Table of Contents

Pre-Tax Benefits

After-Tax Benefits

For Your Reference

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative 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 (i.e., marriage, divorce, birth of a child, etc.) You have 30 days from the date of event to make a change.

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

Mark III
Employee Benefits

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the coverage document at www.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$2,500** person/**$5,000** family Out-of-network: **$5,000** person/**$10,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$5,000** person/**$10,000** family Out-of-network: **$15,000** person/**$30,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit	40% co-insurance	Office surgery subject to deductible/coinsurance.
	Specialist visit	$35 co-pay/visit	40% co-insurance	Office surgery subject to deductible/coinsurance.
	Other practitioner office visit	20% co-insurance	40% co-insurance	Therapy visits limited to 20 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care / screening / immunization	No Charge	40% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% co-insurance	Not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
More information about **prescription drug coverage** is available at www.bcbst.com.	Preferred brand drugs	$35 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Non-preferred brand drugs	$50 co-pay	40% co-insurance	
	Self-Administered Specialty drugs	$100 co-pay at specialty pharmacy network	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	——————none——————
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/visit for office visits and 20% co-insurance for other outpatient services	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Substance use disorder outpatient services	$35 co-pay/visit for office visits and 20% co-insurance for other outpatient services	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	——————none——————
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 60 visits.
	Rehabilitation services	20% co-insurance	40% co-insurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	40% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-565-9140**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at **1-800-565-9140** or **www.bcbst.com**.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at **1-800-342-4029** or visit **www.tn.gov/insurance/consumerRes.shtml**.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at **1-800-342-4029**, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,150
- **Patient pays** $3,390

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$60
Co-insurance	$800
Limits or exclusions	$30
Total	**$3,390**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,600
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,600**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Medical Rates
26 Pay (Bi-Weekly)

Employee Only	$54.81
Employee and Child	$109.90
Employee and Spouse	$208.80
Family	$298.73

Customer Service
1-800-451-9097

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Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$4,000** person/**$8,000** family Out-of-network: **$8,000** person/**$16,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$4,000** person/**$8,000** family Out-of-network: **$12,000** person/**$24,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge, after deductible	20% co-insurance	——————none——————
	Specialist visit	No charge, after deductible	20% co-insurance	——————none——————
	Other practitioner office visit	No charge, after deductible	20% co-insurance	Therapy visits limited to 20 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care / screening / immunization	No Charge	20% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge, after deductible	20% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge, after deductible	20% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	No charge, after deductible	20% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. $3/$25/$50 co-pay per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
More information about **prescription drug coverage** is available at www.bcbst.com.	Preferred brand drugs	No charge, after deductible	20% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. $3/$25/$50 co-pay per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Non-preferred brand drugs	No charge, after deductible	20% co-insurance	
	Self-Administered Specialty drugs	No charge, after deductible at specialty pharmacy network	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, after deductible	20% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No charge, after deductible	20% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room services	No charge, after deductible	No charge, after deductible	——————none——————
	Emergency medical transportation	No charge, after deductible	No charge, after deductible	——————none——————
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge, after deductible	20% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fee	No charge, after deductible	20% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge, after deductible	20% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Mental/Behavioral health inpatient services	No charge, after deductible	20% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Substance use disorder outpatient services	No charge, after deductible	20% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder inpatient services	No charge, after deductible	20% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Prenatal and postnatal care	No charge, after deductible	20% co-insurance	——————none——————
	Delivery and all inpatient services	No charge, after deductible	20% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge, after deductible	20% co-insurance	Limited to 60 visits.
	Rehabilitation services	No charge, after deductible	20% co-insurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	No charge, after deductible	20% co-insurance	
	Skilled nursing care	No charge, after deductible	20% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	No charge, after deductible	20% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No charge, after deductible	20% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

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- The Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at 1-800-342-4029 or visit www.tn.gov/insurance/consumerRes.shtml.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,510
- **Patient pays** $4,030

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Copays	$0
Co-insurance	$0
Limits or exclusions	$30
Total	**$4,030**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,360
- **Patient pays** $4,040

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,000
Copays	$40
Co-insurance	$0
Limits or exclusions	$0
Total	**$4,040**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Medical Rates
26 Pay (Bi-Weekly)

Employee Only	$15.45
Employee and Child	$42.91
Employee and Spouse	$55.06
Family	$115.96

Customer Service
1-800-451-9097

BCBS TN Vision Blue

BlueCross BlueShield Vision Blue for First Tennessee Human Resource Agency

Services	In-Network	Out-Of-Network Allowance
Exam with Dilation as Necessary	$20 Copay	$35
Exam Options		
Standard Contact Lens Fit and Follow-Up	$55 Copay	N/A
Premium Contact Lens Fit and Follow-Up	10% Off Retail	N/A
Frames	$0 Copay; $120 Allowance 20% Off Balance Over Allowance	$60
Standard Plastic Lenses		
Single Vision	$25 Copay	$30
Bifocal	$25 Copay	$45
Trifocal	$25 Copay	$60
Standard Progressive (Add onto Bifocal)	$65 Additional Copay	$45
Premium Progressive (Add onto Bifocal)	$65 Additional Copay 20% Off Retail Price Less $120	$45
Lens Options		
UV Coating	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Scratch Resistance	$15 Copay	N/A
Standard Polycarbonate (Adult)	$40 Copay	N/A
Standard Polycarbonate (Under Age 19)	$0 Copay	$5
Standard Anti-Reflective Coating	$45 Copay	N/A
Other Lens Options	20% Off Retail	N/A
Contact Lenses		
Conventional	$0 Copay; $120 Allowance, 15% Off Balance Over Allowance	$96
Disposable	$0 Copay; $120 Allowance	$96
Medically Necessary	Paid-in-Full	$200
Frequency		
Examination	Once Every 12 Months	
Frame	Once Every 24 Months	
Lenses or Contact Lenses	Once Every 12 Months	

Bi-Weekly Rates: Individual = $2.83 2 Person =$ 5.66 Family = $ 9.05

Creditable Coverage Information

of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Dear Group Administrator,

If your business offers a prescription drug benefit, you must furnish a creditable coverage notice to each Medicare-eligible individual. This annual notification must be made prior to the start of the Medicare Part D Annual coordinated Election Period October 15, 2016 - December 7, 2016. Prescription drug coverage is creditable if the total expected paid claims for your members who are Medicare beneficiaries under your group's plan will be at least equal to the total expected paid claims for the same beneficiaries under the defined standard prescription drug coverage under Part D.

