Mark III
Employee Benefits


***Plan Year: January 1, 2019 - December 31, 2019***
*Arranged and Enrolled by Mark III Brokerage, Inc.*

# **Employee** Benefits

Guilford County Schools offers a comprehensive benefits package specifically designed to protect your income and assets. The benefit plans are arranged and enrolled by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. During annual enrollment, you may purchase coverage through pre-tax and after-tax payroll deductions.

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## ***PRE-TAX BENEFITS***

*Paying for benefits by this method reduces your applicable FICA and income tax withholding resulting in increases to your take home pay.*



## ***AFTER-TAX BENEFITS***



## ***GENERAL INFORMATION***



*(This booklet highlights the benefits offered through your employer for the current plan year. This is **not** an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only. Please read your certificate for each product for the exact terms and conditions).*

# How to Enroll Guide

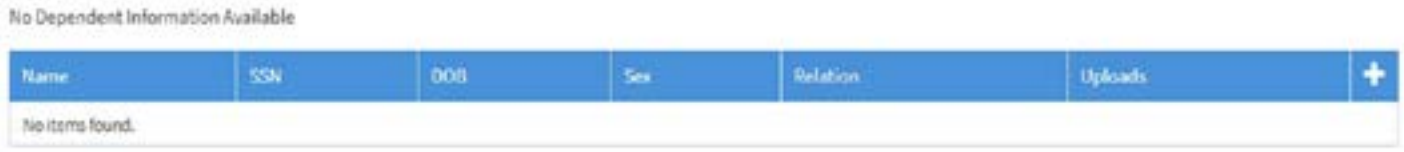
## 4 SIMPLE STEPS:

***Login.*** Your Social Security Number and PIN are your credentials. PINs are defaulted to the last four digits of your social plus the last two digits of your birth year.

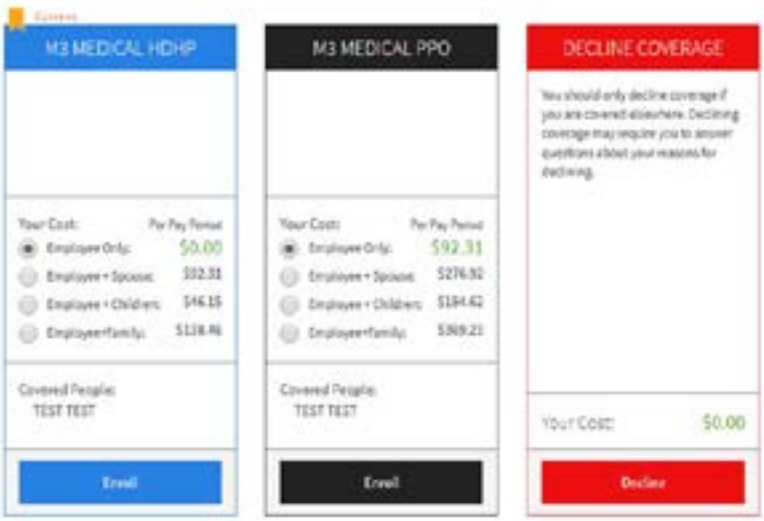
*Login Page: [http://mymarkiii.com/gcsnc](http://mymarkiii.com/gcsnc)*

E.g. Jane Doe, 123-45-6789, 01/01/1974: PIN: 678974

***Add Dependents.*** Click on the Plus icon on the far-right hand side. This will bring up the screen to add additional dependents. To edit a dependent, simply click on their name in the list. Click Save once complete.




***Elect Benefits.*** Follow the on-screen selections to elect or decline your benefit options. The system will display per pay period amounts and show you the coverages available to you.




***Sign & Submit.*** Finalize your benefit selections by signing the benefit summary at the very end of enrollment. You will utilize your PIN to electronically sign the benefits elected.


