000
■ Specialist co-pay	$50
■ Hospital (facility) coinsurance	30%
■ Other: co-insurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$37
Coinsurance	$2,915
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,952**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$2,000
■ Specialist co-pay	$50
■ Hospital (facility) co-insurance	30%
■ Other: co-insurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,728
Copayments	$636
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,364**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$2,000
■ Specialist co-pay	$50
■ Hospital (facility) co-insurance	30%
■ Other: co-insurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Schedule of Benefits

VISION CARE	
Eligibility	Unexcepted Benefit (separate election)
Routine Eye Exams	100%, limited to $60 in a calendar year
Frames, Lenses & Contacts	100%, limited to $250 in a calendar year includes prescription sun glasses Includes contact fitting
DENTAL CARE	
Eligibility	Employee - Excepted Benefit (bundled with Medical) Dependents - Unexcepted Benefit (separate election)
Calendar Year Deductible	$50 (2 x family)
Preventive Services	100% - deductible waived
Basic Services	80% after deductible
Major Services	80% after deductible (includes implants)
Annual Maximum	$1,500 per person
Orthodontia dependent children to age 19	50% after deductible limited to $3,000 in a lifetime
Miscellaneous	Wisdom teeth removal paid as Dental first with excess rolling to medical

Medcost Medical, Dental & Vision

24 pay Deductions

	Employee Medical	Employee Dental	Employee Vision
Employee	$261.45 (paid 100% by City of Asheboro)	$21.08	$4.62
Employee & Child(ren)	$168.00	$18.25	$2.50
Employee & Spouse	$202.00	$25.00	$3.75
Employee & Family	$308.00	$30.00	$5.50

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Website: www.medcost.com

Address: 165 Kimel Park Drive, Winston-Salem, NC 27103

City of Asheboro
Effective July 1, 2017

Prescription Drug Plan

	1-30 Day Supply Retail	90 Day Supply Retail	90 Day Supply Mail*
Over-the-counter Prilosec	**$ 8**	**$ 16**	**$ 16**
Generic Medications	**$ 4**	**$ 8**	**$ 8**
Preferred Medications	**$ 35**	**$ 70**	**$ 70**
Non-Preferred Medications	**$ 50**	**$ 100**	**$ 100**
Specialty Medications	**$ 50**	**N/A**	**N/A**

***Does not apply to the Medicare Supplement Plan. Refer to Retiree Prescription Drug Benefits**

Maximum Out of Pocket (MOOP): $5,500 single/$11,000 family
The calendar year MOOP applies to pharmacy and medical. Each individual family member must meet the single MOOP unless the family MOOP has been met by any two or more covered family members. The deductible applies to the MOOP. Once met, your covered prescriptions are paid at 100%. Dispense as written penalties (i.e. generic policy) do not apply to the MOOP.

Specialty Medications: Specialty medications must be ordered through Briova Rx at 1-800-850-9122. Limited to a 30 day supply and may require prior authorization.

Generic Policy: If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug. This does not apply when your physician does not allow substitutions.

Step Therapy Program: Your plan has step therapy with quantity limits and/or prior authorizations. If you choose to use certain brand-name drugs before trying a generic medication, your prescription may not be covered and you may need to pay the full cost. Step therapy applies to the following therapeutic categories: Anti-Infectives, Cardiovascular, Central Nervous System, Dermatology, Diabetes, Endocrinology, Gastroenterology, Ophthalmology, Respiratory and Urology. Please contact Member Services 1-800-334-8134 for a list of medications.

DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below.
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script will require prior authorization.
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes and lancets.
- Contraceptives: Oral, Transdermal, Diaphragms, Intravaginal, Implants/IUD and Injectable; extended cycle products are subject to 3x retail copays for a 90 day supply
- Narcolepsy medications (prior authorization and quantity limits may apply)
- ADD/ADHD medications (prior authorization required and quantity limits may apply)
- Migraine medications (quantity limits)
- Extended Release Controls-Opioid Analgesics (step therapy and quantity limits apply)
- Sleep Aids/Hypnotics (quantity limits apply)
- Impotency Medications (quantity limits apply)
- Androgens/Anabolic Steroids (prior authorization and quantity limits may apply)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required and quantity limits apply)
- Topical Acne Agents (prior authorization required over age 26)
- Growth Hormones (prior authorization required)

DRUGS COVERED (continued)*

- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year) OTC requires prescription

EXCLUSIONS*

- Biological, blood products, serums and Non ACA immunization agents
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants & removal products)
- Experimental and investigational drugs, including compounded medications for non-FDA approved use.
- Compounded prescriptions that use ingredients such as bulk chemicals and powders.
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Anti-obesity/Appetite suppression
- Oral Anti-Fungal Medications
- Infertility Medications
- Topical Analgesic Pain Patches
- Nutritional Supplements
- OTC products
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.

***This is not an inclusive list but is a representation of the most commonly used medications. Contact Member Services for specific drug coverage information.**

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Member Services if you have specific drug questions or register at www.Optumrx.com/myCatamaranrx to check drug costs and coverage.

Aflac Accident Advantage Plus - 7800

Effective Date: July 1, 2017

Plan Features

• Benefits are payable regardless of any other insurance programs.

• Coverage is guaranteed-issue, provided the applicant is eligible for coverage.

• The plan features benefits for both inpatient and outpatient treatment of covered accidents.

• Benefits are available for spouse and/or dependent children.

• There's no limit on the number of claims an insured can file.

• Premiums are paid by convenient payroll deduction.

• Immediate effective date – Coverage will be effective the date the employee signs the application.

• 24-Hour Coverage.

Eligibility

Issue Ages

• Employee at least age 18

• Spouse at least age 18

• Children under age 26

The employee may purchase Accident Plus coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

Coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

Portability

When coverage would otherwise terminate because an employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- the date he fails to pay the required premium; or
- the date the class of coverage is terminated.

Coverage may not be continued:

- if the employee fails to pay any required premium; or
- if the Company receives notice of Class I plan termination.

Accident Benefits – High Option

Complete Fractures		Closed Reduction Benefits
	Employee	Spouse / Children
Hip/Thigh	$4,500	$4,000
Vertebrae	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (Depressed	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand/Wrist	$2,250	$2,000
Foot/Ankle/Knee Cap	$2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (Mandible)	$1,800	$1,600
Skull (Simple)	$1,575	$1,400
Upper Arm/Upper Jaw	$1,575	$1,400
Facial Bones (Except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320

If the fracture requires open reduction, we will pay 150% of the amount shown.

A *fracture* is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown.

Multiple fractures refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture.

However, we will pay no more than 150% of the benefit amount for the fractured bone which has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown for the affected bone.

The maximum amount payable for the Fracture Benefit per covered accident is 150% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations		Closed Reduction Benefits
	Employee	Spouse / Child(ren)
Hip	$3,600	$2,700
Knee (not kneecap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

If the dislocation requires open reduction, we will pay 150% of the amount shown.

Dislocation refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan.

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 150% of the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint. The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount. If you have both fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident:

•The insured is injured,

•The injury causes paralysis which lasts more than 90 days, and

•The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations	
Up to 2” long	$50
2” - 6” long	$200
More than 6” long	$400
Lacerations not requiring stitches	$25

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration. If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	$250
Removal of foreign body from eye (requiring no surgery)	$50
Tendons / Ligaments* (treatment within 60 days, surgical repair within 90 days Single Multiple If the insured fractures a bone or dislocate a joint, and tears, severe, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	 $400 $600
Ruptured Disc (treatment with 60 days, surgical repair within one year) Injury occurs during first certificate year Injury occurs after first certificate year	 $100 $400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year) Injury occurs during first certificate year Injury occurs after first certificate year	 $100 $400

Burns (treatment within 14 days, first degree burns not covered)	
	Benefit
Second Degree	
Less than 10% of body surface covered	$100
At least 10%, but not more than 25% of body surface covered	$200
At least 25%, but not more than 35% of body surface covered	$500
More than 35% of body surface covered	$1,000
Third Degree	
Less than 10% of body surface covered	$1,000
At least 10%, but not more than 25% of body surface covered	$5,000
At least 25%, but not more than 35% of body surface covered	$10,000
More than 35% of body surface covered	$20,000

Concussion (A concussion or Mild Traumatic Brain Injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: Concussion and MTBI are used interchangeably. The concussion must be diagnosed by a doctor.)	$200
Coma (state of profound unconsciousness lasting 30 days or more)	$10,000
Internal injuries (resulting in open abdominal or thoracic surgery	$1,000
Exploratory Surgery (without repair, i.e.arthroscopy)	$250
Emergency Dental Work (injury to sound, natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50

Medical Fees (for each accident)	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for X-rays or doctor services.