Tax-free Subsidy
If your coverage is creditable, you can pursue a 28 percent tax-free subsidy from the Centers for Medicare and Medicaid Services (CMS). This optional step requires additional testing of your plan and an application process. You must apply to CMS for the subsidy by no later than 90 days prior to the beginning of the plan year or request an extension from CMS. Information about the subsidy is found at http://rds.cms.hhs.gov/app_deadline.htm.

2016 Medicare Part D Creditable Coverage Test Results
BlueCross BlueShield of Tennessee bulk-tested our benefit designs to satisfy the actuarial value test of the creditable coverage. Most of our plans passed the creditable coverage test (see enclosed list). The test results can help you as you prepare your notification of creditable coverage for all your Medicare-eligible members. Interactive notification letter templates are available at http://www.cms.hhs.gov/CreditableCoverage/.

HSA-Qualified High-Deductible Health Plans
If our tests reveal your High-Deductible Health Plan (HDHP) integrated prescription drug benefit is not creditable coverage and your employees participate in a Health Reimbursement Arrangement (HRA), then for purposes of determining whether the benefits are creditable coverage, amounts credited to the HRA in a given year may be treated as increasing the expected prescription drug claims payable from the HDHP for that year.

Please be aware that contributions cannot be made to Health Savings Accounts (HSAs) once a retiree becomes enrolled in Medicare. HSAs cannot be taken into account in determining whether an HDHP qualifies as creditable coverage or into account in determining whether the HDHP can qualify for the retiree drug subsidy.

For more information about high-deductible health plans visit the CMS web site and review *Treatment of Account-Based health Arrangements under the Medicare Modernization Act.*

In addition to the list of bulk- tested plans, you will find enclosed a document from the CMS Web site entitled "Creditable Coverage Simplified Determination." These materials should be helpful as you prepare for your annual notification.

We appreciate the opportunity to be of service to you. Please review the enclosed materials. If you have questions or need assistance contact your BlueCross sales or account executive.

Best in health,

John Maki
Vice President Sales and Account Management
BlueCross BlueShield of Tennessee

	Plan Description	2017
Large Group Standard Copay Plans	$10/20/40	PASS
	$10/35/50	PASS
	$8/40/60	PASS
	$2500/5000/80% $10/35/50 after ded	PASS
	$5/20%/40%	PASS
	$10/30%/50%	PASS
	$10/75/150	PASS
	$3/45/75	PASS

Other Large Group Popular Copay Plans	$5/10/10	PASS
	$5/15/15	PASS
	$10/20/20	PASS
	$5/15/25	PASS
	$8/18/28	PASS
	$5/15/30	PASS
	$10/20/35	PASS
	$10/20/35 50 Rx ded	PASS
	$10/20/35 100 Rx ded	PASS
	$10/35/35	PASS
	$4/20/40	PASS
	$5/20/40	PASS
	20%/20%/20%	PASS
	20%/20%/20% 1000 oop	PASS
	$10/20/40 200 BO ded	PASS
	20%/20%/20% 100 BO ded	PASS
	$10/25/45	PASS
	$10/30/45	PASS
	$10/30/45 100 BO ded	PASS
	$10/25/45 100 Rx ded	PASS
	$8/30/50	PASS
	25%/25%/25%	PASS
	$5/30/65	PASS
	25%/25%/25%	PASS
	$3/35/75	PASS
	$0/60/80	PASS
	$3/35/75	PASS
	$15/25/45	PASS
	$10/20/50	PASS
	$10/25/50	PASS
	$3/45/75	PASS
	$3/45/75 100 BO ded	PASS
	$10/30/50	PASS
	$10/35/50 100 BO ded	PASS
	$0/20%/50%	PASS
	$8/35/60	PASS
	$10/35/50 200 BO ded	PASS
	$10/35/55	PASS
	$7/30/70	PASS
	$10/35/55 100 BO ded	PASS
	$8/40/60 200 BO ded	PASS
	$10/30/60	PASS
	$5/20%/40%	PASS
	$10/35/60	PASS
	30%/30%/30%	PASS
	$10/35/60 100 BO ded	PASS
	$8/35/70	PASS
	$15/30/50	PASS
	$7/45/70	PASS
	$10/40/60	PASS
	$15/35/50	PASS
	30%/30%/30%	PASS
	$8/35/60 500 BO ded	PASS
	$10/40/60 100 BO ded	PASS
	$8/40/70	PASS
	$10/35/60 200 BO ded	PASS
	$3/50/100	PASS
	$8/35/70 200 BO ded	PASS
	$10/45/60	PASS
	$10/35/65	PASS
	$8/40/75	PASS
	$15/35/50 200 BO ded	PASS
	$10/35/70	PASS
	$8/40/75 200 BO ded	PASS
	$10/40/70	PASS
	$5/50/100	PASS
	$10/35/75	PASS
	$10/35/70 200 BO ded	PASS
	$20/35/50	PASS

