City of Monroe

Employee Benefits Booklet

Plan Year: July 1, 2020 - June 30, 2021
Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits

Table of Contents

Pre-Tax Benefits

After-Tax Benefits

For Your Reference

Plan Arranged By:

Mark III
Employee Benefits

* * * * * * * * *NOTICE* * * * * * * * *

The products described in this booklet are part of an Insurance Benefits Plan arranged by Mark III Brokerage for City of Monroe employees working **30 hours** or more per week. The Insurance Benefits Plan allows you to pay for certain insurance premiums before taxes are deducted from your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The Plan Year is July 1, 2020 through June 30, 2021.

All products described in this booklet are deducted on a pre-tax basis **EXCEPT:**

Aflac Critical Illness
The Standard Disability
The Standard Term Life
Boston Mutual Whole Life

If you wish to add or make changes to your insurance coverage(s), please consult a Mark III Enroller during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.

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 premium) 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 Tucker Administrators at 704-525-9666. 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 www.healthcare.gov/sbc-glossary or call 704-525-9666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1500** person / **$4500** family Network providers Doesn't apply to Network physician office visits and Network Diagnostic Testing benefits Coinsurance; copayments; precertification and cost containment penalties; premiums don't count toward deductible.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart titled Common Medical Event for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$3500** person / **$10500** family Network providers	The out-of-pocket limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. **The total out of pocket limit includes the deductible, coinsurance, and copayments.**
What is not included in the out-of-pocket limit?	Premiums, precertification and cost containment penalties, amounts over allowed amount, (balance-billed charges for non-network providers) and health care this plan doesn't cover	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 1-800-824-7406 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. Plans use the term panel, in-network, preferred, or participating for providers in their network. See the chart titled Common Medical Event for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	**No**	You can see a specialist you choose without permission for this plan.

All **copayment** and **coinsurance** costs shown in this chart are 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	$35 copay / visit	Plan only covers Network providers	----------none----------
	Specialist visit	$70 copay / visit	Plan only covers Network providers	----------none----------
	Preventive care/screening/ immunization	No charge, Deductible does not apply	Plan only covers Network Providers	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance Deductible does not apply	Plan only covers Network Providers	No cost sharing limited to tests without surgery (10% with surgery)
	Imaging (CT/PET scans, MRIs)	0% coinsurance Deductible does not apply	Plan only covers Network Providers	No cost sharing limited to tests without surgery (10% with surgery)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or RX Benefits at 800-334-8134	Generic drugs	At pharmacy: $5.00 copay – 30 day supply Mail order: $10.00 copay – 90 day supply	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Preferred brand drugs	At pharmacy: $45.00 copay – 30 day supply Mail order: $90.00 copay – 90 day supply	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Non-preferred brand drugs	At pharmacy: $60.00 copay – 30 day supply Mail order: $120.00 copay – 90 day supply	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Specialty drugs	25% up to a maximum of $100 for a 30 day supply	Coverage for ingredient costs and dispensing fees only.	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 for ambulatory surgery center	Plan only covers Network Providers	----------none----------

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)	
	Physician/surgeon fees	10% coinsurance	Plan only covers Network Providers	----------none----------
If you need immediate medical attention	Emergency room care	**For medical emergency only: $250** Non-emergency medical care is Not Covered	**For medical emergency only: $250** Non-emergency medical care is Not Covered	Non-emergency medical care is Not Covered
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-emergency not covered
	Urgent care	$70 copay Deductible does not apply	Plan only covers Network Providers	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible the semiprivate room rate	Plan only covers Network Providers	Precertification is required. Penalties for failure to get precertification: benefit payments reduced by 20%
	Physician/surgeon fees	10% coinsurance	Plan only covers Network Providers	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Plan only covers Network Providers	
	Inpatient services	10% coinsurance	Plan only covers Network Providers	Precertification is required. Penalties for failure to get precertification: benefit payments reduced by 20%
If you are pregnant	Office visits	$70 copay / visit	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
	Childbirth/delivery professional services	10% coinsurance	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
	Childbirth/delivery facility services	10% coinsurance	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Plan only covers Network Providers	---------none---------
	Rehabilitation services	Occupational Therapy: $35 primary/ $70 specialist copay Deductible does not apply	Plan only covers Network Providers	---------none---------

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)	
		OR Speech Therapy: $35 primary / $70 specialist copay Deductible does not apply **OR** Physical Therapy: $35 primary / $70 specialist copay Deductible does not apply		
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% coinsurance	Plan only covers Network Providers	Precertification required. Penalties for failure to get precertification: benefit payments reduced by 20%
	Durable medical equipment	10% coinsurance	Plan only covers Network Providers	----------none---------
	Hospice services	10% coinsurance	Plan only covers Network Providers	----------none---------
If your child needs dental or eye care	Children's eye exam	100% after $70 copay	Not covered	$150 calendar year maximum
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U. S. if travel is for the sole purpose of obtaining medical services
- Routine Foot care
- Weight loss programs except in cases of morbid obesity

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Private Duty nursing	• Hearing Aids and Hearing Exams

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: US Dept. of Labor, Employee Benefits Security Administration 1-866-444-3272. 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: City of Monroe Human Resources Dept. (704) 282-4506.

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 704 282-4506
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 704 282-4506
[Chinese (中文): 如果需要中文的帮助， □□打□个号□704 282-4506
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 704 282-4506

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

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	$1500
Specialist copayment	$70
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$90
Coinsurance	$1240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2890**

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

The plan's overall deductible	$1500
Specialist copayment	$70
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7390**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$1160
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1521**

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

The plan's overall deductible	$1500
Specialist copayment	$70
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2141**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$988
Copayments	$960
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2034**

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 premium) 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 Tucker Administrators at 704-525-9666. 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 www.healthcare.gov/sbc-glossary or call 704-525-9666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1500** person / **$3000** family Network providers Doesn't apply to Coinsurance; copayments; precertification and cost containment penalties; premiums don't count toward deductible.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart titled Common Medical Event for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$3500** person / **$5000** family Network providers	The out-of-pocket limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. **The total out of pocket limit includes the deductible, coinsurance, and copayments.**
What is not included in the out-of-pocket limit?	Premiums, precertification and cost containment penalties, amounts over allowed amount, (balance-billed charges for non-network providers) and health care this plan doesn't cover	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 1-800-824-7406 for a list of	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

	network providers.	billing). Be aware, your network provider might use an out-of-network provider for some services. Plans use the term panel, in-network, preferred, or participating for providers in their network. See the chart titled Common Medical Event for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	**No**	You can see a specialist you choose without permission for this plan.

All **copayment** and **coinsurance** costs shown in this chart are 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	20% coinsurance after deductible	Plan only covers Network providers	----------none----------
	Specialist visit	20% coinsurance after deductible	Plan only covers Network providers	----------none----------
	Preventive care/screening/ immunization	No charge, Deductible does not apply	Plan only covers Network Providers	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or RX Benefits at 800-334-8134	Generic drugs	20% coinsurance after deductible	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Preferred brand drugs	20% coinsurance after deductible	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Non-preferred brand drugs	20% coinsurance after deductible	Coverage for ingredient costs and dispensing fees only.	----------none----------
	Specialty drugs	20% coinsurance after deductible	Coverage for ingredient costs and dispensing fees only.	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
	Physician/surgeon fees	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
If you need immediate medical attention	Emergency room care	**For medical emergency only:** 20%	**For medical emergency only:** 20% coinsurance after	Non-emergency medical care is Not Covered

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)	
		coinsurance after deductible, Non-emergency medical care is Not Covered	deductible, Non-emergency medical care is Not Covered	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Non-emergency not covered
	Urgent care	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible the semiprivate room rate	Plan only covers Network Providers	Precertification is required. Penalties for failure to get precertification: benefit payments reduced by 20%
	Physician/surgeon fees	20% coinsurance after deductible	Plan only covers Network Providers	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Plan only covers Network Providers	
	Inpatient services	20% coinsurance after deductible	Plan only covers Network Providers	Precertification is required. Penalties for failure to get precertification: benefit payments reduced by 20%
If you are pregnant	Office visits	20% coinsurance after deductible	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
	Childbirth/delivery professional services	20% coinsurance after deductible	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
	Childbirth/delivery facility services	20% coinsurance after deductible	Plan only covers Network Providers	Coverage for dependents other than spouse excluded.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Plan only covers Network Providers	----------none---------
	Rehabilitation services	Occupational Therapy: 20% coinsurance **OR** Speech Therapy: 20% coinsurance **OR** Physical Therapy: 20% coinsurance	Plan only covers Network Providers	----------none---------

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)	
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance after deductible	Plan only covers Network Providers	Precertification is required. Penalties for failure to get precertification: benefit payments reduced by 20%
	Durable medical equipment	20% coinsurance after deductible	Plan only covers Network Providers	----------none---------
	Hospice services	20% coinsurance after deductible	Plan only covers Network Providers	----------none---------
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	Not covered	$150 calendar year maximum
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U. S. if travel is for the sole purpose of obtaining medical services
- Routine Foot care
- Weight loss programs except in cases of morbid obesity

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

- Chiropractic care
- Private Duty nursing
- Hearing Aids and Hearing Exams

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: US Dept. of Labor, Employee Benefits Security Administration 1-866-444-3272. 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: City of Monroe Human Resources Dept. (704) 282-4506.