For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident.

We will pay the Medical Fees Benefit:

•For treatment received due to injuries from a covered accident and
•For each covered accident up to one year after the accident date.

Emergency Room Treatment	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for injuries received in a covered accident if the insured:
•Receives treatment in a hospital emergency room and
•Receives initial treatment within 14 days after the covered accident.
This benefit is payable only once per 24-hour period and only once per covered accident.
We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit	
Employee or Spouse	$75
Child(ren)	$45

We will pay the amount shown for injuries received in a covered accident if the insured:
•Receives treatment in a hospital emergency room, and
•Is held in a hospital for observation for at least 24 hours, and
•Receives initial treatment within 14 days after the accident.
This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-Up Treatment	$25

We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 14 days of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital

Physical Therapy	$25

We will pay the amount shown for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 14 days of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-up Treatment benefit is paid.

Air Ambulance	$500
Ambulance	$100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

Transportation (within 90 days)	
Train or Plane	$300
Bus	$150

If hospital treatment or diagnostic study is recommended by your physician and is not available in the insured's city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood / Plasma	$100

If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	$500

If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids—including false teeth—are not covered.

Appliance	$100

We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

Family Lodging Benefit (per night)	$100

If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness	$60

This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams
- Blood screenings
- Eye examinations
- Immunizations
- Flexible sigmoidoscopies
- Ultrasounds
- Mammograms
- Pap smears
- PSA tests

Hospital Admission	$1,000

We will pay the amount shown, when because of a covered accident, the insured:

• Is injured,

• Requires hospital confinement, **and**

• Is confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day)	$200

We will pay the amount shown when, because of a covered accident, the insured:

• Is injured, and

• Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day)	$400

We will pay the amount shown when, because of a covered accident, the insured:

• Is injured, and

• Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same injury is 30 days. This benefit is payable in addition to the Hospital Confinement Benefit.

Accidental Death and Dismemberment (within 90 days)			
	Employee	Spouse	Children
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$6,250	$2,500	$1,250
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toes(s) (Including at least one joint)	$100	$100	$100

Dismemberment means:

• Loss of a hand – The hand is cut off at or above the wrist joint; **or**

• Loss of a foot – The foot is cut off at or above the ankle; **or**

• Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**

• Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

• An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**

• A railroad train which is licensed and operated for passenger service only; **or**

• A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

LIMITATIONS AND EXCLUSIONS

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

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

• War – participating in war or any act of war, declared or not; 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 by this certificate when you are in such service. This does not include terrorism.

• Suicide – committing or attempting to commit suicide, while sane or insane.

• Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness. This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.

• Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.

• Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

• Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.

• Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.

• Sports – participating in any organized sport—professional or semiprofessional.

• Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

TERMINATION OF AN EMPLOYEE'S INSURANCE

An employee's insurance will terminate on the earliest of the following:

1. the date the Plan is terminated, for Class I insureds;

2. the 31st day after the premium due date if the required premium has not been paid;

3. the date he ceases to meet the definition of an employee as defined in the Plan, for Class I insureds; or

4. the date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

1. the date the plan is terminated, for dependents of Class I insureds;

2. the 31st day after the premium due date, if the required premium has not been paid;

3. the date the spouse or dependent child ceases to be a dependent; or

4. the premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

DEFINITIONS

Accidental injury or injuries means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of covered accident.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children are your or your Spouse's natural children, step-children, legally adopted children, foster children or children placed for adoption who are younger than age 26.

However, there is an exception to the age 26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday, but not more frequently than annually.

A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same

basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we;

• will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

• will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

• will not disenroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

Dismemberment means loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Employee means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

Family member includes your spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

This includes step-family members and family-members-in-law.

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or prearranged use of X-ray equipment, laboratory, and surgical facilities; maintains permanent medical history records; and a state supported institution even though it may not have an operating room and related equipment for the surgery.

A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Spouse means your legal wife or husband. Coverage may only be issued to your spouse if your spouse is over 18.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions.

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.

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.

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,

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AGCM378NC-25-BK IV (2/17)

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Employee and Dependent Children	$15.45
Employee and Family	$18.93

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Aflac Hospital Indemnity 8500 ~ (Low & High)

Effective Date: July 1, 2017

Plan Description

The Group Supplemental Hospital Indemnity Plan provides benefits for inpatient and outpatient services as a result of covered accidents and sicknesses.

Plan Features

- Benefits available for spouse and/or dependent children.
- Pays regardless of any other insurance programs.
- Premiums are paid by convenient payroll deduction.
- Covers both injuries and sicknesses.
- Admission and per day Hospital Confinement Benefits included.
- Surgery and Anesthesia Benefits included.
- The plan is portable with certain stipulations

Individual Eligibility

Issue Ages

- Employee 18-64
- Spouse 18-64
- Children under age 26

Spouse and Dependent Children Coverage Available

The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate. If the employee is eligible then the employee's spouse and dependent children are eligible to participate.

Guaranteed-Issue

During the initial enrollment, coverage is guaranteed-issue, which means you may not have to answer health questions to be eligible for coverage. Subsequent to the initial enrollment, evidence of insurability may be required.

Portability

When coverage would otherwise terminate because an employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

•the date he fails to pay the required premium; or

•the date the class of coverage is terminated.

Coverage may not be continued:

•if the employee fails to pay any required premium; or

•if the Company receives notice of Class I plan termination.

Benefits

Hospital Confinement (per day)	
Plan I	$100
Plan II	$150

We will pay the amount shown when an insured is confined to a hospital as a resident bed patient as the result of an injury or because of a covered sickness. To receive this benefit for injuries received in an injury, the insured must be confined to a hospital within six months of the date of the covered accident.

The maximum period for which a covered person can collect benefits for hospital confinements resulting from covered sickness or from injuries received in the same covered accident is 180 days.

This benefit is payable for only one hospital confinement at a time—even if the confinement is a result of more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.

Hospital Admission (per confinement)	
Plan I	$500
Plan II	$1,500

We will pay the amount shown when an insured is admitted to a hospital and confined as a resident bed patient because of an injury or because of a covered sickness. To receive this benefit for injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident.

We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment. We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

This benefit option will be based on the insured's current major medical plan's deductible to assist the insured in meeting the out-of-pocket liability.

Residents of Massachusetts are not eligible for Hospital Admission Benefit amounts in excess of $500

Surgical Benefit (per procedure)	
Plan I	Up to $750
Plan II	Up to $1,500

If an insured has surgery performed by a physician due to an injury or because of a covered sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a hospital (on an inpatient or outpatient basis), in an ambulatory surgical center, or in a physician's office.

If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations (the operation that is nearest in severity and complexity).

If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit—the largest—will be provided.

Anesthesia Benefits	
Plan I	Up to $188
Plan II	Up to $375

When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.

Wellness (per calendar year)	
Plan I & II	$50

We will pay the amount shown when an insured visits a doctor and he is neither injured nor sick. This benefit is payable once per calendar year per insured.

Limitations and Exclusions

Pre-Existing Condition Limitation

A pre-existing condition means, within the 12 month period prior to the insured's effective date, conditions for which medical advice or treatment was received or recommended.

We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured's effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less.

A claim for benefits for loss starting after 12 months from the effective date of the insured's certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

Pregnancy is considered a pre-existing condition if conception was before the coverage effective date.

If the certificate is issued as a replacement for a certificate previously issued under this plan, then the pre-existing condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining pre-existing condition limitation period of the prior certificate continues to apply to the prior level of benefits.

Exclusions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above).

We will not pay benefits for loss contributed to by, caused by, or resulting from:

1. War – 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 by this certificate when the insured is in such service.

2. Suicide – Committing or attempting to commit suicide, while sane or insane.

3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.

4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.

5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.

6. Aviation – Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those, which are not motor–driven.

7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.

8. Illegal Acts – Participating or attempting to participate in an illegal activity, or working at an illegal job.

9. Sports – Participating in any organized sport: professional or semi–professional.

10. Routine physical exams and rest cures.

11. Custodial care. This is care meant simply to help people who cannot take care of themselves.

12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.

13. Services performed by a relative.

14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.

15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.