## CONGRATULATIONS! YOUR ENROLLMENT IS NOW COMPLETE!

# Key Points

**Guilford County Schools strongly encourages all full-time employees to add or update beneficiaries for the MetLife term life coverage.**

**You can do this by logging on the Selerix enrollment site or by meeting with a Mark III representative.**

**Aflac Group Hospital Indemnity (New Product)**

GCS is offering a new Hospital Indemnity (HI) plan effective 1/1/2019. The HI plan provides cash benefits directly to you that help pay for some medical and non-medical costs associated with a covered hospital stay due to a sickness or accidental injury. Some key features of the HI plan are:

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

**Aflac Group Critical Illness With and Without Cancer Options**

- $100.00 Health Screening Benefit (You may receive this benefit for one routine examination or other preventive testing once each calendar year.)
- Spouse coverage is available.
- Benefits available for $5,000 to $50,000 for employees and $25,000 for spouse.
- Each eligible dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage is guaranteed-issue up to the guaranteed-issue amounts.

**Aflac Group Accident**

- $60.00 Wellness Benefit (You may receive this benefit for one routine examination or other preventive testing once each calendar year.)
- 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.
- Product Effective Dates:
  - Texas Life: March 1, 2019
  - MetLife: When approved by MetLife
  - All other products: January 1, 2019

First payroll deduction for dental & term life will be deducted one month before the effective date of coverage. All other Flex Benefit deductions begin as follows:

• First payroll deduction for this year's enrollment:

January 15, 2019
- 10 Deductions (Teacher Assistants, 10-Month Office Support, ACES)
- 19 Deductions (Custodians and School Nutrition)
- 24 Deductions (12-Month Custodians)

January 30, 2019
- 10 Deductions (Teachers & Bus Drivers)
- 12 Deductions (Administrative)

• Annual enrollment will be the only time you are allowed to enroll or make changes to your existing coverage without a qualifying event.

• **The maximum for the Gilsbar Medical FSA has increased to $2,650 effective 1/1/2019.**

• Prescriptions are required for OTC items. You will not be able to use your FSA debit card for OTC items.

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

• If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollment and FSA elections. All requests must be made in writing to your benefits office with supporting documentation.

• All claims for FSA reimbursement must be submitted within 90-days following the end of the plan year, or if earlier, 90-days following the date you cease to participate in the plan, or the claims will be denied. Any money remaining in the account(s) after the 90-day grace period will be forfeited.

• Terminated employees have 90-days following their date of termination to submit FSA claims incurred prior to their cancellation/termination date.

• You must ***re-elect*** your Gilsbar Medical Spending and Dependent Care Accounts each year. They <u>do not</u> automatically carry over to the next year.

• Medical Reimbursement and Dependent Care expenses must be *incurred during the plan year* to be eligible for reimbursement.

• For *current* Gilsbar participants, your existing Gilsbar account will be replenished as long as you ***re-elect*** the Flexible Spending Account. Debit cards for the medical spending accounts are good for 3 years from the issue date.

• For *new* Gilsbar participants, a card will be mailed to your home address in a **<u>plain white envelope</u>** with no reference to Gilsbar. Again, this card will be good for three (3) years from issue date as long as you re-elect the Medical Spending Account each year.

• Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to www.myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445- 7227 ext. 883.

• Access your Gilsbar account online.

*1. Go to www.mygilsbar.com to register with a valid email address and your Group Number. The group number is* **S2555.**
*2. Once logged in, click the Reimbursement Account Center link on the left navigation bar.*

• Questions regarding all other benefits can be directed to: GCS Benefits Dept / 336.370.8348

# WELCOME TO GILSBAR
## FLEXIBLE SPENDING ACCOUNTS

Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your plan is administered by Gilsbar, L.L.C. **Your group number is S2555.**

**Plan Year:** January 1, 2019 - December 31, 2019
**Health Care Flexible Spending Account Maximum:** $2,650
**Dependent Care Account Maximum:** $5,000

All claims for reimbursement must be submitted within 90-days following the end of the plan year, or if earlier, 90 days following the date you cease to participate in the Plan, or the claims will be denied.

### Manage your account online 24/7 at myGilsbar.com

- Check your up-to-the-minute plan balances
- View election amounts and reimbursement details
- File claims and submit receipts online

### It's easy to get started:

- **Step 1:** After your effective date, go to mygilsbar.com and register as a new participant. You will complete a brief registration form, and you will need a valid e-mail address and your group number, S2555.
- **Step 2:** Once logged in, choose the FSAs and HRAs link in the left navigation bar.
- **Step 3:** Click the Accounts tab at the top, and then choose Election Summary to confirm that your annual election(s) are accurate. If there are any discrepancies in your account information, please contact us at (800) 445-7227 ext. 1883.