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 704 282-4506
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 704 282-4506
[Chinese (中文): 如果需要中文的帮助，□□打□个号□704 282-4506
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 704 282-4506

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

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	$1500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$0
Coinsurance	$2000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3560**

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

The plan's overall deductible	$1500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$7390**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$0
Coinsurance	$1437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2992**

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

The plan's overall deductible	$1500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1885**

DISCOUNTED RATES (Participate in Biometrics & PASS)

	Bi-Weekly (26 Pay)
Employee Only	**$14.69**
Employee/Child(ren)	**$68.01**
Employee/Spouse	**$157.82**
Employee/Family	**$301.51**

DISCOUNTED+TREND RATES (Participate in Biometrics & FAIL)

	Bi-Weekly (26 Pay)
Employee Only	**$20.29**
Employee/Child(ren)	**$93.96**
Employee/Spouse	**$218.03**
Employee/Family	**$416.56**

BASE RATES (NOT Participate in Biometrics)

	Bi-Weekly (26 Pay)
Employee Only	**$52.64**
Employee/Child(ren)	**$143.94**
Employee/Spouse	**$333.94**
Employee/Family	**$638.24**

Consumer Driven EPO with HSA DISCOUNTED RATES

	Bi-Weekly (26 Pay)
Employee Only	**$0.00**
Employee/Child(ren)	**$68.01**
Employee/Spouse	**$157.82**
Employee/Family	**$301.51**

For Claims/Customer Service
Please Call: 1-800-347-1232
Website Address: www.tuckeradministrators.com

Flexible Spending Accounts
Frequently Asked Questions

What is a Section 125 Plan?
A Section 125 Plan allows employees to select various employee benefits to match their specific needs. Under IRS Code Section "125", certain insurance premiums can be payroll deducted on a pre-tax basis.

How does a Section 125 Plan help employees save money?
By electing to pay for qualified insurance premiums on a pre-tax basis, dollars are deducted for these elections and taxable payroll is reduced before state, federal and FICA withholding are taken out. In the example below, the employee is saving $120 per month, or $1,440 per year.

	With Plan	Without Plan
Salary (monthly)	$3000	$3000
Less Pre-Taxed Dollars:		
Flexible Spending Account (FSA)	$250	0
Qualified Insurance Premiums	$150	0
Taxable Income	$2600	$3000
Less:		
Taxes (30%)	$780	$900
Net Take Home Pay	$1820	$2100
Less FSA & Insurance Premiums	0	$400
Net After Expenses	$1820	$1700

Who can participate in the Section 125 Plan?
All employees of the City of Monroe who are working 30 hours or more, and who meet policy eligibility requirements, will be able to participate in voluntary benefits. Only employees working 40 hours or more qualify for disability and life insurance paid for by the City.

Newly hired employees are immediately eligible for group benefits. Group benefits include health, dental, disability and term life. If benefits are elected, coverage will begin the first of the month following 30 days of employment.

How do I enroll in the Section 125 Plan or other voluntary benefits?
Enrollment is held on an annual basis in the spring. During enrollment, employees can meet with a Mark III Enroller to review current benefit elections and make changes to their benefits for the upcoming plan year. Any changes made during the enrollment period will become effective July 1st of the upcoming year.

Can I make changes to my benefits during the Plan Year?

Generally you cannot change the elections you have made after the beginning of the Plan Year; however, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "***change in status***" and you make an election change that is consistent with the "change in status." If you need to make a change to your benefits due to a "change in status," **you have 30 days from the date of status change to make appropriate changes.**

Currently, federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment.
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits.
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance.
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.
However, with respect to the Health Flexible Spending Account, you **may not** make a change in your benefit election as the result of a change in status.

What is the affect of Health Care Reform (HCR) on my health plan?

Affected benefits on your health plan include:

- Preventive care and wellness screenings covered at 100% unless the exam results in a diagnosis.
- Dependent children are eligible to age 26 regardless of marriage or student status.
- No limit on lifetime maximum benefit.

Who is considered a dependent?

With the exception of the medical plan's definition, a dependent is considered to be anyone you claim on your taxes as a dependent and meets policy eligibility requirements (i.e. age, student status). Your dependent; however, does not have to be enrolled in your medical plan to be considered a dependent under your voluntary insurance benefits.

What do I need to do if I terminate employment with the City of Monroe?

Please see the section "Continuing Your Benefits".

I have existing voluntary insurance policies that are no longer offered through payroll deduction by the City of Monroe . What can I do if I want to keep these polices?

If you wish to keep an existing policy, you must contact the insurance company directly. You may have the option to continue the plans on a direct bill basis.

Can I still purchase over-the-counter medication with my Wex Health Prepaid FSA Debit Card?

No, due to changes in the IRS regulations, over-the-counter medications are no longer considered qualifying expenses unless prescribed by a doctor. So, for example, if you take cold/flu or allergy medicine, you will need to purchase the medication out-of-pocket and submit a reimbursement claim along with a prescription from your physician.

What happens to the money I have already contributed if I elect to terminate or leave the City?

If you terminate your employment with the City, the "Use It or Lose It" rule will apply. If you do not use all dollars set aside through payroll deduction by your date of termination, you must forfeit that money if you do not elect COBRA. On the other hand, if you have used more money than what you have contributed through payroll deductions, you are not required to pay back the difference.

If you have contributed more money than you have spent in your FSA, you will be offered COBRA for your medical spending account. The balance of your annual election will be your benefit and your monthly COBRA premium will be your current FSA deduction converted to a monthly amount plus a 2% administrative fee. After the current plan year, you will not be able to elect a medical spending account for the next plan under COBRA.

What happens if I shop at an establishment that does not accept my Wex Health Card?

If a business does not accept the Wex Health Prepaid FSA Debit Card, you may pay out-of-pocket and file a paper reimbursement claim with Tucker Administrators.

Tucker Administrators
Health Care Flexible Spending Account

Plan Year: July 1, 2020 - June 30, 2021

- **Medical Spending Account Maximum: $2,750**
- **Medical Spending Minimum: $0**
- **Dependent Care Account Maximum: $5,000**

What is a Flexible Spending Account?

Flexible Spending Accounts allow you to use pre-taxed dollars deducted directly from your paycheck towards health care expenses such as prescription and over-the-counter medication, certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA's), you can save a significant amount of money on your health and day care expenses using a Health Care and/or Dependent Care Flexible Spending Account (FSA).

How does the Health Care FSA Work?

With a Health Care FSA, you must decide on your contribution amount at the beginning of the Plan Year. The amount you designate will be equally divided between pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard copays, prescriptions, office visits, and over-the-counter medications and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

The IRS requires you to forfeit any money that is left in the FSA at the end of the plan year. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money. To help avoid forfeitures, check your balance prior to the end of each plan year.

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax or mail your completed claim form and receipts to Tucker Administrators for reimbursement. Claim forms can be downloaded at **tuckeradministrators.com.**

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, copayments and amounts over the maximum your plan pays, expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement."

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier.
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement.
- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the "Explanation of Benefits" showing the unpaid expenses.
- For reimbursement of expenses not covered under a health care plan: ex: over-the-counter medicine. complete the Health Care Expense claim form and attach itemized bills for the expense.

Claims and proof of expense should be faxed to 704.525.9534 or emailed to tucker@tuckeradministrators.com for processing.

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for that expense claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

Can I use my Health Care FSA for my family's expenses?

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

If I do not have any medical insurance through my company, can I still participate in the Health Care FSA?

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health-related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

Is there anything I have to keep in mind when it comes time to file my taxes?

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Tucker Administrators for reimbursement.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information at tuckeradministrators.com or you can call Tucker Administrator at 1.800.347.1232.

Qualified medical expenses are those expenses paid for medical care as described in Section 213(d) of the Internal Revenue Code. IRS Publication 502, titled "Medical and Dental Expenses", provides more detailed information on eligible expenses. The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1.800.829.3676).

General Questions

What is an FSA?

Provided by your employer, an FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help pay for your out-of-pocket medical expenses and/or dependent day care expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means your take home pay increases!

Will I pay taxes on the money I set aside?

No. FSA contributions and reimbursements are exempt from federal income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

What kind of savings can I realize by participating in this program?

Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

Can I submit expenses I incurred before the beginning of the plan year?

No. Only expenses incurred during the Plan Year and while you are a participant are eligible for reimbursement.

How long do I have to file a claim with Tucker Administrators after the plan year ends?