	Plan Description	2017
Other Large Group Popular Copay Plans	$5/25%/50%	PASS
	$5/25%/50% 4000 oop	PASS
	$10/50/70	PASS
	$10/50/70 100 BO ded	PASS
	$10/45/75	PASS
	$10/45/70 200 BO ded	PASS
	$15/40/55	PASS
	$8/60/80	PASS
	$8/30%/35%	PASS
	$10/45/70 300 BO ded	PASS
	$10/45/75 200 BO ded	PASS
	$10/45/80 100 BO ded	PASS
	$15/35/60	PASS
	$8/60/80 200 BO ded	PASS
	$15/40/60	PASS
	$10/50/75 200 BO ded	PASS
	$15/30/60 200 BO ded	PASS
	$10/45/90	PASS
	$15/40/60 200 BO ded	PASS
	$10/40/90 200 BO ded	PASS
	$10/35/100	PASS
	$8/50/100 200 BO ded	PASS
	$3/50%/50%	FAIL
	$15/40/70	PASS
	$10/50/100	PASS
	$15/35/75	PASS
	$15/44/76	PASS
	$5/50%/50% 2500 oop	PASS
	$15/50/75	PASS
	$15/40/80 200 BO ded	PASS
	$15/45/85	PASS
	$10/40%/50%	FAIL
	50%/50%/50%	FAIL
	50%/50%/50% 4000 oop	PASS
	$20/40/80	PASS
	$10/50%/50%	FAIL
	$10/50%/50% 4000 oop	PASS
	$10/50%/50%	FAIL
	50%/50%/50% 200 BO ded	FAIL
	$3/75/250	PASS
	$3/100/250	PASS

HSA - Qualified HDHPs®	$1700/3400/80%	PASS
	$2700/4200/80%	PASS
	$2700/5000/80%	PASS
	$3000/5000/80%	PASS
	$3000/6000/80%	PASS
	$3500/6000/80%	PASS
	$4000/6000/80%	PASS
	$4500/6000/80%	PASS
	$5000/6000/80%	PASS
	$2500/2500/100%	PASS
	$3000/3000/100%	PASS
	$3000/4000/100%	PASS
	$4000/4000/100%	PASS
	$4000/5000/100%	PASS
	$5000/5000/100%	PASS
	$5000/6000/100%	PASS
	$6000/6000/100%	PASS
	$6000/6450/100%	PASS
	$3000/4000/50%	PASS
	$3000/5000/50%	PASS
	$3000/6000/50%	PASS
	$3500/6500/50%	PASS
	$4000/6000/50%	PASS
	$4500/6500/50%	PASS
	$5500/6400/50%	PASS

Large Group Standard Ded/Coins Plans - 100%	$1000/1000/100%	PASS
	$1500/1500/100%	PASS
	$2000/2000/100%	PASS
	$2500/2500/100%	PASS
	$3000/3000/100%	PASS
	$4000/4000/100%	PASS
	$5000/5000/100%	PASS
	$6000/6000/100%	PASS
	$6600/6600/100%	PASS
	$6850/6850/100%	PASS
	$7150/7150/100%	PASS

Large Group Standard Ded/Coins Plans - 90%

Plan Description	2017
$100/1000/90%	PASS
$100/1500/90%	PASS
$100/2000/90%	PASS
$100/2500/90%	PASS
$250/1000/90%	PASS
$250/1500/90%	PASS
$250/2000/90%	PASS
$250/2500/90%	PASS
$500/1000/90%	PASS
$500/1500/90%	PASS
$500/2000/90%	PASS
$500/2500/90%	PASS
$500/3000/90%	PASS
$500/4000/90%	PASS
$750/1000/90%	PASS
$750/1500/90%	PASS
$750/2000/90%	PASS
$750/2500/90%	PASS
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$1000/1500/90%	PASS
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$6600/7150/90%	PASS
$6850/7150/90%	PASS

Large Group Standard Ded/Coins Plans - 90%

Plan Description	2017
$100/1000/80%	PASS
$100/1500/80%	PASS
$100/2000/80%	PASS
$100/2500/80%	PASS
$250/1000/80%	PASS
$250/1500/80%	PASS
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$6000/6850/80%	PASS
$6000/7150/80%	PASS
$6600/6850/80%	PASS
$6600/7150/80%	PASS
$6850/7150/80%	PASS

Large Group Standard Ded/Coins Plans - 90%

Plan Description	2017
$100/1000/70%	PASS
$100/1500/70%	PASS
$100/2000/70%	PASS
$100/2500/70%	PASS
$250/1000/70%	PASS
$250/1500/70%	PASS
$250/2000/70%	PASS
$250/2500/70%	PASS
$500/1000/70%	PASS
$500/1500/70%	PASS
$500/2000/70%	PASS
$500/2500/70%	PASS
$500/3000/70%	PASS
$500/4000/70%	PASS
$750/1000/70%	PASS
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$1500/6600/70%	PASS
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$6000/6600/70%	PASS
$6000/6850/70%	PASS
$6000/7150/70%	PASS
$6600/6850/70%	PASS
$6600/7150/70%	PASS
$6850/7150/70%	PASS

* HSAs - No contributions can be made to HSAs once a retiree becomes enrolled in Medicare. These types of accounts cannot be taken into consideration when determining whether an HDHP qualifies as creditable coverage. For more information see CMS.com, Treatment of Account-Based health Arrangements under the Medicare Modernization Act. As a courtesy, BlueCross BlueShield of Tennessee has performed testing of our benefit designs to satisfy the actuarial value test of the creditable coverage determination using a consultant model. However, according to CMS guidelines, it is ultimately the employer's responsibility to determine/confirm whether their plan, as implemented, offers creditable coverage.

Creditable Coverage Simplified Determination

This document is an update of the Simplified Determination of Creditable Coverage Status which was released on September 18, 2009 in the Updated Creditable Coverage Guidance.

Benefit Designs for Simplified Determination of Creditable Coverage Status

If an entity is not an employer or union that is applying for the retiree drug subsidy, it can use the simplified determination of creditable coverage status annually to determine whether its prescription drug plan's coverage is creditable or not. The plan will be determined to be creditable if the plan prescription drug plan design meets all four of the following standards. However, the standards listed under 4(a) and 4(b) may not be used if the entity's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e. Medical, Dental, etc.). Integrated plans must satisfy the standard in 4(c).

A prescription drug plan is deemed to be creditable if it:

1) Provides coverage for brand and generic prescriptions;
2) Provides reasonable access to retail providers;
3) The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
4) Satisfies at least one of the following:

a) The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000, or b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual.
c) For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000 and has no less than a $1,000,000 lifetime combined benefit maximum.

Integrated Plan - An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

1) a combined plan year deductible for all benefits under the plan,
2) a combined annual benefit maximum for all benefits under the plan, and
3) a combined lifetime benefit maximum for all benefits under the plan.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet steps 1, 2, 3 and 4(c) of the simplified method If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet steps 1, 2, 3 and either 4(a) or 4(b).