### Submit Your Claims

For fastest processing, upload your claims online. You may also fax claims and receipts to (866) 635.1329.

**Mail claims and receipts to:**
Gilsbar, L.L.C
Attn: Flex
PO Box 965, Covington, LA 70434
*(Please keep the original documents for your records.)*

# YOUR HEALTHCARE FSA

## What is a Healthcare FSA?

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

Any employee with eligible out-of-pocket expenses that exceed the benefits covered by their health plan can save money by enrolling in the Healthcare FSA. Eligible out-of-pocket expenses are determined by the IRS and include deductibles, co-insurance, co-payments, and other non-covered expenses in excess of the maximum amounts allowed under your plan.

## How does the Healthcare FSA work?

Employer healthcare FSA Plans will allow an end of the year grace period to spend unused funds, or they will have a rollover provision, or funds will be forfeited at the end of the plan year if claims are not filed within 90 days after the end of the plan year. It is important to know which option your plan has because different rules apply.

Healthcare FSA with Grace Periods: For healthcare FSA plans that elect to have a grace period, the IRS requires all money in the account to be used during the plan year. Money cannot be returned to you or carried over to the following year. This is what is commonly known as a "use-it-or-lose-it" account. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your election amount. To help avoid a situation where you have underspent your account, prior to the end of the plan year, you will be provided a balance notification. You should use the remaining funds to make qualified purchases prior to the last day of the current plan year.

Healthcare FSA with Rollover Provisions: For healthcare FSA Plans that elect to have a rollover provision, the IRS rules allow FSA account owners to rollover up to $500 of unspent FSA funds annually, although your Employer FSA Plan is allowed to designate a smaller rollover amount. In this situation, underspending your account is okay as long as you don't leave more than the designated rollover amount, usually $500, at the end of the plan year. You will be provided with account balance information prior to the end of the plan year and if your balance exceeds the rollover amount, you will need to make qualified purchases prior to the end of the plan year to reduce your balance. But any funds remaining at the end of the plan year that do not exceed the rollover provisions, will automatically rollover and be ready for your use in the new plan year.

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

## How does the Healthcare FSA save me money?

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

| | w/FSA | w/out FSA |
|---|---|---|
| **Salary:** | $1,000.00 | $1,000.00 |
| Less Pre-Taxed Dollars Healthcare Reimbursement | - $100.00 | - $0.00 |
| Taxable Income | $900.00 | $1,000.00 |
| **Less:** | | |
| Federal Income Tax (15%*) | - $135.00 | - $150.00 |
| State Income Tax (5%*) | - $45.00 | - $50.00 |
| Social Security (7.65%*) | - $68.85 | - $76.50 |
| | $651.15 | $723.50 |
| **Net Take Home Pay:** Less Healthcare Expenses | - $0.00 | - $100.00 |
| **Net After Expenses:** | $651.15 | $623.50 |

**1-800-445-7227 ext. 1883 | flex@gilsbar.com | 7 a.m. to 7 p.m. CT.**

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# YOUR HEALTHCARE FSA

### How easy is it to use my Healthcare FSA?

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

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

### Can I change my contribution amount?

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

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

### How will Healthcare reform affect my FSA?

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

### Most common eligible expenses:

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

Fax FSA claims & proof of expense to:
**866-635-1329**

**1-800-445-7227 ext. 1883 | flex@gilsbar.com | 7 a.m. to 7 p.m. CT.**

# FSA DEBIT CARD
## WHAT YOU NEED TO KNOW

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

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

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

### Where can I use my FSA debit card?
Your FSA Debit Card will only be accepted at authorized vendors who have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers, and pharmacies.

### What do I need to know about paying for prescriptions?
Effective January 1, 2011, OTC medications and drugs (other than insulin) will no longer be reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medications or drugs must meet one of the following criteria to be eligible for reimbursement:

1. The medicine or drug requires a prescription.
2. The medicine or drug is available without a prescription and the individual obtains a prescription.
3. The medicine or drug is insulin.