You have a grace period (90 days) after the end of the Plan Year to submit expenses that were incurred during the plan year.

Can I change the amount of my election(s) in the FSA program during the plan year (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)?

Generally, you *may not* change your FSA elections during the Plan Year; however, you may change during the annual enrollment period for the coming Plan Year.

If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?

You will be reimbursed *only* for expenses incurred prior to your termination date.

Can I view my FSA balances online?

Yes. Visit **tuckeradministrators.com** and login to access claims information and FSA balances online. Once you are logged in, you may view your account balances. If you are new to Tucker Administrators, when you log into the website, you will be asked to create your own user ID and password.

What if I have a question?

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at **tuckeradministrators.com** or you can call Customer Service at **1.800.347.1232**.

How does participating in an FSA save me money?

The following *example* illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

	With FSA	**Without FSA**
Salary	$1000	$1000
Less Pre-Taxed Dollars:		
Health Care Reimbursement	$100	0
Dependent Day Care Reimbursement	$150	0
Taxable Income	$750	$1000
Less:		
Federal Income Tax	$82	$121
State Income Tax	$17.58	$23.44
Social Security	$57.37	$76.50
Net Take Home Pay	$593.05	$779.06
Less Health Care & Dependent Care Expenses	$0	$250
Net After Expenses	$593.05	$529.06

Tax Savings This Pay Period: $63.99
Annual Tax Savings: $63.99 X 26 pay periods = $1,663.74

Maximize the Value of Your Reimbursement Account

Your Health Care FSA dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses.

TUCKER ADMINISTRATORS, Inc.
3800 Arco Corporate Drive, Suite 450
Charlotte, North Carolina 28273-3412
Tel: 704-525-9666 • Fax: 704-525-9534
www.TuckerAdministrators.com
Since 1976
Employee Benefit Consultants, Risk Managers and Administrators

Know Your Health Care FSA Eligible and Ineligible Expenses

Revised April, 2011

Maximize the Value of Your Reimbursement Account

Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses.

Eligible Expenses

BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING
- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS
- Insulin
- Prescription Drugs

OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Tucker Administrators at 704-525-9666.

NOTE: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note or Medical Necessity form your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Tucker Administrators at 704-525-9666.

The IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Insurance Premiums and Interest
- Long Term Care Premiums
- Marriage or Career Counseling
- Personal Trainers
- Sunscreen (spf less than 30)
- Swimming Lessons

Note: This list is not meant to be all-inclusive.

Please Note: The IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, can use your benefits card for these purchases.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiparasitic treatments
- Antiseptics & wound cleansers
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Contraceptives
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care
- Eye care
- Feminine antifungal & anti-itch
- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment
- Hemorrhoidal preps
- Homeopathic remedies
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drop inhalers
- Medicated respiratory treatm & vapor products
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated nasal sprays, drops & inhalers
- Unmedicated vapor product

OTC items that are not medicines or drugs remain eligible for purchase with FSAs. You can use your benefits card for th items.

Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- **Baby Electrolytes and Dehydration**
  Pedialyte, Enfalyte
- **Contraceptives**
  Unmedicated condoms
- **Denture Adhesives, Repair, and Cleansers**
  PoliGrip, Benzodent, Plate Weld, Efferdent
- **Diabetes Testing and Aids**
  Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
  Thermometers, blood pressure monitors, cholesterol testing
- **Ear Care**
  Unmedicated ear drops, syringes, ear wax removal
- **Elastics/Athletic Treatments**
  ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
  Contact lens care
- **Family Planning**
  Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
  Band Aid, 3M Nexcare, non-sport tapes
- **Foot Care Treatment**
  Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles
- **Glucosamine &/or Chondroitin**
  Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements
- **Hearing Aid/Medical Batterie**
- **Home Health Care (limited segments)**
  Ostomy, walking aids, decubi pressure relief, enteral/parent feeding supplies, patient liftin aids, orthopedic braces/supp splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedic

  wound care, wheel chairs
- **Incontinence Products**
  Attends, Depend, GoodNites juvenile incontinence, Prevail
- **Prenatal Vitamins**
  Stuart Prenatal, Nature's Boun Prenatal Vitamins
- **Reading Glasses and Maintenance Accessories**

Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year. Keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles	
(medical and dental)	$ _____
Benefit percentage/co-insurance	
(The amount NOT paid by your insurance)	$ _____
Amounts paid over plan limits	
Over reasonable and customary allowance	$ _____
Over psychiatric limits	$ _____
Over private room allowance	$ _____
Expenses NOT covered by your insurance plan	
Copays	$ _____
Prescription drugs	$ _____
Vision care	$ _____
Hearing expenses	$ _____
Psychiatric care	$ _____
Dental and orthodontic care	$ _____
Assistance for the handicapped	$ _____
Therapy/treatments	$ _____
Physician's fees/services	$ _____
Medical equipment	$ _____
Miscellaneous charges	$ _____
My out-of-pocket health care	
(expenses last year)	$ _____

Wex Health Prepaid Flex Debit Card

Not just any FSA – We offer Wex Health™!

Your FSA comes with the Wex Health Prepaid Flex Debit Card, which is loaded with the value of your annual FSA election amount. Using the flex debit card helps you keep cash in your wallet. You'll never "pay twice" with the flex debit card – first from your paycheck into your FSA and then again at time of purchase. Most importantly, you will not have to wait to get a check in the mail. You can check balances or account details anytime – online or with a quick phone call.

You can use the flex debit card to pay for eligible medical expenses such as:

- Covered prescription and doctor copayments and deductibles
- LASIK surgery and eyeglasses
- Out-of-pocket dentist or other provider fees
- Mail-order and online prescription copayments and deductibles
- Health plan deductibles and coinsurance
- Orthodontics

Simply swipe your flex debit card and the amount of your eligible expense will be automatically deducted from your account. **(DON'T FORGET! Always save your receipts for FSA purchases made with the flex debit card because IRS guidelines require it and you may be asked to submit receipts to verify that your expenses comply with IRS guidelines.)**

There is another great reason to sign up for an FSA. IRS rules mean fewer receipt requests for eligible items purchased at participating pharmacies, discount stores, department stores, and supermarkets that can identify FSA-eligible items at checkout. You will be able to purchase the FSA-eligible items on your flex debit card and will be asked for a different form of payment for non-eligible items. In most cases, no receipts will be needed to verify the eligibility of FSA-eligible purchases at participating stores! See Tucker's website or contact them for a list of participating stores.

PARTICIPANT FREQUENTLY ASKED QUESTIONS AND ANSWERS

Question: IS THERE ANY RISK IN PRE-TAXING HEALTH PREMIUMS?

Answer: While participation in the premium conversion portion of the Plan can save employees around 30% on their premiums, they may not change "elections or coverage" during the Plan Year without a "change in their family status." Examples of status change would include, birth, death, marriage, divorce, adoption, loss of dependent eligibility for health insurance, change in spouse employment, change in hours from part-time to full-time (or vice-versa) or termination. Any requested change must be consistent with the status change. Unless you know of a change in your coverage that does not fall into one of the above examples of a status change, the premium conversion will allow employees tax relief on their health premiums.

Question: IS THERE ANY RISK TO AN EMPLOYEE BY PARTICIPATING IN A MEDICAL SPENDING ACCOUNT OR A DEPENDENT CARE ACCOUNT?

Answer:
Changes in elections for dependent care expenses may be made if there is a status change during the Plan Year (example: birth of a new baby). However, you may not change your elections for a Medical Spending Account during the Plan Year. Contributions are treated on a "use it or lose it" basis. If you do not incur expenses during the Plan Year for reimbursement, you will lose it. Therefore, the key to participation is to be conservative.

Question: I PAID FOR AN ELIGIBLE ITEM, AND DID NOT USE MY WEX HEALTH CARD. HOW AM I REIMBURSED?

Answer:
(a) Please have your requests for reimbursement to Tucker Administrators by Wednesday before the Friday night update to make sure your claim is processed in a timely manner. The reimbursement will be deposited into your bank account the first part of the following week.
(b) Make sure the claim form is signed when submitting a request for reimbursement. Claim forms are available from the Human Resources Department or on-line at www.tuckeradministrators.com, then click on Forms.
(c) Please attach all back up documentation to your claim form. Make sure that the original date of service appears on your documentation. Balance due statements and paid on account receipts usually do not contain the original date of service; therefore, you may need to include additional documentation to show when the service was incurred.
(d) Some of the acceptable documentation for Medical Spending Accounts would include the following:

Explanation of Benefit from health plans
Walk out statements from health providers
Copies of RX receipts

Note: Itemized cash register receipts would be acceptable documentation for contact lens solution or over the counter items that are not medicines or drugs.