16. Elective abortion.

17. Treatment, services, or supplies received outside the United States and its possessions or Canada.

18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.

19. Dental services or treatment.

20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

21. Mental or emotional disorders without demonstrable organic disease.

22. Alcoholism, drug addiction, or chemical dependency.

Terminations

An employee's insurance will terminate on the earliest of the following:

1. The date the plan is terminated, for Class I insureds;
2. The 31st day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

Definitions

Injury or Injuries – Accidental bodily injury or injuries caused solely by or as the result of a covered accident.

Covered Accident – An accident, which occurs on or after the insured's effective date, while the insured's certificate is in force, and which is not specifically excluded.

Sickness – An illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an injury.

Covered Person - means the insured if the certificate is issued as Individual coverage.
If the certificate is issued as:
1. Employee/Spouse coverage Covered Person means the insured and the insured's legal spouse;

2. Single Parent Family coverage Covered Person means the insured and insured's covered dependent children as defined in the applicable rider, that have been accepted for coverage;

3. Family coverage Covered Person means the insured, the insured's spouse, and the insured's covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

Covered Sickness – An illness, infection, disease or any other abnormal physical condition which is not caused solely by or the result of any injury which:

1. Occurs while the insured's coverage is in force; and

2. Was not treated or for which the insured did not receive advice within 12 months before the insured's effective date; and

3. Is not excluded by name or specific description in the plan.

Doctor or Physician – A person, other than the insured, or a member of the insured's immediate family, who:

- Is licensed by the state to practice a healing art;
- Performs services which are allowed by his or her license; and
- Performs services for which benefits are provided by the Plan.

A hospital is not:
- A nursing home;
- An extended-care facility;
- A convalescent home;
- A rest home or a home for the aged;
- A place for alcoholics or drug addicts; or
- A mental institution.

Hospital includes any duly licensed state tax supported institution, including those community health centers and other health clinics which are certified as Medicaid providers.

Effective Date – The date as shown in the certificate schedule if you are on that date actively at work for the policyholder. If not, the certificate will become effective on the next date you are actively at work as an eligible employee. The certificate will remain in effect for the period for which the premium has been paid. The certificate may be continued for further periods as stated in the plan. The certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application will be attached and made a part of the certificate. The certificate, on its effective date, automatically replaces any certificate or certificates previously issued to you under the plan.

Dependent Children – means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.
a. Coverage on Dependent Children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, and not more frequently than annually from then forward.

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

i. Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

ii. Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

iii. May not dis-enroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of dis-enrollment.

iv. Will not impose pre-ex limitations or waiting periods.

If Dependent Children are covered under the plan, Dependent Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Spouse – An employee's legal spouse who is between the ages of 18–64 and who is named on the enrollment application.

Treatment – Consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions.

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.

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.

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.

Aflac Hospital Indemnity ~ Low & High Options

(24 pay deductions)

	High Option	Low Option
Employee	$15.48	$7.85
Employee and Spouse	$30.59	$15.52
Employee and Dependent Children	$21.46	$10.76
Employee and Family	$36.57	$18.43

Continental American Insurance Company, Columbia, South Carolina

Toll Free ~ **800.433.3036** | Website ~ **aflacgroupinsurance.com**

AGCM385NC-HL-BK IV (1/17)

Humana Group Cancer & Specified Disease

Effective Date: July 1, 2017

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 coverages

Benefit	Benefit Amounts
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	1. $0 2. $2,500 3. $0 4. $5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Actual Charges
Non-Local Transportation. Payable for transportation to a Hospital, clinic, treatment center, or from one medical facility to another which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.

BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Form Number: HIC-GP-CAN-SB-NC

Benefit	Benefit Amounts
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. Ambulance benefits shall include transportation from one medical facility to another. No Lifetime Maximum	Actual Charges
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
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.	(a) $200 (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to $50 per day
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	Actual charges to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum For anesthesia in connection with the treatment of skin Cancer. No Lifetime Maximum	Up to 25% of surgical benefit paid. $100 maximum per Covered Person
Ambulatory Surgical Center. We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum	$250 Per Day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year
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	1. Actual charges up to $2,500 per month 2. Actual charges up to $2,500 per month 3. Actual charges up to $5,000 per month 4. Actual charges up to $5,000 per month
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.	Actual charges up to a lifetime maximum of $10,000

Benefit	Benefit Amounts
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	Actual charges up to $4,000 per month
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	Actual charges up to $500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Actual charges up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
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.	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.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Actual Charges
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	$1,500 lifetime maximum per amputation.
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	Up to $35 per session
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	$300 per day
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	Up to $50 per day
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	Up to $100 per day

Benefit	Benefit Amounts
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	Up to $7,500 per calendar year
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	Up to $50 per day
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	$200 per day
Hairpiece. We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual charge up to a lifetime maximum of $150
Rental or Purchase of Durable Goods. We will pay the actual expenses incurred for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Actual charges up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 per day

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
- Reye'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

Form Number: HIC-GP-CAN-SB-NC

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;
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.

CONTACT INFORMATION

- **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 - with Options

	Option 1	Option 2	Option 3	Option 4
Room Rate	$100 per day	$100 per day	$100 per day	$100 per day
Surgical Schedule	$3,000 per schedule	$3,000 per schedule	$3,000 per schedule	$3,000 per schedule
Radiation, Chemotherapy, Immunotherapy Benefit	Actual charges up to $2,500 per month	Actual charges up to $2,500 per month	Actual charges up to $5,000 per month	Actual charges up to $5,000 per month
First Diagnosis Benefit	$0	$2,500	$0	$5,000
Colony Stimulating Factors Benefit	$500 per month	$500 per month	$500 per month	$500 per month
Wellness Benefit	$100 per calendar year	$100 per calendar year	$100 per calendar year	$100 per calendar year
Intensive Care Rider	$0	$325	$0	$625

(24 pay deductions)

	Option 1	Option 2	Option 3	Option 4
Employee Only	$8.83	$11.69	$9.82	$15.45
Employee & Children	$12.60	$16.60	$13.82	$21.68
Employee & Spouse	$17.79	$23.80	$19.72	$31.44
Employee & Family	$21.55	$28.72	$23.73	$37.67

Aflac Critical Illness Advantage Plan ~ without Cancer

Effective Date: July 1, 2017

Plan Features *(21000)*

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available up from $5,000 up to $50,000 for employees and $5,000 to $30,000 for spouse.
- An annual Health Screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- The plan doesn't have a waiting period for benefits
- Coverage is portable, with certain stipulation
- Benefits do not reduce as you get older
- Annual health screening benefits are included

Underwriting Guidelines – Guaranteed-Issue

• Guaranteed-issue coverage is offered for All Employees:

Up to **$20,000** for employees and up to **$10,000** for spouses with no participation requirement.

• For employee amounts over **$20,000** and spouse amounts over **$10,000**:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages

• Employee 18-69

• Spouse 18-69

• Children under age 26

Benefit-eligible employees, working at least **26** hours or more weekly, with at least 0 days of continuous employment by the date of the enrollment. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Class I

All full-time and part-time benefit-eligible employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

Class II

A Class I primary insured is eligible for Class II coverage if he:

• Was previously insured under Class I; and

• Is no longer employed by the policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate. Only dependents covered under Class I coverage are eligible for continued coverage under Class II. Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

Spouse Coverage Available

Spouse coverage is available up to 100% of the employee's face amount, subject to the minimum face amount of $5,000. To apply for spouse coverage, the employee must also apply. To be eligible, the spouse must not be disabled or unable to work at the time of application.

If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and be limited to face amounts between $5,000 and $30,000.

Dependent Children Coverage at No Additional Charge

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. Children-only coverage is not available.

Waiver of Premium Benefit

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Termination of an Employee's Insurance

An employee's insurance will terminate on the earliest of the following:

1. The date the plan is terminated, for Class I insureds;
2. The 31st day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an employee as defined in the plan, for Class I insured or
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Group Critical Illness Benefits

Initial Diagnosis – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Critical Illnesses Covered Under Plan	Percentage of Face Amount
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery+	25%
Additional Benefits Covered Under Plan	**Percentage of Face Amount**
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Transient Ischemic Attack (TIA)	$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Additional Diagnosis - Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence Benefit - Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Health Screening Benefit- (Employee & Spouse only) $100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. The covered health screening tests include, but are not limited to, the following:

- Stress test on a bicycle or treadmill
- 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
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- DNA stool analysis
- Spiral CT screening for lung cancer
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL

Heart Event Rider

Covered Surgeries and Procedures	Percentage of Maximum Benefit
Category 1- Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%
Mitral valve replacement or repair	100%
Aortic valve replacement or repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Category 2- Invasive Procedures & Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon Valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent implantation	10%
Cardiac catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

OPTIONAL BENEFITS RIDER

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if you are diagnosed with one of the conditions listed.