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

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

### What should I do to pay for an expense that is more than my account balance?
You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

# YOUR DEPENDENT CARE FSA

### What is a Dependent Care FSA?

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

### How does the Dependent Care FSA work?

With a Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate for the year will be pro-rated so that an equal amount is deducted from each pay check during the year. To estimate your dependent care expenses, consider your expenses from last year.

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

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

### What expenses are covered?

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

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

### How do I get reimbursed?

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

### Can I change my election during the plan year?

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

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

Fax FSA claims & proof of expense to:
**866-635-1329**

**1-800-445-7227 ext. 1883 | flex@gilsbar.com | 7 a.m. to 7 p.m. CT.**

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# FSA SUBSTANTIATION
## PROOF OF ELIGIBLE DEBIT CARD PURCHASES

### IRS Regulations on FSA Debit Cards
The IRS sets regulations regarding how debit cards operate in conjunction with a Flexible Spending Account (FSA). According to these rules, there are five basic requirements that must be met for you to use an FSA debit card.

- Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.
- The participant must retain all receipts for all transactions.
- 100% of debit card transactions must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee "self-certification" is not allowed.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

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

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

### Why does the IRS have these rules? Isn't it my money?
Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

### What should I do if I receive a substantiation request?
You may receive requests for Manual Substantiation in the event that the charges do not qualify for Auto-Substantiation. If you receive a substantiation request, please go to myGilsbar.com to electronically upload any required receipts.

For each claim that requires a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page, and follow the instructions. (Receipts must be in a JPG, GIF, PNG or PDF format and cannot exceed 2 MB.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records.

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

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

### Are providers, pharmacies, hospitals, etc required to provide a receipt with service?
No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

### Should I keep copies of my receipts?
Yes, because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending them to Gilsbar.

**1-800-445-7227 ext. 1883 | flex@gilsbar.com | 7 a.m. to 7 p.m. CT.**

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# FSA/HRA MOBILE APP
## MANAGE YOUR ACCOUNTS ON THE GO

**s pleased to announce the release of our FSA & HRA mobile app for your Android, and tablet devices. With the mobile app, you can:**

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

## DOWNLOADING THE APP

**For Apple Devices:**

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

**For Android Devices:**

- Open the Google Play Store or Market and search for "Gilsbar FSA HRA"
- Tap the Gilsbar app icon
- Tap "Install" and then "OK"
- Once the app is downloaded, tap its icon to open it on your device.

## LOGGING IN TO THE MOBILE APP

- Before you log in for the first time, you will need your participant ID number. Your participant ID can be found in the FSA/HRA section of myGilsbar.com by clicking the arrow to the right of your name.
- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1)
- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

**1-800-445-7227 ext. 1883 | flex@gilsbar.com | 7 a.m. to 7 p.m. CT.**

# Ameritas Dental

***As an employee of Guilford County Schools, you have the option of choosing between 2 dental benefit plans. The Non PPO and PPO plans have the exact same benefits except that services reimbursed under the PPO option are reimbursed based on network allowances (MAC – Maximum Allowable Charge). Services reimbursed under the Non-PPO plan are reimbursed based on the zip code of the dental provider (U&C – Usual and Customary).***

*****Important: Members enrolling in the PPO option should always utilize network providers in order to fully benefit from the plan. Services will be reimbursed at network allowances, even if a member does not visit a network provider .***

## Non PPO Dental Plan Summary

| | |
|---|---|
| **Coinsurance** | |
| **Type 1 - Preventive** | 100% |
| **Type 2 - Basic** | 80% |
| **Type 3 - Major** | 50% |
| **Deductible** | |
| | $50/Calendar Year Type 2 & 3<br>Waived Type 1, 3 Family Maximum |
| **Maximum** *(per person)* | $2,000 per calendar year |
| **Allowance** | 90th U&C |
| **Adult & Child Orthodontia** | $1500 Lifetime Benefit, No Deductible |
| **Ameritas Rewards Orthodontia – (Lifetime, per person)** | $100-New Treatment Plan and Services Only |
| **Waiting Period** | |
| **Dependent Age** | None<br>26 |