(e) Remember, you may submit claims for yourself and any dependent family members. You may submit claims for deductibles, coinsurance and office copays for your spouse's health insurance as long as those expenses have not been reimbursed by another 125 Medical Spending Account or claimed for income tax purposes.
(f) If you are submitting claims for dependent care reimbursement, please include the name, address and tax ID or Social Security number of your daycare provider. Daycare reimbursement is made after the service has been rendered. You may send your claims directly to Tucker Administrators at the following address:

Tucker Administrators, Inc.
3800 Arco Corporate Drive, Suite 450
Charlotte, NC 28273
Ph: 1.800.347.1232
Fax: 704.525.9534

Question: HOW WILL I KNOW WHEN TO SUBMIT A RECEIPT OR BACKUP DOCUMENTATION?

Answer:
When you use your flex debit card and the purchase amount or vendor is not automatically approved, a letter will be generated and sent to your home. This letter will be requesting a copy of the receipt, walk out statement, or other approved documentation showing the purchase to be eligible for the FSA plan. Mail or fax a copy of the documentation to Tucker Administrators using the Flex Debit Card Receipt Form found on our website at www.tuckeradministrators.com, and click on Forms.

So, sign up today, and let the savings begin! Look for additional information about the flex debit card in your enrollment materials. If you have any questions concerning your Plan, **please feel free to contact Tommy Bartz at 704-227-3902.**

Question: HOW DO I ACCESS MY BALANCE ONLINE?

Answer:
To access your Wex Health pre-paid debit card balance, you will need to register on the my wex health website. The address is: https://my.wexhealthcard.com.
My wex health page has an area for first time users. Click on the area that says "Please Register" and follow the instructions. The Member ID is 17 digits long 84230001 plus your Social Security Number (without punctuation).

After you have successfully logged into mybenny.com you will have the ability to:
- View All Transaction Activity for your account
- Print out your own Cardholder Statement, showing all transaction activity
- Update your email address via Cardholder Profile

To log into the Wex Health website, visit, https://my.wexhealthcard.com

Tucker Administrators
Dependent Care Flexible Spending Account

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent. **The Dependent Care FSA creates tax savings on up to $5,000 of daycare expenses.** That can mean $1,500 in tax savings, enough to pay for weeks of eligible child or adult daycare!

How Does a Dependent Care FSA work?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each Plan Year is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax…which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the Plan Year. You can access balance information online via tuckeradministrators.com.

Am I eligible to use the Dependent Care FSA?

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed.
- You are a single parent.
- Your spouse is a full-time student at least five months during the year while you are working.
- Your spouse is physically or mentally unable to provide his/her own care.
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Who is an eligible dependent?

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age.
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself.
- Is your spouse who is physically or mentally incapable of caring for himself or herself.
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

What expenses are covered?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attend school full-time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In-home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

Is there anything I have to keep in mind when it comes time to file my taxes?

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return. If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit ($3,000 for one dependent or $6,000 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA. You may wish to consult your tax advisor to see if the Flexible Spending Account or the tax credit will be more advantageous to your family.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care Claim Form to Tucker Administrators with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction at which time you will receive reimbursement.

Can I pay my in-home daycare provider through the Dependent Care FSA?

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider's home or a daycare center. Receipts for the expenses and the caregiver's tax ID number or Social Security number must be provided.

I'm divorced; my ex-spouse claims our child as a deduction for tax purposes. I pay for child care. Can I use the Dependent Care FSA?

If your child resides with you most of the year, you can use the Dependent Care Account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

If I have a question about my account, what should I do?

If you have any questions, you can call Tucker Administrators Customer Service at 1.800.347.1232.

Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities*

Day Care Center / Nursery School $ _____

Family Day Care / Adult Day Care Centers** $ _____

Wages paid to a nanny or in-home care provider*** $ _____

* The facility must follow all local and state laws.

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

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS $ _____

TOTAL ESTIMATED DEPENDENT CARE EXPENSES $ _____

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

FAX CLAIMS AND PROOF OF EXPENSE TO 704.525.9534 OR EMAIL TO
tucker@tuckeradministrators.com FOR PROCESSING.
(PLEASE KEEP YOUR ORIGINALS)

Tucker Administrators, Inc.
3800 Arco Corporate Dr., Suite 450
Charlotte, NC 28273
Telephone: 800.347.1232
Fax: 704.525.9534
www.tuckeradministrators.com

Dental Plan

Effective Date: July 1, 2020

SCHEDULE OF DENTAL BENEFITS

Maximum Lifetime Benefit for Orthodontia Services:	$4,000 Per Covered Person
Maximum Calendar Year Benefit for Preventive, Basic and Major Services:	$2,000 Per Covered Person

Deductible Amount

Accumulation Period - Calendar Year	
Individual Deductible:	$50
(applies to all services except Orthodontia Services)	

Benefit Percentage

Preventive Services:	100% After $50 deductible
Basic Services:	80% After $50 deductible
Major Services:	50% After $50 deductible
Orthodontia Services:	60% No deductible

(services for covered dependent children up to age 26)

***12 month waiting period applies to Major Services and Orthodontia Services**

Please refer to your Dental Summary Plan Description Booklet for a full explanation of your benefits.

Bi-Weekly (26 Pay) Rates

Employee Only	**$20.39**
Employee/Child(ren)	**$37.56**
Employee/Spouse	**$37.83**
Employee/Family	**$64.89**

Superior Vision Plans - Full Coverage & Materials Only

Exam & Materials Plan	
Co-Pays	
Exam	$10
Materials[1]	$25
Contact Lens Fitting	$25
Semi-Monthly Premiums	
Emp. only	$4.49
Emp. + spouse	$8.90
Emp. + children	$8.71
Emp. + family	$13.25
Services/Frequency	
Exam	12 months
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Materials Only Plan	
Co-Pays	
Exam	N/A
Materials[1]	$25
Contact Lens Fitting	$25
Semi-Monthly Premiums	
Emp. only	$3.10
Emp. + spouse	$6.13
Emp. + children	$5.99
Emp. + family	$9.13
Services/Frequency	
Exam	N/A
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Benefits through Superior National Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam (MD)	Covered in full	Up to $44	N/A	N/A
Exam (OD)	Covered in full	Up to $39	N/A	N/A
Frames	$125 retail allowance	Up to $64	$125 retail allowance	Up to $64
Contact Lens Fitting (standard[2])	Covered in full	Not covered	Covered in full	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance	Not covered	$50 retail allowance	Not covered
Lenses (standard) per pair				
Single Vision	Covered in full	Up to $34	Covered in full	Up to $34
Bifocal	Covered in full	Up to $48	Covered in full	Up to $48
Trifocal	Covered in full	Up to $64	Covered in full	Up to $64
Progressive lens upgrade	See description[3]	Up to $64	See description[3]	Up to $64
Contact Lenses[4]	$120 retail allowance	Up to $100	$120 retail allowance	Up to $100

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *See your benefits materials for definitions of standard and specialty contact lens fittings*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

[5] *Discounts and maximums may vary by lens type. Please check with your provider.*

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any question

North Carolina residents: Please contact our customer service department if you are unable to secure a timely (at least 30 days) appointment with your provider or need assistance finding a provider within a reasonable distance (30 miles) of your residence. Adjustments to your benefits may be available.

Superior Vision Services, Inc. P.O. Box 967 Rancho Co
The Superior Vision Plan is underwritten by National Guardian Life Insurance
The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life
NVIGRP 5-07 0716-BSv4/NC

Allstate Benefits Group Cancer Plan

Effective Date: July 1, 2020

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

Meeting Your Needs:

Our cancer coverage can help offer you and your family member financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It can help protect you and your family 24 hours a day, seven days a week. Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse and dependent children. This valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive benefits that help pay for treatment, hospital stays, transportation, and much more!

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Group Voluntary Cancer Supplemental Insurance can help offset some of the expenses your health insurance may not cover, so you can focus on getting well.

Eligibility - Family members eligible for coverage include you, your spouse or domestic partner and children.

**Employee only*
***List of covered diseases on the following page*

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A $100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to: 1. a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2. a hospital that does not charge for the services it provides(charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery**

Up to a $3,000 benefit will be paid when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; Allstate Benefits pays the amount for the procedure with the greatest benefit. Allstate Benefits pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

- ***Second Opinion***

A $400 benefit will be paid for a second surgical opinion, if physician recommends surgery for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

- ***Physical or Speech Therapy***

A $50 benefit will be paid per day, for physical or speech therapy for restoration of normal body function.

- ***Anesthesia***

25% of the surgery benefit will be paid for anesthesia.

- ***Ambulatory Surgical Center***

A $500 benefit will be paid for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.

- ***Radiation/Chemotherapy for Cancer***

Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid per 12 month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision.

Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period.

- ***Anti-Nausea Benefit***

Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

- ***Inpatient Drugs and Medicine***

A $25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

- ***Hematological Drugs***

Up to a $200 (Low and Mid) or $400 (High) benefit will be paid per calendar year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

- ***Medical Imaging***

Actual cost up to a $500 (Low and Mid) or $1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to one payment per calendar year per covered person.