Limitations and Exclusions

(Applies to all riders unless otherwise noted)

Exclusions

We will not pay for loss due to any of the following:

• **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.

• **Suicide** – committing or attempting to commit suicide, while sane or insane.

• **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.

• **Participation in Aggressive Conflict** of any kind, including:

o War (declared or undeclared) or military conflicts. This does not include terrorism.

o Insurrection or riot.

o Civil commotion or civil state of belligerence.

• **Illegal substance abuse**, which includes the following:

o Abuse of legally-obtained prescription medication.

o Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

Terms You Need to Know

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a bone marrow transplant (stem cell transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant)**: The date the surgery occurs.
- **Coronary Artery Bypass Surgery**: The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial infarction) definition.
- **Kidney Failure (End-Stage Renal Failure)**: The date a doctor recommends that an insured begin renal dialysis.
- **Major Organ Transplant**: The date the surgery occurs.
- **Stroke**: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the **Sudden Cardiac Arrest** definition).
- **Transient Ischemic Attack (TIA)**: The date the transient ischemic attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).
- **Coma**: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Loss of Sight, Speech, or Hearing**: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- **Paralysis:** The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- **Severe Burn**: The date the burn takes place.

Dependent means the primary insured's spouse or dependent child. **Spouse** is the primary insured's legal wife or husband who is listed on his application. **Dependent Children** are the primary insured's or his spouse's natural children, foster children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26.

However, there is an exception to the age 26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must provide us with proof of this incapacity and dependency within 31 days following the dependent child's 26th birthday, but not more frequently than annually.

Newborn, adopted and foster children are equally considered under this plan. A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we:

- Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

• Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

• Will not dis-enroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

• Is made by a doctor and

• Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this plan for the particular critical illness being diagnosed. Diagnosis must be made and treatment must be received in the United States or its territories.

Doctor is a person who is:

• Legally qualified to practice medicine,

• Licensed as a doctor by the state where treatment is received, and

• Licensed to treat the type of condition for which a claim is made.

A doctor does not include the primary insured or any of his family members. For the purposes of this definition, family member includes the primary insured's spouse as well as the following members of his immediate family:

• Son

• Daughter

• Mother

• Father

• Sister

• Brother

• Step-Family Members and Family-Members-in-law

Employee is a person who meets eligibility requirements under Section I – Eligibility, Effective Date, and Termination, and who is covered under this plan. The employee is the primary insured under this plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary artery disease or acute coronary syndrome. Heart attack (myocardial infarction) does not include the following:

• Any other disease or injury involving the cardiovascular system

• Cardiac arrest not caused by a heart attack (myocardial infarction)

Diagnosis of a heart attack (myocardial infarction) must include the following:

• New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and

• Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function. Kidney failure (end-stage renal failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital heart disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary artery disease.
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.

to chronic inflammation.

- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

A major organ transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Pathologist is a doctor who is licensed:

- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy.

A pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours.

Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or

• **Hemorrhagic:** Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include the following:

• Transient ischemic attacks (TIAs)

• Head injury

• Chronic cerebrovascular insufficiency

• Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

• Computed Axial Tomography (CAT scan) images, or

• Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden cardiac arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

• Not working at any job for pay or benefits,

• Under the care of a doctor for the treatment of a covered critical illness, and

• Unable to Work, which means either:

o During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or

o After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

• Advanced arteriosclerosis

• Arteriosclerosis of the arteries of the neck or brain

• Vascular embolism

• Hypertension

• Malignant hypertension

• Brain aneurysm

• Arteriovenous malformation

The TIA must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- Encephalitis, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- Epilepsy, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- Hyperglycemia, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- Hypoglycemia, which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- Meningitis, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease, which is a disease that affects the retina of the eye;
- Optic nerve disease, which is a disease that affects the optic nerve of the eye; or
- Hypoxia, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease, which is a progressive mental deterioration due to generalized degeneration of the brain; or
- Arteriovenous malformation, which is a congenital disease of blood vessels in the brain, brain stem, or spinal-cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

• Alport syndrome, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;

• Autoimmune inner ear disease, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;

• Chicken pox, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;

• Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;

• Goldenhar syndrome, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;

• Meniere's disease, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;

• Meningitis, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or

• Mumps, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

• Amyotrophic lateral sclerosis, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;

• Cerebral palsy, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;

• Parkinson's disease, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or

• Poliomyelitis, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The diagnosis of paralysis must be supported by neurological evidence.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

• Be a full-thickness or third-degree burn, as determined by a doctor. A full-thickness burn or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.

• Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.

• Be caused solely by or be solely attributed to a covered accident.

Covered Heart Procedure is one of the Category I or Category II procedures defined below:

Category I – Specified Surgeries of the Heart

Specified surgeries of the heart (open heart surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

• **Coronary Artery Bypass Surgery (also Coronary Artery Bypass Graft Surgery or Bypass Surgery)** is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.

o **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart-lung machine.

o **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries. A blood vessel is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this rider.

• Mitral Valve Replacement or Repair is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.

• Aortic Valve Replacement or Repair is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.

• Surgical Treatment of Abdominal Aortic Aneurysm involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

• **AngioJet Clot Busting** clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.

• **Balloon Angioplasty (or Balloon Valvuloplasty)** opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

• **Laser Angioplasty** uses a laser tip to burn/break down plaque in the clogged blood vessel.

• **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

• **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.

• **Cardiac Catheterization (also Heart Catheterization)** is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

• **Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD**) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

• **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

• **Valvular Heart Disease** is a disease characterized by damage to or a defect in one of the four heart valves.

Optional Benefits Rider

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:

• Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;

• Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

• Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;

• Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;

• Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;

• Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and

• Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Date of Diagnosis is defined as follows:

• **Advanced Alzheimer's Disease:** The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.

• **Advanced Parkinson's Disease:** The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.

• **Benign Brain Tumor:** The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific

Advanced Alzheimer's Disease means Alzheimer's disease that causes the Insured to be incapacitated. Alzheimer's disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease. To be incapacitated due to Alzheimer's disease, the Insured must:

• Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; and

• Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's disease that causes the Insured to be incapacitated. Parkinson's disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease. To be incapacitated due to Parkinson's disease, the insured must:

Exhibit at least two of the following clinical manifestations:

- Muscle rigidity
- Tremor
- Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a cancer. Benign brain tumor must be caused by multiple endocrine neoplasia, neurofibromatosis, or Von Hippel-Lindau syndrome.

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions.

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. AGC1600272 IV (3/16)

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.

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AGCM321-NC-BK IV (1/17)

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We've got you under our wing.®

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Employee & Spouse Rates (24 pay deductions)

NONTOBACCO - Employee										
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18-29	$ 2.26	$ 3.00	$ 3.73	$ 4.46	$ 5.20	$ 5.93	$ 6.66	$ 7.39	$ 8.13	$ 8.86
30-39	$ 2.67	$ 3.80	$ 4.94	$ 6.08	$ 7.21	$ 8.35	$ 9.49	$ 10.62	$ 11.76	$ 12.90
40-49	$ 4.14	$ 6.76	$ 9.37	$ 11.98	$ 14.59	$ 17.21	$ 19.82	$ 22.43	$ 25.04	$ 27.66
50-59	$ 5.82	$ 10.11	$ 14.40	$ 18.69	$ 22.98	$ 27.27	$ 31.57	$ 35.86	$ 40.15	$ 44.44
60+	$ 8.55	$ 15.57	$ 22.59	$ 29.61	$ 36.63	$ 43.65	$ 50.67	$ 57.69	$ 64.71	$ 71.74

NONTOBACCO - Spouse						
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$ 2.26	$ 3.00	$ 3.73	$ 4.46	$ 5.20	$ 5.93
30-39	$ 2.67	$ 3.80	$ 4.94	$ 6.08	$ 7.21	$ 8.35
40-49	$ 4.14	$ 6.76	$ 9.37	$ 11.98	$ 14.59	$ 17.21
50-59	$ 5.82	$ 10.11	$ 14.40	$ 18.69	$ 22.98	$ 27.27
60+	$ 8.55	$ 15.57	$ 22.59	$ 29.61	$ 36.63	$ 43.65