NOTE: If the entity cannot use the Simplified Determination method stated above to determine the creditable coverage status of the prescription drug plan offered to Medicare eligible individuals, then the entity must make an actuarial determination annually of whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

Aetna Employee Assistance Program (EAP)

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

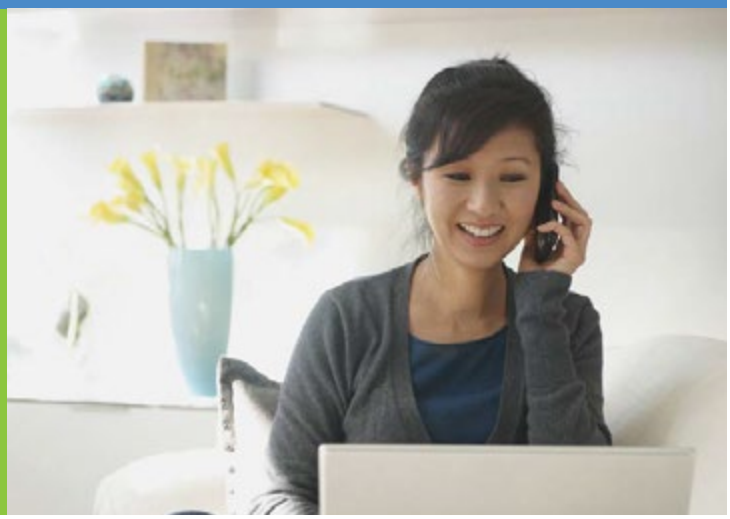
aetna℠

Aetna Resources For Living℠

Employee Assistance Program (EAP) and Worklife Services for

First Tennessee Human Resource Agency

To access services, simply call 1-888-238-6232 or visit us online at www.mylifevalues.com
Username: FTHRA / Password: eap



Aetna Resources For Living services are available to you, all members of your household and your adult children up to the age of 26, regardless of your medical insurance coverage. Services are confidential and are available 24 hours a day, 7 days a week.

Counseling and Relationship Support

- Unlimited, toll-free telephonic access to EAP dedicated staff, 24 hours per day
- Telephonic access to licensed behavioral health professionals
- Support, consultation and resources for stress, family relationship issues, anger management, substance abuse, and helping you balance work and home life
- Direct access to a full range of Web-based tools and resources, such as easy-to-find information, self-assessments and more, on a variety of relevant topics
- 6 face to face counseling sessions, with licensed network professionals, at no cost to you; i.e., no copays or deductibles

Worklife Balance

- Consultation, information, and assistance with locating resources that families need, such as:
  - Child care
  - Parenting
  - Special needs
  - Urgent/daily living needs
  - Summer care
  - Convenience/personal services
  - Pet care
  - Elder care
  - Caregiver support
  - Care for people with disabilities
  - Adoption
  - Temporary back-up care
  - School/college planning
  - Consumer information
- Online Discounts on brand-name products and services, including categories such as computers & electronics, theme parks, movie tickets, local attractions, travel, gifts, apparel, child and elder care, flowers, jewelry, fitness centers and more

74.03.962.1-ARFL (8/12)

Legal Services

- 1/2 hour free consultation with a participating attorney for an unlimited number of new legal topics (each plan year) related to:
  - General law (excluding employment law)
  - Mediation Services
  - Special Needs, including emergency matters
  - Document preparation
- A discount of 25% off the hourly rate charged by the participating attorney for any legal services not covered and/or beyond the 1/2 hour initial consultations referenced above
- All services must be for legal matters related to the employee and eligible household members

Financial Services

- 1/2 hour free consultation on an unlimited number of new financial counseling topics each plan year
- Topics include Budgeting, Credit, Debt, Retirement, College Funding, Buying vs. Leasing, Mortgages/Refinancing, Financial Planning, Tax Questions & Preparation, IRS Matters, Tax Levies & Garnishments, Consumer Credit Counseling, Community Services
- A discount of 25% off the tax preparation services
- All services must be for financial matters related to the employee and eligible household members

Other Services

- Identity Theft Services--One hour telephonic fraud resolution consultation as well as coaching and direction on prevention and restoring credit for victims of ID Theft, and a free Identity Theft Emergency Response Kit for victims of ID Theft

Ameritas Dental Plan

Effective Date: November 1, 2016
*Deductible is waived on ALL services when a network dentist is utilized.

COMBINED CALENDAR YEAR DEDUCTIBLE
$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

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

- Routine Exam (2 per period)
- Bitewing X-rays (2 per period)
- Panoramic X-rays (1 in 3 years)
- Fluoride for Children 18 and under (1 per period)
- Cleaning (2 per period)
- Periapical X-rays
- Space Maintainers

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

- Sealants (age 16 and under)
- Restorative Amalgams & Resins
- Endodontics
- Periodontics
- Denture Repair
- Extractions (simple & complex)
- Anesthesia

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

- Onlays
- Crowns (1 in 5 years)
- Implants
- Crown Repair
- Prosthodontics

LATE ENTRANT PROVISION
*There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

ANNUAL MAXIMUM BENEFIT
- Type I, II and III Procedures - $1,500 per calendar year per person.

*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:
1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $750.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $750, additional amounts of $250 will be added to the carryover. Also, if you visit a network dentist you will be eligible for an additional $150 PPO Bonus carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,500 in any one year.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 24 and unmarried

AMERITAS MANAGED CARE PRODUCTS

- Employers achieve a balance between cost and efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentist must meet our credentialing and quality assurance evaluation requirements.

PASSIVE PPO

In the passive PPO, the coinsurance, deductible, and maximum are the same for member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in-network dentist; however there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket cost by seeing an in-network dentist.

PASSIVE PPO DEDUCTIBLE REDUCTION

Deductible Reduction continues the difference of in-network and out-of-network claim allowance and allows a reduced deductible for those who visit an in-network. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket cost by seeing an in-network dentist.