- ***Private Duty Nursing Services***

A $100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least eight hours of attendance during a 24 hour period. These services must be required and authorized by a physician and must be provided by a nurse.

- ***New or Experimental Treatment***

Actual charges up to a $5,000 benefit will be paid per 12 month period for new or experimental treatment. New or Experimental Treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician, and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

- ***Blood, Plasma, and Platelets***

Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid per 12 month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges); processing and procurement costs; and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

- ***Physician's Attendance***

A $50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

- ***At Home Nursing***

A $100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

- ***Prosthesis***

Up to a $2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

- ***Hair Prosthesis***

A $25 benefit will be paid every two years, for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis

Up to a $50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

- ***Ambulance***

A $100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

- ***Hospice Care***

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live six months or less and the attending physician has approved services: 1. Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or 2. Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

- ***Extended Care Facility***

A $100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

- ***Outpatient Lodging***

A $50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits during treatment, up to the maximum $2,000 per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

- ***Non-Local Transportation***

$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment visits to a physician's office or clinic, or for services other than actual treatment.

- ***Family Member Lodging and Transportation***

Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment. 1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement. 2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

- ***Waiver of Premium (employee only)***

If, while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

- ***Bone Marrow or Stem Cell Transplant****

A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person. 1. A transplant which is other than non-autologous. 2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia. 3. A transplant which is non-autologous for the treatment of Leukemia.

***This benefit is payable only once per covered person per calendar year.**

Additional Benefit

Wellness

A $100 benefit will be paid per calendar year for one of the following wellness tests: biopsy for skin cancer; blood test for triglycerides bone marrow testing; CA15-3 (cancer antigen 15–3 - blood test for breast cancer); CA125 (cancer antigen 125–blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); blood test for colon cancer); chest x-ray; colonoscopy; doppler screening for carotids; doppler screening for peripheral vascular disease; echocardiogram; EKG (electrocardiogram); Flexible sigmoidoscopy; hemocult stool analysis; HPV (human papillomavirus) vaccination; lipid panel (total cholesterol count); mammography, including breast ultrasound; cervical cancer screening; PSA (prostate specific antigen–blood test for prostate cancer); serum protein electrophoresis (test for myeloma); stress test on bike or treadmill; thermography; and ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

****This benefit is not disease-specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**

Issue Ages: 18 and older while actively at work.

Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Optional Benefits

- ***Cancer Initial Diagnosis (First Occurrence)***

A one time benefit of $3,000 (Low and High) or $10,000 (Mid) will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

- ***Intensive Care (Optional for Low and High only)*****

A benefit will be paid for each day for the following types of intensive care confinement:

A. **Hospital Intensive Care Unit Confinement $600*** - This benefit is for hospital intensive care unit confinement for any illness or accident.

B. **Step-Down Hospital Intensive Care Unit Confinement $300***- This benefit is for step-down hospital intensive care unit confinement for any illness or accident.

C. **Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the ambulance benefit in the policy.

***This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a prorata share of the daily benefit is paid.**

Portability Privilege - Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; Allstate Benefits receives a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination; and the request is made for that purpose. No portability coverage will be provided to you if your insurance under the policy terminates due to your failure to make required premium payments.

Pre-Existing Condition - Allstate Benefits does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn, adopted or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A pre-existing Condition is a disease or physical condition for which symptoms medical advice or treatment was recommended or received from a medical professional within the 12 month period prior to the effective date.

Exclusions and Limitations - Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. Allstate Benefits does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; intentional self-inflicted injury; intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

Allstate Benefits Group Cancer Semi-Monthly (24 Pay) Rates

Low Option without Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$10.04
Employee + Child(ren)	$13.86
Employee + Spouse	$15.48
Family	$19.29

Low Option with Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$13.03
Employee + Child(ren)	$18.41
Employee + Spouse	$20.75
Family	$26.12

Mid Option with Cancer Initial Diagnosis

Insureds	24-Pay Rates
Employee	$14.88
Employee + Child(ren)	$21.08
Employee + Spouse	$23.51
Family	$29.70

High Option without Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$15.55
Employee + Child(ren)	$21.83
Employee + Spouse	$23.76
Family	$30.02

High Option with Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$18.54
Employee + Child(ren)	$26.38
Employee + Spouse	$29.03
Family	$36.85

For Radiation/Chemotherapy for Cancer benefit, we do not pay for: any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; treatment planning, consultation or management; the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; or the diagnostic tests related to these treatments; or any devices or supplies including intravenous solutions and needles related to these treatments.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. Your consent is not required for this. Allstate Benefits is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

The coverage is provided by a limited benefit supplemental insurance policy. This material is valid as long as information remains current. Group Cancer and Specified Disease benefits provided by policy GVCP3 or state variations thereof. This brochure highlights some features of the policy, but is not the insurance contract. Only the actual policy provisions control. The policy sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

This information is for use in enrollments which are sitused in North Carolina.

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), the underwriting company and a subsidiary of The Allstate Corporation.

Allstate Benefits
The Workplace Marketer ®
1776 American Heritage Life Drive, Jacksonville, Florida 32224

Customer Care Center: 1.800.521.3535
Customer Claims : 1.800.348.4489
www.allstate.com or AllstateBenefits.com

Aflac Group Accident Plan

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

Coverage may be continued with certain stipulations. See certificate for details.
Accident Benefits – High Option

Complete Fractures		
	Employee Closed Reduction	Spouse/Child Closed Reduction
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 10% 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		
	Employee Closed Reduction	Spouse/Child(ren) Closed Reduction
Hip	$4,000	$3,000
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 dislocates a joint, and tears, severs, 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 within 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* *At least 10%, but not more than 25% of body surface covered* *At least 25%, but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $100 $200 $500 $1,000
Third Degree *Less than 10% of body surface covered* *At least 10%, but not more than 25% of body surface covered* *At least 25%, but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $1,000 $5,000 $10,000 $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* *Resulting in extraction*	 $150 $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 & 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	$12,500	$5,000	$2,500
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 Toe(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.
- Loss of a foot – the foot is cut off at or above the ankle.
- Loss of sight – at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable,
- 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,
- A railroad train which is licensed and operated for passenger service only.
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

LIMITATIONS AND EXCLUSIONS

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.

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.

Group Accident Rates

Type of Coverage	Monthly (24 Pay)
Employee	$8.10
Employee + Spouse	$11.59
Employee + Dependent Child(ren)	$15.45
Employee + Spouse + Dependent Child(ren)	$18.94

Continental American Insurance Company
Columbia, South Carolina
800.433.3036

Aflac Group Critical Illness Plan Without Cancer

Plan Features

- 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 up to $25,000 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).
- Includes an Additional Benefits Rider with benefits for the following:
    - Coma
    - Paralysis
    - Severe burn
    - Loss of sight
    - Loss of hearing
    - Loss of speech
- Includes a Heart Event Rider

Guaranteed-issue coverage is available for all eligible employees. The following options are available:

Up to $10,000 for employees and up to $5,000 for spouses with no participation requirement.

For employee amounts over $10,000 and spouse amounts over $5,000: 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.

Issue Ages

Employee 18-69

Spouse 18-69

Children under age 26

Benefit-eligible employees, working at least **30 hours** or more weekly, with at least 0 days of continuous employment by the date of the enrollment are eligible. 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.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling 50% of the employee amount, not to exceed the $25,000 maximum benefit.

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 is limited to face amounts up to $25,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured.

Children-only coverage is not available.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Group Critical Illness Benefits

First Occurrence Benefit – 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%
Coronary Artery Bypass Surgery+	25%

If diagnosis occurs after age 70, benefits are reduced by 50%.

Additional Occurrence Benefit – We will pay benefits for each different critical illness in the order the events occur. We will pay benefits for any one critical illness once every six months. Therefore, no benefits are payable for each different critical illness after the first unless its date of diagnosis is separated from the prior critical illness by at least six months.

Re-occurrence Benefit - We will pay benefits for the re-occurrence of any Critical Illness once every 12 months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months.

+ Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.

Health Screening Benefit - $100

After the waiting period, an insured may receive a maximum of $100 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains in force.

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:

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

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe burns	100%
Loss of speech	100%
Loss of sight	100%
Loss of hearing	100%

If diagnosis occurs after age 70, benefits are reduced by 50%.

Heart Event Rider

Covered Surgeries and Procedures	Percentage of Face Amount
Category 1	
Coronary artery bypass surgery	100%
Mitral valve replacement or repair	100%
Aortic valve replacement or repair	100%
Surgical treatment of abdominal aortic aneurysm	100%

Category 2**

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%

If diagnosis occurs after age 70, benefits are reduced by 50%.

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

EXCEPTIONS AND REDUCTIONS

If diagnosis occurs after age 70, benefits are reduced by 50%.

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description.