## PPO Dental Plan Summary

| | |
|---|---|
| **Coinsurance** | |
| **Type 1 - Preventive** | 100% |
| **Type 2 - Basic** | 80% |
| **Type 3 - Major** | 50% |
| **Deductible** | |
| | $50/Calendar Year Type 2 & 3<br>Waived Type 1, 3 Family Maximum |
| **Maximum** *(per person)* | $2,000 per calendar year |
| **Allowance** | Maximum Allowable Charge |
| **Adult & Child Orthodontia** | $1500 Lifetime Benefit, No Deductible |
| **Ameritas Rewards - Orthodontia (Lifetime, per person)** | $100-New Treatment Plan and Services Only |
| **Ameritas Rewards – Hearing Care (annual, per person)** | $100 |
| **Waiting Period** | None |
| **Dependent Age** | 26 |

### Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

| Type 1 - Preventive | Type 2 – Basic | Type 3- Major |
|---|---|---|
| • Routine Exam (2 per benefit period)<br>• Bitewing X-rays (2 per benefit period)<br>• Full Mouth/Panoramic X-rays (1 in 3 years)<br>• Periapical X-rays<br>• Cleaning (2 per benefit period)<br>• Fluoride for Children 18 and under (1 Per Benefit Period)<br>• Sealants (age 16 and under) | • Restorative Amalgams<br>• Restorative Composites (anterior teeth only)<br>• Denture Repair<br>• Crown Repair<br>• Endodontics (surgical & non surgical)<br>• Simple & Complex Extractions<br>• Anesthesia<br>• Space Maintainers | • Onlays<br>• Crowns (1 in 5 years per tooth)<br>• Periodontics (nonsurgical & surgical)<br>• Implants<br>• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) |

# Guilford County Schools

*Dental Highlight Sheet*

**PPO Hearing Care Summary**

| | |
|---|---|
| **Plan Benefit** | |
| **Annual Hearing Exam** | 100% |
| **Hearing Aid** | 50% |
| **Hearing Aid Maintenance** | 100% |
| **Deductible** | |
| **Annual Hearing Exam** | $0 |
| **Hearing Aid** | $0 |
| **Hearing Aid Maintenance** | $0 |
| **Maximum** *(per benefit period)* | |
| **Annual Hearing Exam** | Up to $75 |
| **Hearing Aids** ***(per ear)*** | |
| **Year One** | Up to $400 |
| **Year Two** | Up to $600 |
| **Year Three** | Up to $800 |
| **Hearing Aid Maintenance** | Up to $40 |

## Ameritas Rewards®

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

| | | |
|---|---|---|
| Benefit Threshold | $750 | Dental benefits received for the year cannot exceed this amount |
| Annual Carryover Amount | $250 | Dental Rewards amount is added to the following year's maximum |
| PPO Bonus **(PPO Plan Only)** | $150 | Additional bonus is earned if the member sees a network provider |
| Maximum Carryover | Unlimited | Maximum possible accumulation for Dental Rewards & PPO Combined |

## Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only Preventive and Basic procedures for the first 12 months they are covered.

## Eligible Dependents

Eligible Child Dependents up to Age 26, regardless of student status.

## Non PPO & PPO

Guilford County Schools proudly offers employees a dental program, administered by Ameritas Life Insurance Corp., providing excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. The Non PPO option allows members to visit any licensed dental provider of their choice and benefits will be reimbursed based on the Usual & Customary charges in the zip code of the provider. Members enrolling in the PPO plan option should utilize a network provider for all services. Members can find up to date network provider options by accessing the Ameritas website at www.ameritas.com.

## Ameritas Information

This plan was designed specifically for the associates of ***Guilford County Schools.*** At Ameritas, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com/member.

***This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For a complete list of covered procedures, please see your benefits administrator.***

| 12 Month Rates | | |
|---|---|---|
| | **PPO Plan** | **Non-PPO Plan** |
| **Employee Only** | **$29.09** | **$38.75** |
| **Employee and Family** | **$99.85** | **$133.40** |
| **10 and 11 month Rates** | | |
| | **PPO Plan** | **Non-PPO Plan** |
| **Employee Only** | **$34.91** | **$46.50** |
| **Employee and Family** | **$119.82** | **$160.08** |

# Direct Reimbursement Dental

The plan year deductible per insured is $0.00. The plan year deductible per family is $0.00. The plan year maximum per insured is $1,000.00. Any licensed provider/dentist can be used. No pre-determination/ prior authorization is required.