COMMONLY ASKED PPO QUESTIONS

DO I HAVE TO SEE AN AMERITAS PPO PROVIDER?

No, employees and their covered dependents may utilize any licensed dental provider they choose. Please note, their is no difference in the coinsurance, deductible, and maximums when a PPO provider is utilized or not.

WHY WOULD I USE AN AMERITAS PPO PROVIDER?

By using a PPO Provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Amerita's plans for a specific fee. Any insured member who chooses to go to a PPO provider will receive this discount fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the providers cannot "back bill" the patient for the difference the dentist normal charges and the discounted fees that the dentist agreed to charge as an Ameritas provider.

- PPO providers are required to file the claim for the patient.
- PPO Providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amount exceeding the annual maximum benefit, etc.

PPO panels are available in many areas, please visit the Ameritas web site at www.ameritasgroups.com to search for a provider in your area.

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

LIMITATIONS/EXCLUSIONS (This is not a complete List)

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

26 PAY RATES

Employee only	$14.18
Employee + 1	$28.37
Employee + 2 or more	$44.82

FOR CLAIMS/CUSTOMER SERVICE QUESTIONS CONTACT AMERITAS AT:

(800) 487-5553 or www.ameritas.com

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS GROUP DENTAL
The Dental Health Experts℠

Aflac Group Accident Plan

Aflac Accident Insurance

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI7700.

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

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

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

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

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

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

- ***There's no limit on the number of claims you can file.***
- ***An annual Wellness Benefit is included.***
- ***Spouse and dependent child coverage is available.***
- ***The plan provides 24-hour protection.***
- ***There are benefits for inpatient and outpatient treatment of covered accidents.***
- ***Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).***
- ***Your premiums are paid through the convenience of payroll deduction.***
- ***Coverage will be effective the date you sign the enrollment form.***
- ***Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.***

Underwritten by Continental American Insurance Company
A proud member of the Aflac family of insurers

What is guaranteed-issue coverage? Am I eligible?

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

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

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

- ***Are between the ages of 18 and 69;***
- ***Are a full-time, benefit-eligible employee;***
- ***Are working at least 16 hours per week;***
  and
- ***Are not a seasonal or temporary employee.***

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

What core benefits does the Aflac accident plan feature?

Accident Benefits

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

- ***Fractures***
- ***Dislocations***
- ***Paralysis***
- ***Lacerations***
- ***Injuries requiring surgery***
- ***Eye injuries***
- ***Removal of foreign body***
- ***Ruptured disc***
- ***Torn knee cartilage***
- ***Tendons/ligaments***
- ***Burns (second- and third-degree)***
- ***Concussion***
- ***Coma***
- ***Internal injuries***
- ***Exploratory surgery***
- ***Emergency dental work***

Medical Fees Benefit

You may receive this benefit for up to six treatments per covered accident for physician charges, emergency room services and supplies, and X-rays.

Accident Follow-Up Treatment Benefit

You may receive this benefit for up to six treatments per covered accident for follow-up treatment.

Physical Therapy Benefit

You may receive this benefit for up to six treatments per covered accident for physical therapy.

Ambulance Benefit

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

Transportation Benefit

You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn't available in your city/town of residence).

Blood/Plasma Benefit

You may receive this benefit if you receive blood and plasma within 90 days after a covered accident.

Prosthesis Benefit

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

Appliance Benefit

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

Family Lodging Benefit

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

Wellness Benefit - $60

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

- ***Annual physical exams***
- ***Mammograms***
- ***Pap smears***
- ***Eye examinations***
- ***Immunizations***
- ***Flexible sigmoidoscopies***
- ***PSAs***
- ***Ultrasounds***
- ***Blood screenings***

Hospital Admission Benefit

You may receive this benefit if you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the accident.

Hospital Confinement Benefit (per day)

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

Hospital Intensive Care (per day)

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

Accidental-Death and -Dismemberment Benefit

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

What else do I need to know about the Aflac accident plan?

You should know that the plan includes:

- ***A pre-existing condition limitation. Pre-Existing Condition means within the 12-months period prior to the effective date of a certificate and attached riders, as applicable, those conditions for which medical advice or treatment was received or recommended. A claim for benefits for loss starting after 12-months from the effective date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A certificate may have been issued as a replacement for a certificate previously issued under the plan. If so, then the pre-existing condition limitation provision of the certificate applies only to any increase in benefits over the prior certificate. Any remaining period of the pre-existing condition limitation of the prior certificate will continue to apply to the prior level of benefits. We will not pay benefits for a loss that is caused by, that is contributed to, or that results from a pre-existing condition for 12 months after the effective date of coverage.***

- **Exclusions*. No benefits are payable for loss resulting from:***

- ***Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. Aflac will return the prorated premium for any period not covered when you are in such service.***
- ***Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.***
- ***Participating or attempting to participate in an illegal activity or working at an illegal job.***
- ***Committing or attempting to commit suicide, while sane or insane.***
- ***Injuring or attempting to injure yourself intentionally.***
- ***Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica (except under the Accidental Common Carrier Death Benefit).***
- ***Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.***
- ***Participating in any organized sport, professional or semi-professional.***
- ***Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.***
- ***Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.***
- ***Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.***
- ***Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.***
- ***Having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment of diagnostic procedures for such illness.***
- ***A doctor or physician does not include you or a member of your immediate family.***
- ***A hospital is not a nursing home, an extended-care facility, a convalescent home, a rest home or a home for the aged, a place for alcoholics or drug addicts, or a mental institution.***

Bi-Weekly Premium Rates

Employee	$7.48
Employee and Spouse	$10.70
Employee and Dependent Child(ren)	$14.26
Employee, Spouse, and Dependent Child(ren)	$17.48

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

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Continental American Insurance Company
Columbia, South Carolina

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.