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action.
- Suicide or attempted suicide while sane.
- Illegal activities or participation in an illegal occupation.
- War, whether declared or undeclared or military conflicts, participation in an
- insurrection or riot, civil commotion or state of belligerence.
- Substance abuse; or
- Pre-existing conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the effective date.

No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation and Exceptions

Pre-existing condition means a sickness or physical condition which, within the 12-month period prior to the effective date resulted in the insured receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a Pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a Pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Additional Benefit Rider Exceptions

If diagnosis occurs after age 70, benefits are reduced by 50%.

All limitations and exclusions that apply to the critical illness plan also apply to the rider. The waiting period and pre-existing condition limitation apply from the date the rider is effective.

No benefits will be paid for loss which occurred prior to the effective date of the rider.

Benefits are not payable for loss if these conditions result from another Critical Illness.

The date of diagnosis of a specified critical illness must be separated from the date of diagnosis of a subsequent different critical illness by at least six months.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the rider is in force; and the cause of the illness is not excluded by name or specific description.

Heart Event Rider Exceptions

If diagnosis occurs after age 70, benefits are reduced by 50%.

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium.

Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness.

Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, re-occurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

PRE-EXISTING CONDITIONS EXCEPTION

Pre-existing condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment.

We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition.

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

A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date.

Any benefits for coronary artery bypass surgery denied under the coverage due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

EXCEPTIONS

No benefits will be paid if the specified critical illness is a result of: (a) intentionally self-inflicted injury or action; (b) suicide or attempted suicide while sane or insane; (c) illegal activities or participation in an illegal occupation; (d) war, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) an injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for loss which occurred prior to the effective date of coverage.

Diagnosis must be made and treatment received in the United States.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

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.

Continental American Insurance Company, Columbia, South Carolina.

AGC2000625 EXP 4/21

Aflac Group Critical Illness Without Cancer
Semi-Monthly Rates

NON-TOBACCO Semi-Monthly Premium (includes $100 HSB, 6 Pack, Heart Rider)										
AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.68	$3.60	$4.53	$5.45	$6.38	$7.30	$8.23	$9.15	$10.08	$11.00
30-39	$3.28	$4.80	$6.33	$7.85	$9.38	$10.90	$12.43	$13.95	$15.48	$17.00
40-49	$4.85	$7.95	$11.05	$14.15	$17.25	$20.35	$23.45	$26.55	$29.65	$32.75
50-59	$6.73	$11.70	$16.68	$21.65	$26.63	$31.60	$36.58	$41.55	$46.53	$51.50
60-69	$9.75	$17.75	$25.75	$33.75	$41.75	$49.75	$57.75	$65.75	$73.75	$81.75

NON-TOBACCO Semi-Monthly Premium (includes $100 HSB, 6 Pack, Heart Rider)- Spouse									
AGES	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.68	$3.14	$3.60	$4.06	$4.53	$4.99	$5.45	$5.91	$6.38
30-39	$3.28	$4.04	$4.80	$5.56	$6.33	$7.09	$7.85	$8.61	$9.38
40-49	$4.85	$6.40	$7.95	$9.50	$11.05	$12.60	$14.15	$15.70	$17.25
50-59	$6.73	$9.21	$11.70	$14.19	$16.68	$19.16	$21.65	$24.14	$26.63
60-69	$9.75	$13.75	$17.75	$21.75	$25.75	$29.75	$33.75	$37.75	$41.75

TOBACCO Semi-Monthly Premium (includes $100 HSB, 6 Pack, Heart Rider)										
AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.15	$4.55	$5.95	$7.35	$8.75	$10.15	$11.55	$12.95	$14.35	$15.75
30-39	$4.18	$6.60	$9.03	$11.45	$13.88	$16.30	$18.73	$21.15	$23.58	$26.00
40-49	$7.90	$14.05	$20.20	$26.35	$32.50	$38.65	$44.80	$50.95	$57.10	$63.25
50-59	$11.58	$21.40	$31.23	$41.05	$50.88	$60.70	$70.53	$80.35	$90.18	$100.00
60-69	$17.05	$32.35	$47.65	$62.95	$78.25	$93.55	$108.85	$124.15	$139.45	$154.75

TOBACCO Semi-Monthly Premium (includes $100 HSB, 6 Pack, Heart Rider) - Spouse									
AGES	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.15	$3.85	$4.55	$5.25	$5.95	$6.65	$7.35	$8.05	$8.75
30-39	$4.18	$5.39	$6.60	$7.81	$9.03	$10.24	$11.45	$12.66	$13.88
40-49	$7.90	$10.98	$14.05	$17.13	$20.20	$23.28	$26.35	$29.43	$32.50
50-59	$11.58	$16.49	$21.40	$26.31	$31.23	$36.14	$41.05	$45.96	$50.88
60-69	$17.05	$24.70	$32.35	$40.00	$47.65	$55.30	$62.95	$70.60	$78.25

Aflac.

Continental American Insurance Company
Columbia, South Carolina
800.433.3036

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.

SERVICES AVAILABLE AS SOON AS YOUR COVERAGE STARTS

These three services are now embedded in your group plan. Best of all, you can start using them as soon as your Aflac coverage starts.

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD 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!

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service Providers, and does not own or administer any of the products or services provided by the Value Added Service providers. Each Value-Added Service Provider offers its products and services subject to its own terms, limitations and exclusions. Value Added Services are not available in Idaho or Minnesota. Value Added Services are also not available with group plans underwritten by American Family Life Assurance Company of New York. State availability may vary.

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.

Telemedicine by MeMD

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.

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

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. For groups situsted in California, group coverage is underwritten by Continental American Life Insurance Company.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

The Standard Insurance Company- Disability

Your Choice Voluntary Long Term Disability
Coverage Highlights
City of Monroe

Voluntary Long Term Disability Insurance

Standard Insurance Company has developed this document to provide you with information about the optional insurance coverage you may select through the City of Monroe. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please refer to the Your Choice Group Voluntary Long Term Disability Insurance brochure included in your packet or check with your human resources representative.

Employer Plan Effective Date

The group policy effective date is July 1, 2011.

Eligibility

To become insured, you must be:

- A regular, full-time employee of the City of Monroe, excluding temporary or seasonal employees, full-time members of the armed forces, leased employees or independent contractors
- Actively at work at least 30 hours each week
- A citizen or resident of the United States or Canada

Employee Coverage Effective Date

Please contact your human resources representative for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An eligibility waiting period of the first of the month coinciding with or next following 30 days as an eligible employee
- An evidence of insurability requirement, if applicable
- An active work requirement. This means that if you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one day of active work as an eligible employee.

Benefit Amount

You may select a monthly benefit amount in $100 increments, based on the table and guidelines presented in the Rates section of these Coverage Highlights. The monthly benefit amount must not exceed 60 percent of your monthly earnings.

Plan Maximum Monthly Benefit: 60 percent of predisability earnings

Plan Minimum Monthly Benefit: $100

Benefit Waiting Period

The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. Benefits are not payable during the benefit waiting period. The benefit waiting period options associated with your plan include:

Accidental Injury	Other Disabilities
0 days	7 days
14 days	14 days
30 days	30 days

Preexisting Condition Exclusion

A general description of the preexisting condition exclusion is included in the Your Choice Group Voluntary Long Term Disability Insurance brochure. If you have questions, please check with your human resources representative.

Preexisting Condition Period: The 180-day period just before your insurance becomes effective

Exclusion Period: 12 months

Own Occupation Period

For the plan's definition of disability, as described in your brochure, the own occupation period is the first 24 months for which LTD benefits are paid.

Any Occupation Period

The any occupation period begins at the end of the own occupation period and continues until the end of the maximum benefit period.

Maximum Benefit Period

The maximum period for which benefits are payable is shown in the table below.

If you become disabled before age 62, LTD benefits may continue during disability for 5 years. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

When Benefits End

LTD benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date benefits become payable under any other LTD plan under which you become insured through employment during a period of temporary recovery
- The date you fail to provide proof of continued disability and entitlement to benefits

Rates

Employees can select a monthly LTD benefit ranging from a minimum of $200 to a maximum amount based on how much they earn. Referencing the appropriate attached chart, follow these steps to find the semi-monthly cost for your desired level of monthly LTD benefit and benefit waiting period:

1. Find the maximum LTD benefit by locating the amount of your earnings in either the Annual Earnings or Monthly Earnings column. The LTD benefit amount shown associated with these earnings is the maximum amount you can receive. If your earnings fall between two amounts, you must select the lower amount.
2. Select the desired monthly LTD benefit between the minimum of $200 and the determined maximum amount, making sure not to exceed the maximum for your earnings.
3. In the same row, select the desired benefit waiting period to see the semi-monthly cost for that selection.

If you have questions regarding how to determine your monthly LTD benefit, the benefit waiting period, or the premium payment of your desired benefit, please contact your human resources representative.

Group Insurance Certificate

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Standard Insurance Company.