TOBACCO - Employee										
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18-29	$ 2.91	$ 4.30	$ 5.68	$ 7.07	$ 8.45	$ 9.83	$ 11.22	$ 12.60	$ 13.98	$ 15.37
30-39	$ 4.22	$ 6.91	$ 9.61	$ 12.30	$ 14.99	$ 17.68	$ 20.37	$ 23.06	$ 25.76	$ 28.45
40-49	$ 7.22	$ 12.90	$ 18.59	$ 24.28	$ 29.97	$ 35.65	$ 41.34	$ 47.03	$ 52.72	$ 58.40
50-59	$ 10.46	$ 19.39	$ 28.32	$ 37.25	$ 46.18	$ 55.11	$ 64.04	$ 72.97	$ 81.90	$ 90.83
60+	$ 16.69	$ 31.85	$ 47.01	$ 62.17	$ 77.33	$ 92.49	$ 107.65	$ 122.81	$ 137.97	$ 153.13

TOBACCO - Spouse						
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$ 2.91	$ 4.30	$ 5.68	$ 7.07	$ 8.45	$ 9.83
30-39	$ 4.22	$ 6.91	$ 9.61	$ 12.30	$ 14.99	$ 17.68
40-49	$ 7.22	$ 12.90	$ 18.59	$ 24.28	$ 29.97	$ 35.65
50-59	$ 10.46	$ 19.39	$ 28.32	$ 37.25	$ 46.18	$ 55.11
60+	$ 16.69	$ 31.85	$ 47.01	$ 62.17	$ 77.33	$ 92.49

Base Plan:
-Without Cancer Benefit
-$100 Health Screening Benefit
-Without Skin Cancer Benefit
-With Additional Benefits
(Loss of Sight, Speech, Hearing)
(Coma, Burns, Paralysis)

Riders:
-Optional Benefits Rider (BTAP)
-Heart Rider
-$250 TIA (mini-stroke) Rider

Provisions:
-No Pre-Existing Condition Limitation
-Add'l Separation Waiting Period: 6 Months
-Re-Separation Waiting Period: 6 Months
-Class I/II Portability
-Rate Guarantee: 3 Years

Group Attributes:
-Situs State: NC
-Eligible Lives: 750

Please Note: Premiums shown are accurate as of publication. They are subject to change.

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Aflac Critical Illness Advantage Plan ~ with Cancer

Effective Date: July 1, 2017

Plan Features *(21000)*

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available from $5,000 up to $50,000 for employees and $5,000 to $30,000 for spouse.
- An annual Health Screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- The plan doesn't have a waiting period for benefits
- Coverage is portable, with certain stipulation
- Benefits do not reduce as you get older
- Annual health screening benefits are included

Underwriting Guidelines – Guaranteed-Issue

• Guaranteed-issue coverage is offered for All Employees:

Up to **$20,000** for employees and up to **$10,000** for spouses with no participation requirement.

• For employee amounts over **$20,000** and spouse amounts over **$10,000**:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages

• Employee 18-69

• Spouse 18-69

• Children under age 26

Benefit-eligible employees, working at least **26** hours or more weekly, with at least **0** days of continuous employment by the date of the enrollment. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Class I

All full-time and part-time benefit-eligible employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

Class II

A Class I primary insured is eligible for Class II coverage if he:

• Was previously insured under Class I; and

• Is no longer employed by the policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate. Only dependents covered under Class I coverage are eligible for continued coverage under Class II. Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

Spouse Coverage Available

Spouse coverage is available up to 100% of the employee's face amount, subject to the minimum face amount of $5,000. To apply for spouse coverage, the employee must also apply. To be eligible, the spouse must not be disabled or unable to work at the time of application.

If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and be limited to face amounts between $5,000 and $30,000.

Dependent Children Coverage at No Additional Charge

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. Children-only coverage is not available.

Waiver of Premium Benefit

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

Successor Insured Benefit

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Termination of an Employee's Insurance

An employee's insurance will terminate on the earliest of the following:

1. The date the plan is terminated, for Class I insureds;
2. The 31st day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Group Critical Illness Benefits

Initial Diagnosis – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Critical Illnesses Covered Under Plan	Percentage of Face Amount
Cancer (Internal or Invasive)	100%
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer	25%
Coronary Artery Bypass Surgery+	25%
Additional Benefits Covered Under Plan	**Percentage of Face Amount**
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Skin Cancer	$250 (once per calendar year/insured)
Transient Ischemic Attack (TIA)	$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Additional Diagnosis - Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence Benefit - Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

+If the claim is for a cancer diagnosis, the insured must be treatment-free from cancer for at least 12 months and must be in complete remission before the date of a subsequent cancer diagnosis.

Health Screening Benefit- (Employee & Spouse only) $100 per calendar year

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. The covered health screening tests include, but are not limited to, the following:

- Stress test on a bicycle or treadmill
- 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
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- DNA stool analysis
- Spiral CT screening for lung cancer
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL

Heart Event Rider

Covered Surgeries and Procedures	Percentage of Maximum Benefit
Category 1- Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%
Mitral valve replacement or repair	100%
Aortic valve replacement or repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Category 2- Invasive Procedures & Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon Valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent implantation	10%
Cardiac catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

OPTIONAL BENEFITS RIDER

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if you are diagnosed with one of the conditions listed.

Limitations and Exclusions

(Applies to all riders unless otherwise noted)

Cancer Diagnosis Limitation

Benefits are payable for Cancer and/or Non-Invasive Cancer as long as the Insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
  - o War (declared or undeclared) or military conflicts. This does not include terrorism.
  - o Insurrection or riot.
  - o Civil commotion or civil state of belligerence.
- **Illegal substance abuse**, which includes the following:
  - o Abuse of legally-obtained prescription medication.
  - o Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

Terms You Need to Know

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a bone marrow transplant (stem cell transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
  - The uncontrolled growth and spread of malignant cells, and
  - The invasion of distant tissue.
  - A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology.
  - Cancer (internal or invasive) also includes:
  - Melanoma that is Clark's level III or higher or Breslow depth equal to or greater than 0.77mm,
  - Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
  - Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
  - Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
  - Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

- The following are not considered internal or invasive cancers:
  - Pre-malignant tumors or polyps
  - Carcinomas in situ
  - Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
  - Melanoma in situ
  - Melanoma that is diagnosed as
  - Clark's level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM staging

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this plan, a non-invasive cancer is:

- Internal carcinoma in situ
- Myelodysplastic syndrome – RA (refractory anemia)
- Myelodysplastic syndrome – RARS (refractory anemia with ring sideroblasts)

Skin cancer, as defined in this plan, is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a cancer that forms in the tissues of the skin.

The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in situ

Melanoma that is diagnosed as

- o Clark's level I or II,
- o Breslow depth less than 0.77mm, or
- o Stage 1A melanomas under TNM staging

These conditions are not payable under the cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, or Skin Cancer must be diagnosed in one of two ways:

1. Pathological diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system.

2. Clinical diagnosis is based only on the study of symptoms. The company will accept a clinical diagno sis only if:

- o A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
- o Medical evidence exists to support the diagnosis,
- o A doctor is treating the insured for cancer or carcinoma in situ, or
- o A positive diagnosis cannot otherwise be made by a doctor without jeopardizing the life of the claimant.

If a pathological or clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant)**: The date the surgery occurs.
- **Cancer:** The day tissue specimens, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical diagnosis is the date the diagnosis is communicated to the insured. (Diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- **Coronary Artery Bypass Surgery**: The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial infarction) definition.
- **Kidney Failure (End-Stage Renal Failure)**: The date a doctor recommends that an insured begin renal dialysis.
- **Major Organ Transplant**: The date the surgery occurs.

• **Non-Invasive Cancer:** The day tissue specimens, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical diagnosis is the date the diagnosis is communicated to the insured. (Diagnosis of cancer and/or carcinoma in situ is based on such specimens).

• **Skin Cancer:** The date the skin biopsy samples are taken for microscopic examination.

• **Stroke**: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).

• **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the **Sudden Cardiac Arrest** definition).

• **Transient Ischemic Attack (TIA)**: The date the transient ischemic attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).

• **Coma**: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.

• **Loss of Sight, Speech, or Hearing**: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.

• **Paralysis:** The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.

• **Severe Burn**: The date the burn takes place.