800.433.3036 | aflacgroupinsurance.com

Aflac Group Critical Illness Plan

Benefit Amounts Available:

Employee: $5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000, $50,000

Spouse: $5,000, $7,500, $10,000, $12,500, $15,000, $17,500, $20,000, $22,500, $25,000

Guaranteed Issue Amounts:

- **Employee: $10,000**
- **Spouse: $5,000**

Health Screening Benefit: $100.00

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

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

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

Heart Attack (Myocardial Infarction)
Stroke
Major Organ Transplant
End-Stage Renal Failure
Coronary Artery Bypass Surgery
Carcinoma In Situ

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

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

- ***An annual Health Screening Benefit is included.***
- ***Spouse coverage is available.***
- ***Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $25,000.***
- ***Each dependent child is covered at 25% of the primary insured's amount at no additional charge.***
- ***Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).***
- ***Your premiums are paid through the convenience of payroll deduction.***
- ***Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.***

Am I eligible for Aflac critical illness coverage? What about my family?

You are eligible to apply for Aflac critical illness coverage if you:

- ***Are between the ages of 18 and 69;***
- ***Are a full-time, benefit-eligible employee;***
- ***Are working at least 16 hours per week;***
  and
- ***Are not a seasonal or temporary employee.***

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

What is guaranteed-issue coverage? Am I eligible?

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

The following guaranteed-issue coverage amounts are available to you:

- ***$10,000 for you***
- ***$5,000 for your spouse***

If you would like to apply for a higher coverage amount, you will be asked to answer health questions. If you answer “yes” to any health questions on the enrollment form, you will be not be issued a higher coverage amount; however, you will still be eligible for the guaranteed-issue benefit amount (listed above).

What core benefits does the Aflac critical illness plan feature?

First Occurrence Benefit

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

Additional Occurrence Benefit

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

Reoccurrence Benefit

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

Heart Event Rider

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

100% FOR OPENHEART SURGERIES

-Coronary Artery Bypass Surgery (CABS)*
-Mitral Valve Replacement or Repair
-Aortic Valve Replacement or Repair
-Surgical Treatment of Abdominal Aortic Aneurysm

10% FOR INVASIVEHEART PROCEDURE

-AngioJet Clot Busting
-Balloon Angioplasty
-Laser Angioplasty
-Atherectomy
-Stent Implantation
-Cardiac Catheterization
-Automatic Implantable (or Internal) Cardioverter Defibrillator
-Pacemakers

*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%.

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.

Additional Benefits Rider

After the waiting period, you may receive benefits for the following covered conditions:

-Paralysis
-Severe Burns
-Coma
-Loss of Speech
-Loss of Sight
-Loss of Hearing

-

This benefit is paid based on your selected Critical Illness Benefit Amount.

Health Screening Benefit

After the waiting period, you may receive a maximum of $100 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

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

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

You should know that the plan includes:

- ***A* 30-day waiting period.** *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 medically related specified 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.*

A pre-existing condition limitation means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment or caused symptoms for which an ordinarily prudent person would seek medical advice or treatment. We will not pay benefits for any condition or 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 condition will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Exclusions: ***Benefits will not be paid for loss due to:***

- ***Intentionally self-inflicted injury or action;***
- ***Suicide or attempted suicide while sane or insane;***
- ***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.***

Underwritten by Continental American Insurance Company
A pround member of the Aflac family of insurers

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

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Continental American Insurance Company Columbia, South Carolina

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Aflac Group Critical Illness Plan - Employee and Spouse

NON-TOBACCO - Employee Bi-weekly

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.88	$4.15	$5.42	$6.69	$7.96	$9.23	$10.50	$11.77	$13.04	$14.31
30-39	$3.67	$5.72	$7.78	$9.83	$11.88	$13.94	$15.99	$18.05	$20.10	$22.15
40-49	$5.93	$10.25	$14.56	$18.88	$23.19	$27.51	$31.82	$36.14	$40.45	$44.77
50-59	$8.85	$16.08	$23.31	$30.54	$37.77	$45.00	$52.23	$59.46	$66.69	$73.92
60-69	$13.15	$24.69	$36.23	$47.77	$59.31	$70.85	$82.38	$93.92	$105.46	$117.00

NON-TOBACCO - Spouse Bi-weekly

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.88	$3.52	$4.15	$4.79	$5.42	$6.06	$6.69	$7.33	$7.96
30-39	$3.67	$4.70	$5.72	$6.75	$7.78	$8.80	$9.83	$10.86	$11.88
40-49	$5.93	$8.09	$10.25	$12.40	$14.56	$16.72	$18.88	$21.03	$23.19
50-59	$8.85	$12.46	$16.08	$19.69	$23.31	$26.92	$30.54	$34.15	$37.77
60-69	$13.15	$18.92	$24.69	$30.46	$36.23	$42.00	$47.77	$53.54	$59.31

TOBACCO - Employee Bi-weekly

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.62	$5.63	$7.64	$9.65	$11.65	$13.66	$15.67	$17.68	$19.68	$21.69
30-39	$5.05	$8.49	$11.93	$15.37	$18.81	$22.25	$25.68	$29.12	$32.56	$36.00
40-49	$10.52	$19.43	$28.34	$37.25	$46.15	$55.06	$63.97	$72.88	$81.78	$90.69
50-59	$15.88	$30.14	$44.40	$58.66	$72.92	$87.18	$101.45	$115.71	$129.97	$144.23
60-69	$24.39	$47.17	$69.95	$92.72	$115.50	$138.28	$161.05	$183.83	$206.61	$229.38

TOBACCO - Spouse Bi-weekly

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.62	$4.63	$5.63	$6.63	$7.64	$8.64	$9.65	$10.65	$11.65
30-39	$5.05	$6.77	$8.49	$10.21	$11.93	$13.65	$15.37	$17.09	$18.81
40-49	$10.52	$14.98	$19.43	$23.88	$28.34	$32.79	$37.25	$41.70	$46.15
50-59	$15.88	$23.01	$30.14	$37.27	$44.40	$51.53	$58.66	$65.79	$72.92
60-69	$24.39	$35.78	$47.17	$58.56	$69.95	$81.33	$92.72	$104.11	$115.50

Aflac Individual Insurance Policies

Aflac is voluntary insurance that pays cash benefits directly to you (unless otherwise assigned), if you're sick or injured–cash to spend any way you want. It can help cover things major medical insurance doesn't pay for, like your mortgage/rent payments, car payments, groceries, or other out-of-pocket expenses.