Employee Semi-Monthly Premiums

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Semi-Monthly Cost (24 Pay Period) Based on Benefit Waiting Period		
			0/7	14/14	30/30
4,000	333	200	4.94	4.14	3.68
6,000	500	300	7.41	6.21	5.52
8,000	667	400	9.88	8.28	7.36
10,000	833	500	12.35	10.35	9.20
12,000	1000	600	14.82	12.42	11.04
14,000	1167	700	17.29	14.49	12.88
16,000	1333	800	19.76	16.56	14.72
18,000	1500	900	22.23	18.63	16.56
20,000	1667	1,000	24.70	20.70	18.40
22,000	1833	1,100	27.17	22.77	20.24
24,000	2000	1,200	29.64	24.84	22.08
26,000	2167	1,300	32.11	26.91	23.92
28,000	2333	1,400	34.58	28.98	25.76
30,000	2500	1,500	37.05	31.05	27.60
32,000	2667	1,600	39.52	33.12	29.44
34,000	2833	1,700	41.99	35.19	31.28
36,000	3000	1,800	44.46	37.26	33.12
38,000	3167	1,900	46.93	39.33	34.96
40,000	3333	2,000	49.40	41.40	36.80
42,000	3500	2,100	51.87	43.47	38.64
44,000	3667	2,200	54.34	45.54	40.48
46,000	3833	2,300	56.81	47.61	42.32
48,000	4000	2,400	59.28	49.68	44.16
50,000	4167	2,500	61.75	51.75	46.00
52,000	4333	2,600	64.22	53.82	47.84
54,000	4500	2,700	66.69	55.89	49.68
56,000	4667	2,800	69.16	57.96	51.52
58,000	4833	2,900	71.63	60.03	53.36
60,000	5000	3,000	74.10	62.10	55.20
62,000	5167	3,100	76.57	64.17	57.04
64,000	5333	3,200	79.04	66.24	58.88
66,000	5500	3,300	81.51	68.31	60.72
68,000	5667	3,400	83.98	70.38	62.56
70,000	5833	3,500	86.45	72.45	64.40
72,000	6000	3,600	88.92	74.52	66.24
74,000	6167	3,700	91.39	76.59	68.08
76,000	6333	3,800	93.86	78.66	69.92
78,000	6500	3,900	96.33	80.73	71.76
80,000	6667	4,000	98.80	82.80	73.60

Employee Semi-Monthly Premiums (Continued)

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Semi-Monthly Cost (24 Pay Period) Based on Benefit Waiting Period		
			0/7	14/14	30/30
82,000	6833	4,100	101.27	84.87	75.44
84,000	7000	4,200	103.74	86.94	77.28
86,000	7167	4,300	106.21	89.01	79.12
88,000	7333	4,400	108.68	91.08	80.96
90,000	7500	4,500	111.15	93.15	82.80
92,000	7667	4,600	113.62	95.22	84.64
94,000	7833	4,700	116.09	97.29	86.48
96,000	8000	4,800	118.56	99.36	88.32
98,000	8167	4,900	121.03	101.43	90.16
100,000	8333	5,000	123.50	103.50	92.00
102,000	8500	5,100	125.97	105.57	93.84
104,000	8667	5,200	128.44	107.64	95.68
106,000	8833	5,300	130.91	109.71	97.52
108,000	9000	5,400	133.38	111.78	99.36
110,000	9167	5,500	135.85	113.85	101.20
112,000	9333	5,600	138.32	115.92	103.04
114,000	9500	5,700	140.79	117.99	104.88
116,000	9667	5,800	143.26	120.06	106.72
118,000	9833	5,900	145.73	122.13	108.56
120,000	10000	6,000	148.20	124.20	110.40
122,000	10167	6,100	150.67	126.27	112.24
124,000	10333	6,200	153.14	128.34	114.08
126,000	10500	6,300	155.61	130.41	115.92
128,000	10667	6,400	158.08	132.48	117.76
130,000	10833	6,500	160.55	134.55	119.60
132,000	11000	6,600	163.02	136.62	121.44
134,000	11167	6,700	165.49	138.69	123.28
136,000	11333	6,800	167.96	140.76	125.12
138,000	11500	6,900	170.43	142.83	126.96
140,000	11667	7,000	172.90	144.90	128.80

Standard Insurance Company
City of Monroe
Group Policy #142653

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's, or his or her dependent's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by City of Monroe, except for the cost of your dependent's insurance, which is paid by you through payroll deduction. Enrollment materials needed to elect coverage will be provided.

Eligibility

Definition of a Member	You are a member if you are a regular employee of City of Monroe and actively working at least 40 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the date you become a member. Your dependents will need to provide acceptable evidence of good health if you elect coverage after initially becoming eligible.

Benefits

Basic Life Coverage Amount	1 times your annual earnings to a maximum of $150,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65, to 45 percent at age 70, to 30 percent at age 75 and to 20 percent at age 80.
Basic Dependents Life Coverage Amount	The Basic Dependents Life coverage amount for your eligible spouse is $5,000. Your spouse is the person to whom you are legally married. The Basic Dependents Life coverage amount for each of your eligible children is $5,000.

Other Basic Life Features and Services

- Accelerated Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Expanded AD&D Package
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D and Basic Dependents Life insurance policy sponsored by City of Monroe. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and City of Monroe may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279D-142653 (3/16)
4794326-33862

Standard Insurance Company
City of Monroe
Group Policy #142653

Group Life and AD&D Insurance

Help protect your loved ones from financial hardship.

Life insurance coverage is designed to help provide financial support and stability to your family should you pass away. Accidental Death & Dismemberment (AD&D) insurance provides an extra layer of protection if you die or become dismembered in an accident.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you are dismembered, become terminally ill or die

About This Coverage

If you take no action, you'll be covered for the basic amount of Life insurance. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

Life Insurance		
How Much Can I Apply For?	For You:	**1** times your annual earnings up to **$150,000**
AD&D Insurance The benefit is paid if you are seriously injured or pass away as a result of a covered accident.		
What Does My AD&D Benefit Provide?	For You:	The AD&D insurance coverage amount matches what you select for Additional Life insurance.

Keep in mind that the amount payable for certain losses is less than 100 percent of the AD&D insurance benefit.

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Additional Features

Your coverage comes with some added features:

	Life Insurance
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How Much Your Coverage Costs

Your Basic Life insurance is paid for by City of Monroe. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ x _____ = _____ ➡ _____

Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

Age (as of July 1)	Your Rate** (per $1,000 of Total Coverage)
All Ages	$0.27

How much Life insurance do you need?
After a serious accident or death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs**.

*Includes a monthly AD&D rate of $0.05 per $1,000 of AD&D benefit.

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Life and AD&D Insurance Eligibility Requirements

To be eligible for coverage, you must be:

- A regular employee of City of Monroe
- Actively working at least 40 hours per week
- Insured for Basic Life insurance through The Standard

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Medical Underwriting Approval for Life Coverage

Required for:

- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements
- Eligible but not insured under the prior life insurance plan

Visit **www.standard.com/mhs** to submit a medical history statement online.

Coverage Effective Date for Life Coverage

To become insured, you must satisfy the eligibility requirements listed in the previous sections, receive medical underwriting approval (if applicable), apply for coverage and agree to pay premium and be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective. If you are not actively at work on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage.

Life and AD&D Age Reductions

Under this plan, your coverage amount reduces to 65 percent at age 65, to 40 percent at age 70, to 25 percent at age 75 and to 10 percent at age 80. If you are age 65 or over, ask your human resources representative or plan administrator for the amount of coverage available.

Life Insurance Waiver of Premium

Your Basic and Additional Life premiums may be waived if you:

- Become totally disabled while insured under this plan
- Are under age 60, and
- Complete a waiting period of 180 days

If these conditions are met, your Basic and Additional Life insurance coverage may continue without cost until age Social Security Normal Retirement Age (SSNRA), provided you give us satisfactory proof that you remain totally disabled.

Life and AD&D Insurance Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Life Insurance Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Life Insurance Exclusions

Subject to state variations, you are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

AD&D Benefits

The amount of the AD&D benefit is equal to the amount payable for your Life benefit on the date of the accident. For all other covered losses, the amount is shown as a percentage of the amount payable for the benefit on the date of the accident. No more than 100 percent of the AD&D benefit will be paid for all losses resulting from one accident.

Any loss must be caused solely and directly by an accident within 365 days of the accident. A certified copy of the death certificate is needed to prove loss of life.

All other losses must be certified by a physician in the appropriate specialty determined by The Standard.

Covered loss:	Percentage of AD&D benefit payable:
Life	100%
One hand or one foot	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%
Quadriplegia	100%

Hemiplegia	50%
Paraplegia	50%

[3] This benefit is not payable if an AD&D benefit is payable for the loss of the entire hand.