Dependent means the primary insured's spouse or dependent child. **Spouse** is the primary insured's legal wife or husband who is listed on his application. **Dependent Children** are the primary insured's or his spouse's natural children, foster children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26.

However, there is an exception to the age 26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must provide us with proof of this incapacity and dependency within 31 days following the dependent child's 26th birthday, but not more frequently than annually.

Newborn, adopted and foster children are equally considered under this plan. A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we:

• Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.

• Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

• Will not dis-enroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this plan for the particular critical illness being diagnosed. Diagnosis must be made and treatment must be received in the United States or its territories.

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A doctor does not include the primary insured or any of his family members. For the purposes of this definition, family member includes the primary insured's spouse as well as the following members of his immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother
- Step-Family Members and Family-Members-in-law

Employee is a person who meets eligibility requirements under Section I – Eligibility, Effective Date, and Termination, and who is covered under this plan. The employee is the primary insured under this plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary artery disease or acute coronary syndrome. Heart attack (myocardial infarction) does not include the following:

- Any other disease or injury involving the cardiovascular system
- Cardiac arrest not caused by a heart attack (myocardial infarction)

Diagnosis of a heart attack (myocardial infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.) Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function. Kidney failure (end-stage renal failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital heart disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary artery disease.
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.

to chronic inflammation.

- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

A major organ transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Pathologist is a doctor who is licensed:

- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy.

A pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include the following:

- Transient ischemic attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden cardiac arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:

o During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or

o After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant hypertension
- Brain aneurysm
- Arteriovenous malformation

The TIA must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- Encephalitis, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- Epilepsy, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- Hyperglycemia, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- Hypoglycemia, which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- Meningitis, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease, which is a disease that affects the retina of the eye;
- Optic nerve disease, which is a disease that affects the optic nerve of the eye; or
- Hypoxia, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease, which is a progressive mental deterioration due to generalized degeneration of the brain;

• Arteriovenous malformation, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

• Alport syndrome, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;

• Autoimmune inner ear disease, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;

• Chicken pox, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;

• Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;

• Goldenhar syndrome, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;

• Meniere's disease, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;

• Meningitis, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or

• Mumps, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

• Amyotrophic lateral sclerosis, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;

• Cerebral palsy, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;

• Parkinson's disease, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or

• Poliomyelitis, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The diagnosis of paralysis must be supported by neurological evidence.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

• Be a full-thickness or third-degree burn, as determined by a doctor. A full-thickness burn or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.

Covered Heart Procedure is one of the Category I or Category II procedures defined below:

Category I – Specified Surgeries of the Heart

Specified surgeries of the heart (open heart surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

• **Coronary Artery Bypass Surgery (also Coronary Artery Bypass Graft Surgery or Bypass Surgery)** is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.

o **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart-lung machine.

o **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries. A blood vessel is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this rider.

• Mitral Valve Replacement or Repair is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.

• Aortic Valve Replacement or Repair is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.

• Surgical Treatment of Abdominal Aortic Aneurysm involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

• **AngioJet Clot Busting** clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.

• **Balloon Angioplasty (or Balloon Valvuloplasty)** opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

• **Laser Angioplasty** uses a laser tip to burn/break down plaque in the clogged blood vessel.

• **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

• **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.

• **Cardiac Catheterization (also Heart Catheterization)** is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

• **Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD**) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

• **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

• **Valvular Heart Disease** is a disease characterized by damage to or a defect in one of the four heart valves.

Optional Benefits Rider

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:

• Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;

• Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

• Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;

• Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;

• Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;

• Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and

• Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Date of Diagnosis is defined as follows:

• **Advanced Alzheimer's Disease:** The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.

• **Advanced Parkinson's Disease:** The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.

• **Benign Brain Tumor:** The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific

Advanced Alzheimer's Disease means Alzheimer's disease that causes the Insured to be incapacitated. Alzheimer's disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease. To be incapacitated due to Alzheimer's disease, the Insured must:

• Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; and

• Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's disease that causes the Insured to be incapacitated. Parkinson's disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease. To be incapacitated due to Parkinson's disease, the insured must:

Exhibit at least two of the following clinical manifestations:

- Muscle rigidity
- Tremor
- Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a cancer. Benign brain tumor must be caused by multiple endocrine neoplasia, neurofibromatosis, or Von Hippel-Lindau syndrome.

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Notices

This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions.

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. AGC1600272 IV (3/16)

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.

Toll Free ~ 800.433.3036

Website ~ aflacgroupinsurance.com

Columbia, South Carolina

AGCM321C-NC-BK IV (1/17)

Aflac®

We've got you under our wing.®

Aflac Critical Illness - with Cancer

Employee & Spouse Rates (24 pay deductions)

NONTOBACCO - Employee										
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18-29	$ 3.20	$ 4.87	$ 6.53	$ 8.20	$ 9.86	$ 11.52	$ 13.19	$ 14.85	$ 16.52	$ 18.18
30-39	$ 4.13	$ 6.72	$ 9.32	$ 11.91	$ 14.50	$ 17.09	$ 19.68	$ 22.28	$ 24.87	$ 27.46
40-49	$ 7.03	$ 12.53	$ 18.02	$ 23.52	$ 29.01	$ 34.51	$ 40.00	$ 45.49	$ 50.99	$ 56.48
50-59	$ 11.64	$ 21.75	$ 31.85	$ 41.95	$ 52.06	$ 62.16	$ 72.26	$ 82.37	$ 92.47	$ 102.57
60+	$ 20.17	$ 38.81	$ 57.44	$ 76.07	$ 94.70	$ 113.34	$ 131.97	$ 150.60	$ 169.23	$ 187.87

NONTOBACCO - Spouse						
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$ 3.20	$ 4.87	$ 6.53	$ 8.20	$ 9.86	$ 11.52
30-39	$ 4.13	$ 6.72	$ 9.32	$ 11.91	$ 14.50	$ 17.09
40-49	$ 7.03	$ 12.53	$ 18.02	$ 23.52	$ 29.01	$ 34.51
50-59	$ 11.64	$ 21.75	$ 31.85	$ 41.95	$ 52.06	$ 62.16
60+	$ 20.17	$ 38.81	$ 57.44	$ 76.07	$ 94.70	$ 113.34

TOBACCO - Employee										
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18-29	$ 3.99	$ 6.44	$ 8.88	$ 11.33	$ 13.78	$ 16.23	$ 18.67	$ 21.12	$ 23.57	$ 26.02
30-39	$ 5.92	$ 10.29	$ 14.67	$ 19.05	$ 23.42	$ 27.80	$ 32.17	$ 36.55	$ 40.93	$ 45.30
40-49	$ 10.88	$ 20.21	$ 29.55	$ 38.89	$ 48.22	$ 57.56	$ 66.90	$ 76.24	$ 85.57	$ 94.91
50-59	$ 18.94	$ 36.34	$ 53.73	$ 71.13	$ 88.53	$ 105.93	$ 123.32	$ 140.72	$ 158.12	$ 175.52
60+	$ 33.41	$ 65.29	$ 97.16	$ 129.03	$ 160.90	$ 192.78	$ 224.65	$ 256.52	$ 288.39	$ 320.27

TOBACCO - Spouse						
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**
18-29	$ 3.99	$ 6.44	$ 8.88	$ 11.33	$ 13.78	$ 16.23
30-39	$ 5.92	$ 10.29	$ 14.67	$ 19.05	$ 23.42	$ 27.80
40-49	$ 10.88	$ 20.21	$ 29.55	$ 38.89	$ 48.22	$ 57.56
50-59	$ 18.94	$ 36.34	$ 53.73	$ 71.13	$ 88.53	$ 105.93
60+	$ 33.41	$ 65.29	$ 97.16	$ 129.03	$ 160.90	$ 192.78

Base Plan:
-With Cancer Benefit
-$100 Health Screening Benefit
-$250 Skin Cancer Benefit
-With Additional Benefits
(Loss of Sight, Speech, Hearing)
(Coma, Burns, Paralysis)

Riders:
-Optional Benefits Rider (BTAP)
-Heart Rider
-$250 TIA (mini-stroke) Rider

Provisions:
-No Pre-Existing Condition Limitation
-Add'l Separation Waiting Period: 6 Months
-Re-Separation Waiting Period: 6 Months
-Class I/II Portability
-Rate Guarantee: 3 Years

Group Attributes:
-Situs State: NC
-Eligible Lives: 750

Please Note: Premiums shown are accurate as of publication. They are subject to change.