**DIAGNOSTIC AND PREVENTIVE SERVICES** - 50% coverage.

- Oral Exams & X-rays
- Fluoride Treatments (no age limit)
- Sealants (no age limit)
- Routine Teeth Cleanings (no limit)

**BASIC SERVICES** - 50% coverage.

- Space Maintainers
- Fillings
- Endodontics
- Recementations/Repairs
- Simple Extractions
- Consultations
- Surgical Extractions
- General Anesthesia

**MAJOR SERVICES** - 50% coverage.

- Periodontics
- Inlays/Onlays
- Crowns & Build-ups
- Veneers
- Dentures
- Bridges
- Implants
- Rebases / Relining

**ORTHODONTIA SERVICES**

50% coverage for children up age 26 & adult orthodontia. Orthodontia Lifetime Maximum is $1,000. Orthodontia fees are applied to the plan year maximum.

**ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 26

| | **12-MONTH RATES** |
|---|---|
| Employee Only | $11.25 |
| Employee + Dependent(s) | $39.10 |

| | **10-MONTH AND 11-MONTH RATES** |
|---|---|
| Employee Only | $13.50 |
| Employee + Dependent(s) | $46.92 |

*Payments to dentists are calculated on the 90th percentile of usual and customary charges for the providers in that area.

**No waiting period applies for employees and/or dependents that enroll when first eligible. A 12-month waiting period applies for Major and Orthodontic Services for late enrollees.

This is a brief description of your dental benefits and does not contain all limitations and exclusions under either plan. For more complete information, please consult your plan booklet(s) or your benefits administrator. For more information on the Direct Reimbursement Plan, call 336-889-2003.

# Superior Vision

**Visit SuperiorVision.com**
800.507.3800

| | Exam & Materials Plan | Materials Only Plan |
|---|---|---|
| **Co-Pays** | | |
| Exam | $10 | N/A |
| Materials[1] | $15 | $15 |
| Contact Lens Fitting | $35 | $25 |
| **Monthly Premiums** | | |
| Emp. only | $9.90 | $6.78 |
| Emp. + 1 dependent | $19.22 | $13.18 |
| Emp. + family | $28.24 | $19.32 |
| **Services/Frequency** | | |
| Exam | 12 months | N/A |
| Frames | 24 months | 24 months |
| Contact Lens Fitting | 12 months | 12 months |
| Lenses | 12 months | 12 months |
| Contact Lenses | 12 months | 12 months |

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

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

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

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

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

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

## Discount Features

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

### Discounts on Covered Materials

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

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

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

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

### Discounts on Non-Covered Exam and Materials

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

### Refractive Surgery

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

*The Plan discount features are not insurance.*

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

*Discounts are subject to change without notice.*

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

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

Superior Vision Services, Inc. P.O. Box 967 Rancho Cordova, CA 95741 800-507-3800 SuperiorVision.com
The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life
NVIGRP 5-07 1014-BSv4/NC

# Allstate Benefits Group Cancer

***In the United States, about 1,688,780 new cancer cases were expected to be diagnosed in 2017.[1]***

### *Group Voluntary Cancer*

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

### *Meeting Your Needs:*

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

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

### *Benefit Coverage Highlights*

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It helps protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability†

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

***Employee only**

****List of covered diseases on the following page.**

***† Enrolling after your initial enrollment period may require evidence of insurability***

***[1] Cancer Facts & Figures, American Cancer Society, 2017***

**In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[2]**

***Your Benefit Coverage***

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

***Specified Diseases***

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

***Continuous Hospital Confinement***

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

***Government or Charity Hospital***

**A $100 benefit will be paid** for each day a covered person is confined to:

(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);