If you wish to apply for any of the following Aflac insurance policies, an Aflac agent will be present at open enrollment.

- **Cancer/Specified Disease Insurance** (Policy Series A76000): Helps with the medical expenses related to cancer treatment.
- **Hospital Advantage Insurance** (Policy Series A49000): This policy pays lump sum benefits for hospitalization for accident or sickness plus benefits for emergency room visits, physician's visits, and more.
- **Plus Rider:** This rider is available with the Hospital Advantage plan. This rider covers a wide range of Critical Illnesses.

An Aflac agent will be able to assist you in applying for the policies listed above, as well as change or cancel any coverage and answer any questions that you may have concerning your Aflac policies.

Individual coverage underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters
1932 Wynnton Road
Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)
En español:
1.800.SI.AFLAC (1.800.742.3522)
Visit our website at aflac.com.

AUL Short-Term Disability Plan

Effective Date: November 1, 2016

Why should you consider purchasing disability insurance protection at your workplace?

Many of us lead busy lives and seldom take time to think about life's risks. Consider the following reasons many people purchase disability insurance:

- ***Lost wages***
- ***Daily living expenses, such as mortgage/rent, utilities, car payment, food, childcare, eldercare, hobbies, pet care***

Advantages of shopping at work include:

- ***Affordable group rates***
- ***Convenient payroll deduction***
- ***Guaranteed issue for timely applicants***
- ***Easy access***

Less than 5% of disabling accidents and illnesses are work related. The other 95% are not, meaning Workers' Compensation doesn't cover them.

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2011.asp)

90% of disability are caused by illness.

(Source: Council for Disability Awareness, http://www.disabilitycan-happen.org/chances_disability_stats.asp., August 2012.)

64% of wage earners believe they have a 2% or less chance of being disabled for 3 months or more during their working career. The actual odds for a worker entering the workforce today are about 30%.

(Source: Social Security Administration website, ssa.gov, Fact Sheet, March 18, 2011.)

Less than half (35.6%) of the 2.9 million workers who applied for Social Security Disability Insurance (SSDI) benefits in 2011 were approved.

(Source: Social Security Administration website, ssa.gov, Monthly Statistical Snapshot, December 2012.)

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

Class Description
All Full-Time Eligible Employees working a minimum of 25 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

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

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly benefit is $500.

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

Benefit Duration
This is the period of time that benefits will be payable for disability. The 13 week benefit is what is offered.

Basis of Coverage
24 Hour Coverage, on or off the job.

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

Annual Enrollment
Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions. Current participants may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments

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

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

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

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

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

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

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

Please refer to the Mark III website for a copy of your certificate, claim form or portability form - www.markiiibrokerage.com/fthra

Customer Service
800-553-5318

Disability Claims
855-517-6365
Fax: 1-844-287-9499
Disability Claims Email: OneAmerica.claims@customdisability.com

www.employeebenefits.aul.com

Please refer to the Mark III website
for a copy of your certificate and claim form.

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

AUL Short-Term Disability
Bi-Weekly Rates

Benefit Duration*:*
13 Weeks

Monthly Benefit	Bi-Weekly Premium	Monthly Benefit	Bi-Weekly Premium
$500	$4.78	$1,300	$12.43
$600	$5.74	$1,400	$13.38
$700	$6.69	$1,500	$14.34
$800	$7.65	$1,600	$15.29
$900	$8.60	$1,700	$16.25
$1,000	$9.56	$1,800	$17.21
$1,100	$10.51	$1,900	$18.16
$1,200	$11.47	$2,000	$19.12

AUL Long-Term Disability Plan

LTD Class Description
All Full-Time Eligible Employees working a minimum of 25 hours per week, electing to participate in the Voluntary Long Term Disability Insurance.

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

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

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

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

LTD Total Disability Definition
An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefits have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

LTD Mental & Nervous / Drug & Alcohol
Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

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

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

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

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

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

Portability
Once an employee is on the AUL disability plan for 3 months, you may be Eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

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

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

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

Voluntary Long Term Disability	
Monthly Benefit	**Bi-Weekly Rate**
$500	***$2.95***
$1,000	***$5.91***
$1,500	***$8.86***
$2,000	***$11.81***

Customer Service
800-553-5318
Disability Claims
855-517-6365
Fax: 1-844-287-9499
Disability Claims Email: OneAmerica.claims@customdisability.com
www.employeebenefits.aul.com

This information is provided as a Benefit Outline. It is not a part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

Dearborn National Term Life Plan

BASIC EMPLOYEE LIFE INSURANCE
This insurance is payable for death from any cause to any person you name as beneficiary.

VOLUNTARY EMPLOYEE LIFE INSURANCE
Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the voluntary portion of your program to go along with any personal insurance coverage you may have.

FLEXIBILITY
Simply choose the amount of coverage that suits your needs from the selection provided, as outlined on page 34 of this booklet.

FEATURES
The plan features easy eligibility and simple enrollment procedures.

Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST
Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the Employer absorbs the cost of administering the program which is underwritten by Dearborn National - a leader in the field of group coverage.

ELIGIBILITY
You will be eligible for this program if you are a full-time active employee.

ENROLLMENT
Enrollment is simple -- just fill out the enrollment form provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

BENEFICIARY
You have the right to designate the beneficiary of your choice under employee coverage.

WHEN YOUR INSURANCE STARTS
If you enroll on or before the day you become eligible, your employer provided insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

If you have elected Voluntary Employee Life Insurance, you will be notified as to when that coverage begins. Anyone electing not to enroll when first eligible or within three months thereafter can enroll later only if evidence of insurability satisfactory to the Insurance Company is provided.

TERMINATION OF COVERAGE
All insurance under the plan will terminate upon the earlier of retirement, termination of employment, when the plan ceases or when you withdraw from the plan.

Nevertheless, if you should die within 31 days thereafter, and you are eligible for conversion or portability, your life insurance will still be paid to your beneficiary.