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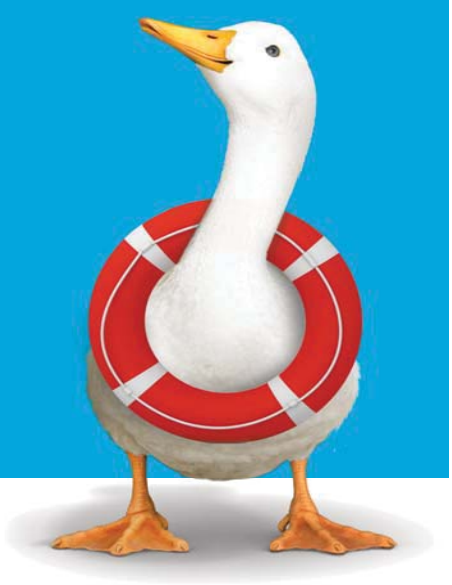
Aflac Value Added Services

NOTE: You will automatically have access to the benefits provided in this summary at no extra cost to you.

Need help with healthcare?

We've got your lifeline.

Introducing Health Advocacy, Medical Bill Saver™ and Telemedicine services, now part of your Aflac plan.



We've enhanced your plan without adding cost.

Now, if you have Aflac Group Critical Illness, Group Accident or Group Hospital Indemnity plans, 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.

SERVICES AVAILABLE AS SOON AS YOUR COVERAGE STARTS

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD when your coverage begins.

Questions? Call **855-423-8585**

DID YOU KNOW?

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.

HealthAdvocate MeMD Aflac

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/Aflac
- 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
- $25.00 per visit!

Questions? Call 855-423-8585

Aflac

Value Added Services
Value Added Services are not available to residents of Idaho. State availability may vary.

Telemedicine
Due to Arkansas state regulations, insureds physically located in Arkansas at the time of a telemedicine session may only receive consultation services from physicians. Physicians are prohibited from providing diagnoses or prescribing drugs to persons located in Arkansas at the time of service.

Medical Bill Saver
Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

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

This offering may not supersede the terms and conditions of any existing contract the client has with Health Advocate. Health Advocate reserves the right to refuse any client group through Aflac if the client group cancels a pre-existing contract with Health Advocate prior to expiration date of the contract.

aflacgroupinsurance.com | 1.800.433.3036

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IV (3/17)

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

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

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1500186 R3

IV (7/16)

AUL Short-Term Disability

Effective Date: July 1, 2017

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 use to kill now disable.[5]

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

1 National Safety Council, Injury Facts, 2003 Edition

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 26 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 in $100 increments. Minimum 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. The benefit duration is 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.

Annual Enrollment
Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions. Current participants 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.

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 apply for portability by calling ***800-553-5318.*** 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).

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.

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

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 Short-Term Disability ~ Benefit Duration (13 weeks)

Monthly Benefit	Premium (24 pay deductions)
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.28
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.53
$1,600	$16.57
$1,700	$17.60
$1,800	$18.64
$1,900	$19.67
$2,000	$20.71

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200

South Portland, ME 04106

Fax: 1.844.287.9499

OneAmerica.claims@customdisability.com

Toll Free: 1.855.517.6365

ONEAMERICA® | AMERICAN UNITED LIFE INSURANCE COMPANY® *a* ONEAMERICA® *company*

AUL Voluntary Long-Term Disability

Effective Date: July 1, 2017

Class Description

All Full-Time Eligible Employees working a minimum of 26 hours per week, electing to participate in the Voluntary Long Term Disability.

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.

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.

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:

Age When Total Disability Begins	Maximum Period Benefits are Payable
Prior to Age 61	5 Years
61	Lesser of SSNRA or 5 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and Over	12 Months

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.

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 maybe 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.

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.

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 apply for portability by calling ***800-553-5318.***

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).

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly 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 certain events or conditions such as but not limited to 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. Additional exclusions and limitations may apply.

Voluntary Long Term Disability	
Benefit Amount	**24 pay deductions**
$500	$3.20
$1,000	$6.40
$1,500	$9.60
$2,000	$12.80

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200

South Portland, ME 04106

Fax: 1.844.287.9499

OneAmerica.claims@customdisability.com

Toll Free: 1.855.517.6365

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

This information is provided as a Benefit Outline. It is not a 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 coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

Lincoln Financial Term Life ~ Basic & Voluntary

Effective Date: July 1, 2017 or when approved by underwriting

(Basic Term Life) - All Full Time Department Heads

Group Term Life Insurance
Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: City of Asheboro

All Full-Time Department Heads

Coverage	**Benefit Amount Employee**	**Benefit Amount Spouse and Dependents**
Life	$40,000	Spouse: $10,000 Child: 14 days to 6 months: $250 Child: 6 months to 26 years: $10,000
Guarantee Issue	$40,000	
AD&D	Will Equal the Life Benefit	N/A
Semi-Monthly Cost	**Employee**	**Spouse and Dependents**
	Your employer pays the cost of your coverage.	$2.12
Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	35% at age 65; An additional 25% of original amount at age 70; An additional 15% of original amount at age 75; Benefits terminate at retirement	Benefits terminate upon Employee's Death
Additional Benefits		
See Understanding Your Benefits Page:	Accelerated Death Benefit Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Conversion	
Enrolling for Coverage	**Employee**	**Spouse or Dependent**
Eligibility:	All employees in an eligible class.	Effective date of coverage will be delayed if Spouse or dependent is in a period of limited activity on policy issue date.

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **CTYASHEBRO**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Should there be a difference between this summary and the policy, the policy will govern.

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Lincoln Financial Group®

Group Term Life Insurance
Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: **City of Asheboro**

All Other Full-Time Employees

Coverage	**Benefit Amount Employee**	**Benefit Amount Spouse and Dependents**
Life	$20,000	Spouse: $10,000 Child: 14 days to 6 months: $250 Child: 6 months to 26 years: $10,000
Guarantee Issue	$20,000	
AD&D	Will Equal the Life Benefit	N/A
Semi-Monthly Cost	**Employee**	**Spouse and Dependents**
	Your employer pays the cost of your coverage.	$2.12
Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	35% at age 65; An additional 25% of original amount at age 70; An additional 15% of original amount at age 75; Benefits terminate at retirement	Benefits terminate upon Employee's Death
Additional Benefits		
See Understanding Your Benefits Page:	Accelerated Death Benefit Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Conversion	
Enrolling for Coverage	**Employee**	**Spouse or Dependent**
Eligibility:	All employees in an eligible class.	Effective date of coverage will be delayed if Spouse or dependent is in a period of limited activity on policy issue date.

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **CTYASHEBRO**	www.LincolnFinancial.com

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Lincoln Financial Group®
You're In Charge®

Voluntary Life Insurance
with Accidental Death and Dismemberment (AD&D)

SUMMARY OF BENEFITS

Sponsored by: **City of Asheboro**

Life Benefit	**Employee**	**Spouse**	**Dependent**
	Employee must elect coverage for Spouse or dependents to be eligible.		
Amount	Choice of $10,000 increments	Choice of $5,000	Age 14 Days to 6 months: $250 6 months to age 26: $10,000 Newborn children to age 14 days are not eligible for a benefit
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$100,000, limited to 5 times your annual salary Employees age 70 and older, maximum benefit is $50,000	$50,000, limited to 50% of employee amount	$10,000
Guarantee Issue for Newly Eligible Employee	$100,000	$50,000	
Current Eligible Employees	You or your Spouse may elect or increase insurance coverage equal to 2 benefit levels on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your Spouse have not been previously declined, withdrawn, or pending for coverage.		

AD&D Benefit	**Employee**	**Spouse**
Amount	Benefit amount equal to the life amount elected by you. Cost included in the schedule.	Same as employee

Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	35% at age 65; Additional 25% of original amount at age 70; Additional 15% of original amount at age 75; Additional 15% of original amount at age 80; Benefits terminate at retirement	35% at Employee Age 65 Benefits terminate at Employee Age 70 or Retirement, whichever occurs first

Eligibility	**Employee**	**Spouse and Dependents**
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Additional Benefits	
See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion
See Definition:	Seat Belt, Airbag, and Common Carrier

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Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Seat Belt, Airbag, and Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Benefit provided to the designated beneficiary upon the death of the insured. The benefit is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 1 year after coverage is effective. May apply if employee contributes toward the premium.
Additional Benefits	
LifeKeys℠	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
TravelConnect℠	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **CTYASHEBRO**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Not for use in New York.