(2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

***Surgery*****

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

***Anesthesia***

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

***Second Opinion***

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

***Physical or Speech Therapy***

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

***Ambulatory Surgical Center***

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

***Radiation/Chemotherapy for Cancer***

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

***[2] Cancer Facts & Figures, American Cancer Society, 2017***

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

***Anti-Nausea Benefit***

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

***Inpatient Drugs and Medicine***

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

***Hematological Drugs***

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

***Medical Imaging***

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

***Private Duty Nursing Services***

**A $100 benefit will be paid** per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

***New or Experimental Treatment***

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

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

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

***Physician's Attendance***

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

***At Home Nursing***

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

***Prosthesis***

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

***Hair Prosthesis***

**A $25 benefit will be paid** every 2 years for a wig or hairpiece if the covered person experiences hair loss.

***Nonsurgical External Breast Prosthesis***

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

***Ambulance***

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

***Hospice Care***

**A $100 benefit will be paid** for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

***Extended Care Facility***

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

***Outpatient Lodging***

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

***Non-Local Transportation***

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

accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

***Family Member Lodging and Transportation***

**Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid** for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.

(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

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

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

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

**A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid** for the following types of bone marrow or stem cell transplants performed on a covered person.

(1) A transplant which is other than non-autologous.

(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.

(3) A transplant which is non-autologous for the treatment of Leukemia.

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

***ADDITIONAL BENEFITS***

***Wellness***

**A $100 benefit will be paid** per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

***OPTIONAL BENEFITS***

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

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

***Intensive Care (Low and High Plans Only)****

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

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

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

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

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

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

Issue Ages: 18 and older while actively at work.

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

**Eligibility** - Family members eligible for coverage include: you, your legal spouse and your unmarried children including adopted children or foster children from the moment of placement in the residence, stepchildren, or legal ward who are under 26 years old, unless he or she continues to meet the definition of a dependent. Your children must be dependent on you for support or reside with you and be named on the enrollment or Evidence of Insurability Form.

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

**Termination of Coverage** - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision, the date you are no longer in an eligible class, or the date your class is no longer eligible Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse’s coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner’s coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child’s coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. • Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child’s attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child’s attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

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

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

| *Low Option without Optional Benefits* | |
|---|---|
| Insureds | Monthly Rates |
| Employee | $20.07 |
| Employee + Child(ren) | $27.71 |
| Employee + Spouse | $30.96 |
| Family | $38.57 |

| *Low Option with Optional Benefits* | |
|---|---|
| Insureds | Monthly Rates |
| Employee | $26.06 |
| Employee + Child(ren) | $36.81 |
| Employee + Spouse | $41.50 |
| Family | $52.23 |

| *Mid Option with $10,000 Initial Diagnosis Benefit* | |
|---|---|
| Insureds | Monthly Rates |
| Employee | $29.75 |
| Employee + Child(ren) | $42.16 |
| Employee + Spouse | $47.02 |
| Family | $59.39 |

| *High Option without Optional Benefits* | |
|---|---|
| Insureds | Monthly Rates |
| Employee | $31.09 |
| Employee + Child(ren) | $43.65 |
| Employee + Spouse | $47.51 |
| Family | $60.04 |

| *High Option with Optional Benefits* | |
|---|---|
| Insureds | Monthly Rates |
| Employee | $37.08 |
| Employee + Child(ren) | $52.75 |
| Employee + Spouse | $58.05 |
| Family | $73.70 |

**Pre-Existing Condition, Exclusions and Limitations** - Allstate Benefits does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. Allstate Benefits does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

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

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

This material is valid as long as information remains current, but in no event later than August 1, 2021.
Group Cancer benefits are provided under policy form GVCP3, or state variations thereof.

The coverage provided is limited benefit supplemental cancer and specified disease insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. There may be instances when a law requires that benefits under this coverage be paid to a third party, rather than to you. If you or a dependent have coverage under Medicare, Medicaid, or a state variation, please refer to your health insurance documents to confirm whether assignments or liens may apply.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

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

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

# Aflac Accident Advantage Plus - 7800

**Plan Features**

- Benefits are payable regardless of any other insurance programs.
- Coverage is guaranteed-issue, provided the applicant is eligible for coverage.
- The plan features benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits are available for spouse and/or dependent children.
- There's no limit on the number of claims an insured can file.
- Premiums are paid by convenient payroll deduction.
- Immediate effective date – Coverage will be effective the date the employee signs the application
- 24-Hour Coverage.