*****REDUCTIONS AT AGES 65 & OVER*****

If you remain in active service beyond age 65 your amount of Basic Employee Life and Voluntary Life Insurance will be as follows:

Attained Age	Percent of Original Amount
65	65%
70	50%

FAMILY STATUS CHANGE

This provision allows you to increase your coverage by one times your basic annual salary without evidence of insurability within 31 days of the following:

- Marriage or divorce
- Death of a spouse or dependent child
- Birth or adoption of a dependent child
- Change in employment status for you or your spouse

WAIVER OF PREMIUM

Your Basic and Voluntary Life coverages include a wavier of premium provision. If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of 6 months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first.

CONVERSION

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Dearborn National Life Insurance Company in any amount up to the amount of your life coverage in effect on your date of termination.

You must apply for this policy within 31 days after the date your coverage terminates. This privilege applies to Supplemental Life Insurance and Supplemental Dependent Life Insurance as well as to Basic Life Insurance.

PORTABILITY

Voluntary Life benefits are portable upon retirement or termination for the employee and/or his insured spouse. Ported coverage terminates at age 70.

ACCELERATED BENEFITS OPTION

Dearborn National Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

GROUP POLICY AND CERTIFICATE

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Dearborn National Life Insurance Company. If you become insured, you will receive a certificate outlining your benefits under the policy.

PLAN SPONSOR

First Tennessee Human Resource Agency
704 Rolling Hills Drive
Johnson City, TN 37604
423-461-8200

CLAIMS PROCEDURE

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

This is only a brief summary of the life insurance benefits available. Some restrictions may apply. For more specific information about the coverage details, including limitations, exclusions and other requirements, please refer to your certificate booklet or contact Human Resources.

This coverage is underwritten by Dearborn National Life Insurance Company.

SCHEDULE OF BENEFITS

BASIC LIFE AND AD&D INSURANCE

In the amount of 1 X your salary up to a maximum $50,000 at no cost to you; paid by the First Tennessee Human Resource Agency.

VOLUNTARY GROUP LIFE INSURANCE Available to EE Only

You may choose amounts from $10,000 to a maximum of $200,000 in increments of $10,000.

YOUR MONTHLY COST FOR EMPLOYEE VOLUNTARY GROUP LIFE INSURANCE
Take monthly rate x 12 divide by 26 for Bi-Weekly Cost

To be eligible for Optional Term Life coverage over $100,000 you must furnish medical evidence of insurability satisfactory to Dearborn National Life Insurance Company.

Guaranteed Issue is $100,000.

Age	Rate Per $1,000
Less than 30	$0.08
30-34	$0.09
35-39	$0.12
40-44	$0.17
45-49	$0.29
50-54	$0.48
55-59	$0.75
60-64	$1.17
65-69	$2.10
70+	$3.76
Vol. AD&D	$.03 per $1,000

Texas Life Whole Life Insurance – SOLUTIONS 121

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

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

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

As an employee, you are eligible to apply once you have satisfied your employer's eligibility period.

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

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

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

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

Texas Life Whole Life Insurance – SOLUTIONS 121

Convenience of payroll deduction Thanks to your employer, SOLUTIONS 121 premiums are paid through convenient payroll deductions and sent to Texas Life by your employer.

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

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

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

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

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

Texas Life Whole Life Insurance – SOLUTIONS 121

Sample Rates

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

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

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit [1]
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness
- Waiver of Premium included for ages 17-59
- If you desire more coverage, you can qualify by answering just four underwriting questions.
- Coverage available for spouse, children and grandchildren[2]

[1] Guarantees are subject to product terms, exclusions and limitations and the insurers claims-paying ability and financial strength.

[2] Coverage and spouse/domestic partner eligibility may vary by state. Coverage not available for children and grandchildren in Washington. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships and legally recognized familial relationships.

[3] Facts About Life, LIMRA International (2011)

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

TEXASLIFE INSURANCE COMPANY

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

15M002-C 1001 CI & Waiver R1115 (exp0117)

See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Continuing Your Benefit Options

Blue Cross Blue Shield of TN Medical Plan

Under the medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA according to the following "qualifying events". If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA for a specified period after you leave your employment. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue medical coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as eligible dependents may continue coverage through COBRA. Examples of an ineligible dependent would be when your child turns 26 years old. To continue coverage thru COBRA, your employer will notify Blue Cross Blue Shield of Tennessee of your termination and then send you a letter reqarding COBRA.

Ameritas Dental Plan

Under the Ameritas dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA for a specified period after you leave your employment. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as eligible dependents may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. To continue coverage thru COBRA, your employer will notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact Interactive Medical Systems (IMS) at (800)426-8739.

Dearborn National Life Insurance Company Term Life Plan

If your employment terminates while you are covered under the plan, you may convert or port your term life coverage within 31 days from the date your coverage terminates. To get information and rates for coverage, please contact your benefits department.

AUL (American United Life) Disability

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for 1 year at the same cost without evidence of insurability.

You have 31 days from your date of termination to apply for portability. Please call 800-553-5318 to apply for the portability option.

To Continue Other Plans

You may continue your Aflac Group Accident, Aflac Group Critical Illness, Aflac Individual Policies, and/or Texas Life policies by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home.

For more information, contact:

Aflac Group at (800) 433-3036

Texas Life at (800) 283-9233, prompt #2

ontac Information for Questions and Claims

Aflac
Worldwide Headquarters
1932 Wynnton Road
Columbus, GA 31999
1-800-99-AFLAC (1-800-992-3522)
En espanol:
1-800-SI-AFLAC (1-800-742-3522)

Aflac Group
Columbia, South Carolina
Customer Service
1-800-433-3036
Aflacgroupinsurance.com

Ameritas Dental
1-800-487-5553
www.ameritas.com

American United Life (AUL)
Claims -1-855-517-6365
Customer Service -1-800-553-5318

BlueCross BlueSheild of TN
Customer Service 1-800-451-9097
www.bcbstn.com

Colonial Life
Mike Tamer 1-865-325-4368
Customer Service-1-800-325-4368

Mark III Brokerage
114 E. Unaka Ave.
Johnson City, TN. 37601
1-800-532-1044 x307

Texas Life Whole Life
1-800-283-9233 prompt #2