Voluntary Term Life ~ Employee (24 pay deductions)

Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Semi-Monthly RATE	AGE	$ 10,000	$ 20,000	$ 30,000	$ 40,000	$ 50,000	$ 60,000	$ 70,000	$ 80,000	$ 90,000	$ 100,000
0.055	<24	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
0.055	25-29	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
0.060	30-34	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
0.065	35-39	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
0.090	40-44	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
0.140	45-49	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00
0.250	50-54	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$25.00
0.380	55-59	$3.80	$7.60	$11.40	$15.20	$19.00	$22.80	$26.60	$30.40	$34.20	$38.00
0.450	60-64	$4.50	$9.00	$13.50	$18.00	$22.50	$27.00	$31.50	$36.00	$40.50	$45.00
0.790	**65-69**	***$6,500***	***$13,000***	***$19,500***	***$26,000***	***$32,500***	***$39,000***	***$45,500***	***$52,000***	***$58,500***	***$65,000***
		$5.14	*$10.27*	*$15.41*	*$20.54*	*$25.68*	*$30.81*	*$35.95*	*$41.08*	*$46.22*	*$51.35*
1.520	**70-74**	***$4,000***	***$8,000***	***$12,000***	***$16,000***	***$20,000***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$6.08	*$12.16*	*$18.24*	*$24.32*	*$30.40*	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
4.045	**75-79**	***$2,500***	***$5,000***	***$7,500***	***$10,000***	***$12,500***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$10.11	*$20.23*	*$30.34*	*$40.45*	*$50.56*	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
9.230	**80+**	***$1,000***	***$2,000***	***$3,000***	***$4,000***	***$5,000***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$9.23	*$18.46*	*$27.69*	*$36.92*	*$46.15*	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***

- ***Dependent Child(ren) coverage amount is: $10,000 ~ Cost = $1.00 (24 pay deductions)***
- ***Premium covers all dependent children regardless of the number of children***

Voluntary Term Life ~ Spouse (24 pay deductions)

Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on the Employee Age
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Semi-Monthly RATE	AGE	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000	$ 35,000	$ 40,000	$ 45,000	$ 50,000
0.055	<24	$0.28	$0.55	$0.83	$1.10	$1.38	$1.65	$1.93	$2.20	$2.48	$2.75
0.055	25-29	$0.28	$0.55	$0.83	$1.10	$1.38	$1.65	$1.93	$2.20	$2.48	$2.75
0.060	30-34	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
0.065	35-39	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
0.090	40-44	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
0.140	45-49	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00
0.250	50-54	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00	$11.25	$12.50
0.380	55-59	$1.90	$3.80	$5.70	$7.60	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00
0.450	60-64	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25	$22.50
0.790	**65-69**	***$3,250***	***$6,500***	***$9,750***	***$13,000***	***$16,250***	***$19,500***	***$22,750***	***$26,000***	***$29,250***	***$32,500***
		$2.57	*$5.14*	*$7.70*	*$10.27*	*$12.84*	*$15.41*	*$17.97*	*$20.54*	*$23.11*	*$25.68*

- ***Dependent Child(ren) coverage amount is: $10,000 ~ Cost = $1.00 (24 pay deductions)***
- ***Premium covers all dependent children regardless of the number of children***

REMINDERS ABOUT THE TERM LIFE:

BASIC TERM LIFE & AD&D *(Accidental Death & Dismemberment; for Employees only)*

- City of Asheboro pays for Employee coverage
- $40,000 ~ for **Full Time department heads**
- $20,000 ~ for all **other Full Time employees**
- Dependent coverage for **Spouse** is $10,000
- Dependent **Child(ren)** coverage is $250 or $10,000 (depending on age of child when application is completed)
- Cost is $2.12 per pay period for Spouse & Child(ren)

*VOLUNTARY TERM LIFE *(may be subject to completing a Health statement)*

EMPLOYEE

- Voluntary Employee Life coverage amounts from $10,000 to $100,000; limited to 5 times your annual salary
- Current Employees may elect or increase coverage during Annual Enrollments equal to 2 benefit levels without completing a Health Statement
- Accidental Death & Dismemberment applies

SPOUSE

- Voluntary Spouse Life coverage amounts from $5,000 to $50,000; limited to 50% of the employee's amount
- Currently covered Dependent Spouse's may elect or increase coverage during Annual Enrollments equal to 2 benefit levels without completing a Health Statement
- Accidental Death & Dismemberment applies

CHILD(REN)

- Voluntary Child Life coverage amounts are $250 to $10,000; depending on age of child when application is submitted
- Child(ren) are covered through age 26

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

- City of Asheboro Human Resources Department - 336.629.2037
- Lincoln Financial Term Life - 800.423.2765

Texas Life Whole Life Insurance – Solutions 121

Effective date of coverage: July 1, 2017
Common Issue Date (for payroll purposes): August 1, 2017

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.
- Adults covered by both group and individual life insurance replace more of their income upon death than adults having group term alone.[3]
- Term policies are created to last for a finite period of time that will likely end before you die.[4]
- 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.

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 death benefit, 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)
(Policy Form ICC-ULABR-11 or Form Series ULABR-11)

Accelerated Death Benefit due to 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 death benefit 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. (Policy Form ICC07-ULCL-WP-07 or 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).

Sample Rates

The chart below displays examples of SOLUTIONS 121 rates at varying ages for a $50,000 policy. Rates shown below for both non-tobacco and tobacco users, and include the cost for Waiver of Premium and the Accelerated Death Benefit due to Chronic Illness rider.

	Solutions 121			
Age	Face Amount	Monthly Premium Non-Tobacco Chronic Illness, Waiver	Monthly Premium Tobacco Chronic Illness, Waiver	Paid-up Age
20	$50,000	$38.11	$46.96	65
25	$50,000	$43.42	$54.63	65
30	$50,000	$53.45	$67.02	65
35	$50,000	$68.20	$86.49	65
40	$50,000	$91.80	$115.40	65
45	$50,000	$125.43	$162.01	65

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire, as long as you pay premiums due
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit [1]
- 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 on all policies
- Waiver of Premium included for ages 17-59
- If desired, you may apply for higher amounts of coverage by answering additional underwriting questions
- Coverage available for spouse, children and grandchildren[2]

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.

3 LIMRA; Life Insurance Ownership Focus – 2016

4 Maurer, Tim. "Term vs Perm (Life Insurance) In 90 Seconds." Forbes. Forbes Magazine, 3 May 2013. Web. 08 Nov. 2016.

If you have any questions regarding your Texas Life policy, please call 800-283-9233, prompt #2

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

16M419-C 1119 (exp1118)

See the SOLUTIONS brochure for complete details.

Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Continuation of Benefits If you Leave Employment

AFLAC GROUP ACCIDENT AND CRITICAL ILLNESS

When you leave your employment, you may continue your Accident and Critical Illness coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, **please contact Aflac at 800.433.3036.**

AUL SHORT-TERM & LONG-TERM DISABILITY

Once you are covered by 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. **You may contact AUL at 800.553.5318.**

HUMANA CANCER

When you leave your employment, you may continue your cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, **please contact Humana at 800.845.7519.**

LINCOLN FINANCIAL TERM LIFE

Conversion: (applies to both Basic & Voluntary Employee coverage)

If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.

Portability: (applies to Voluntary Employee coverage only)

If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.

To receive information for converting or porting your Term Life plan, please contact Lincoln Financial at 800.423.2765.

MEDCOST HEALTH, DENTAL & VISION

Under the Health, Dental and Vision plans, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following “qualifying events”. If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave 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 may be eligible to continue vision 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. **You may contact Medcost directly at 800.217.5097.**

TEXAS LIFE WHOLE LIFE

When you leave employment you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address. **You may contact Texas Life at 800.283.9233, prompt #2.**

Phone Directory

- Aflac Accident, Hospital Indemnity & Critical Illness - 800.433.3036
- AUL Short & Long Term Disability - 800.553.5318
- City of Asheboro Human Resources Department - 336.629.2037
- Humana Cancer - 800.845.7519
- Lincoln Financial Term Life - 800.423.2765
- Mark III Brokerage, Inc. - 800.532.1044
- Medcost Health/Dental/Vision - 800.217.5097
- RX Benefits/Optum RX - 800.334.8134
- Texas Life Whole Life Solutions 121 - 800.283.9233 ~ prompt #2