Voluntary AD&D Insurance Exclusions

You are not covered for death or dismemberment caused or contributed to by any of the following:

- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Suicide or other intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared), and any substantial armed conflict between organized forces of a military nature
- Voluntary consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy
- The date your Life coverage ends, your AD&D coverage will end as well

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at .

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204
www.standard.com

SI 12506D-ALAA-142653 (3/16)
4794326-33863

Boston Mutual Life Insurance
Employee Life Option (ELOP) Life Plus

BML Whole Life Coverage is effective on the date the application is signed.

GUARANTEED BENEFITS, LEVEL PREMIUMS AND POLICY VALUES
The Employee Life Option is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in whole life insurance with the advantages of cash accumulation at current interest rates. This policy is an endowment at 95 with coverage to age 95.

AFFORDABLE, FLEXIBLE PROTECTION
You choose the amount of insurance or the amount of premium that best suits your needs and budget. All eligible employees and their spouses through age 72 may purchase coverage under the basic plan. Weekly deductions range from $2.00-$30.00 per week.

Insurance is also available for your spouse, unmarried dependent children and grandchildren even if you choose not to buy coverage on yourself.

POLICY VALUES*
As long as premiums are paid, your ELOP Basic Plan offers a guaranteed cash value that can grow over the years. The cash value can be used to supplement retirement income, for emergency cash, as an education fund or to provide a paid-up insurance benefit. While this value can never be less than the guaranteed amount, ELOP gives you the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when your policy is issued is guaranteed for the first year. On each policy anniversary date, you will receive an annual statement outlining your policy's accumulated value and changes in the interest rate, if any.
* *The actual cash value may be decreased by loans or withdrawals.*

CONSTANT COVERAGE
ELOP participants are protected worldwide, 24 hours a day. Your policy is owned by you and supplements any other insurance you may have.

BENEFITS YOU CAN KEEP
Once purchased, your ELOP plan remains in force as long as premiums continue to be paid, and your permanent plan premiums cannot be increased. If you change jobs or retire, as long as you continue to pay premiums, your insurance will remain in force without interruption. Boston Mutual will bill you at home and you may choose from several payment options — annual, semi-annual, quarterly, monthly coupon book or monthly automatic check plan.

ACCIDENTAL DEATH BENEFIT (ADB)
This option could *double or even triple* your ELOP death benefit. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage (up to $100,000). This extra protection is available at affordable rates. Any basic plan participant age 5 years through age 60 is eligible for this benefit.

PAYOR WAIVER OF PREMIUM
This benefit pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy. This benefit is available for issue on policies owned by employees up to and including issue age 55 at a cost of 10% of the basic premium for each policy. This benefit terminates on the policy anniversary on or following the payor's 60th birthday, as long as the payor is not disabled at that time.

QUESTIONS AND ANSWERS

CAN I BUY THIS PLAN ON MY OWN?
No! This plan is available only to employees of companies that provide the convenience of payroll deduction for the ELOP plan. Because your employer has chosen to offer ELOP, you receive the advantages of more liberal underwriting and the convenience of payroll deduction. All of this results in savings that reduce the cost of the policies.

DOES THIS POLICY REPLACE MY PRESENT GROUP INSURANCE?
No! ELOP coverage is independent of and supplements your present group insurance program.

IF I LEAVE MY EMPLOYER WHAT HAPPENS TO MY ELOP PLAN?
You can take the ELOP plan with you when you leave with no change in cost or benefits. We will bill you at home.

WHAT HAPPENS IF I CAN'T PAY MY PREMIUM AS A RESULT OF A LEAVE OF ABSENCE OR TERMINATION FROM MY EMPLOYER?
Your policy includes the "Automatic Premium Loan" provision which will be used to pay your premium at the end of your grace period, provided you have accumulated cash value.

WHAT OPTIONS DOES MY ELOP POLICY PROVIDE AT RETIREMENT?
Depending on how long your policy has been in force, you have the following options: (1) continue your premium payments and value accumulation; (2) opt for a paid-up policy; (3) decide to turn your policy in for its accumulated cash value.

CAN I INCREASE MY COVERAGE IN THE FUTURE?
You may apply for additional coverage in the future if you are actively at work with the employer - sponsored company and will be subject to the ELOP underwriting guidelines.

CAN I TAKE A LOAN ON MY POLICY?
Yes. You may borrow all or part of your loan value at an 8% fixed interest rate.

DOES THE ELOP COVERAGE HAVE A SURRENDER CHARGE?
If you discontinue your plan before the 21st policy year, there will be a surrender charge. The amount of this charge decreases every year. No charge is made if you decide to terminate your coverage after it has been in force for at least 20 years.

WILL ELOP BENEFITS BE PAID FOR SUICIDE?
If suicide occurs during the first two years your policy is in effect, benefits will not be paid, but any premiums paid will be refunded. After two years, benefits will be paid if death is caused by suicide.

CONSIDER....

IF YOU HAVE A FAMILY
The ELOP plan enables you to build a cash reserve for yourself, your spouse and your children for less than 1 hour's pay per week. It is a sound way to protect your family without exceeding your present budget.

IF YOU'RE SINGLE WITH NO DEPENDENTS
For a single working person insurance is the foundation for future financial planning. The longer you wait to buy insurance the more expensive it will be. The flexibility of the ELOP plan enables you to expand your coverage to meet future responsibilities.

IF YOU ARE OLDER AND NEARING RETIREMENT
A lot of obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your ELOP plan can be continued after retirement.

No matter where you are in your life and career, you will benefit from ELOP – Life Insurance that Works for Life.

GUARANTEED ISSUE

Employee: up to $18 per week

Spouse: up to $3/ $5* per week
•Must be able to answer NO to "During the past six months, has your spouse been seen or treated, including testing, in a hospital or any other medical facility, excluding physicians' offices for routine medical care?"

*Employee must purchase $5 in order for the spouse to be eligible for $5

Children: up to $3 per week
•Child must be between ages 15 days and 25 years old to be eligible for coverage.

Grandchildren: up to $3 per week
•Grandchildren must be between ages 15 days and 15 years old to be eligible for coverage.

For questions concerning this policy please contact:

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, MA 02021
(800) 669-2668 • (781) 828-7000
Extension 222 - Customer Service
Web site: www.bostonmutual.com
BOSTON MUTUAL
LIFE INSURANCE COMPANY SINCE 1891
Policy Series ICC13 END-95(ESO) (3/13) and END-95 (ESO) 3/13

Continuing Your Benefits

Upon Termination of Employment

To Continue Your Health and/or Dental Plan

Under the group health and dental plans, you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, you will receive notification from Tucker Administrators with premium and continuation options. Should you have any questions regarding your plans, you may contact Tucker Administrators at 1-800-347-1232.

To Convert Your Term Life Insurance

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact The Standard at 800.378.4668. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.

To Continue Other Policies

You may continue your Aflac Group Accident and/or Group Critical Illness, Allstate Benefits Cancer, and Boston Mutual Whole Life policies by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home.

<u>For more information, contact:</u>

Aflac Insurance Company - 1-800-433-3036

Allstate Benefits - 1-800-521-3535

Boston Mutual - 1-800-669-2668

The Standard Term Life - 1 800-378-4668

Contact Information for Questions and Claims

Aflac Insurance Company

(CAIC is now part of the Aflac family)
P O Box 427
Columbia, SC 29202

Customer Service
1-800-433-3036
csc@caicworksite.com

Allstate Benefits

1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your policy please call:
1-800-521-3535
For questions concerning your claim please call:
1-800-348-4489
or e-mail claimsresearch@allstate.com

Boston Mutual Life Insurance Company

120 Royall Street
Canton, MA 02021
1-877-624-2249
www.bostonmutual.com

Caremark/RxBenefits

P O Box 382377
Birmingham, AL 35238
1-800-334-8134
www.caremark.com

Superior Vision

11101 White Rock Rd, Suite 150
Rancho Cordova, CA 95670
1-800-507-3800
www.superiorvision.com
Non-Network Claims Submission:
PO Box 967
Rancho Cordova, CA 95741

The Standard Insurance Company
Employee Benefits Department
P O Box 2800
Portland, OR 97208
Disability: 1-800-368-2859
Term Life: 1-800-378-4668
Fax: 971-321-8400
www.standard.com

Tucker Administrators, Inc.
3800 Arco Corporate Dr., Suite 450
Charlotte, NC 28273
Telephone: 1-800-347-1232
Fax: 704-525-9534
www.tuckeradministrators.com

Mark III Brokerage
211 Greenwich Rd
Charlotte, NC 28211
1-800-532-1044
www.markiiibrokerage.com/cityofmonroenc

View Benefit Information &
Download Forms at:
www.markiiibrokerage.com/cityofmonroenc

OR

scan this QR with your smartphone!*

*-3rd party iOS or Android app required

Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits

211 Greenwich Road
Charlotte, NC 28211

(800) 532-1044
(704) 365-4280

learn more at: www.markiiieb.com