**Eligibility**

**Issue Ages**

Employee at least age 18

Spouse at least age 18

Children under age 26

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

**Guaranteed-Issue**

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

**Portability**

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

## Accident Benefits – High Option

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

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

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

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

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

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

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

| Complete Dislocations | | Closed Reduction Benefits |
|---|---|---|
| | Employee | Spouse / Child(ren) |
| **Hip** | $4,000 | $3,000 |
| **Knee (not kneecap)** | $2,600 | $1,950 |
| **Shoulder** | $2,000 | $1,500 |
| **Foot/Ankle** | $1,600 | $1,200 |
| **Hand** | $1,400 | $1,050 |
| **Lower Jaw** | $1,200 | $900 |
| **Wrist** | $1,000 | $750 |
| **Elbow** | $800 | $600 |
| **Finger/Toe** | $320 | $240 |

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

Dislocation refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan.

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

Partial dislocation is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint.

The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount.

If you have both fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

| **Paralysis** | |
|---|---|
| Quadriplegia | $10,000 |
| Paraplegia | $5,000 |

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

• The insured is injured,

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

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

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

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

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

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration.

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

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

| Burns (treatment within 14 days, first degree burns not covered) | |
|---|---|
| | **Benefit** |
| **Second Degree** | |
| Less than 10% of body surface covered | $100 |
| At least 10%, but not more than 25% of body surface covered | $200 |
| At least 25%, but not more than 35% of body surface covered | $500 |
| More than 35% of body surface covered | $1,000 |
| **Third Degree** | |
| Less than 10% of body surface covered | $1,000 |
| At least 10%, but not more than 25% of body surface covered | $5,000 |
| At least 25%, but not more than 35% of body surface covered | $10,000 |
| More than 35% of body surface covered | $20,000 |
| | |
| **Concussion** (A concussion or Mild Traumatic Brain Injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: Concussion and MTBI are used interchangeably. The concussion must be diagnosed by a doctor.) | $200 |
| **Coma** (state of profound unconsciousness lasting 30 days or more) | $10,000 |
| **Internal Injuries** (resulting in open abdominal or thoracic surgery) | $1,000 |
| **Exploratory Surgery** (without repair, i.e., arthroscopy) | $250 |
| **Emergency Dental Work** (injury to sound, natural teeth) | |
| Repaired with crown | $150 |
| Repaired in extraction | $50 |

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

We will pay the amount shown for X-rays or doctor services.
For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident.
We will pay the Medical Fees Benefit:
• For treatment received due to injuries from a covered accident and
• For each covered accident up to one year after the accident date.

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

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

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

We will pay the amount shown for injuries received in a covered accident if the insured:
- Receives treatment in a hospital emergency room, and
- Is held in a hospital for observation for at least 24 hours, and
- Receives initial treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

| Accident Follow-Up Treatment | $25 |
|---|---|

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

| Physical Therapy | $25 |
|---|---|

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

| Air Ambulance | $500 |
|---|---|
| Ambulance | $100 |

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

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

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

| Blood / Plasma | $100 |
|---|---|

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

| Prosthesis | $500 |
|---|---|

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

| Appliance | $100 |
|---|---|

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

| Family Lodging Benefit (per night) | $100 |
|---|---|

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

| Wellness | $60 |
|---|---|

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

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

| Hospital Admission | $1,000 |
|---|---|

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

- Is injured,
- Requires hospital confinement, and
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.

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

| Hospital Confinement (per day) | $200 |
|---|---|

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

- Is injured, and
- Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

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

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

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

| Hospital Intensive Care (per day) | $400 |
|---|---|

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

• Is injured, and

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

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

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

Dismemberment means:

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

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

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

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

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

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

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

Common carrier means:

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

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

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

**LIMITATIONS AND EXCLUSIONS**

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

• War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service. This does not include terrorism.

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

• Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.

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

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

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

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

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

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

**Notices**

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

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

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

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

Puerto Rico, or the Virgin Islands.

Continental American Insurance Company, Columbia, South Carolina.

AGCM378NC-25-BK R2 IV (3/18)

## What would my monthly payroll deduction cost be for the Aflac accident plan?

| 24 Hour Coverage | Monthly Premium |
|---|---|
| Employee | $16.21 |
| Employee and Spouse | $23.18 |
| Employee and Dependent Child(ren) | $30.90 |
| Employee & Family | $37.89 |


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# Aflac Group Hospital Indemnity

**Plan Description**

The Aflac Group Hospital Indemnity plan provides cash benefits directly to you (unless otherwise assigned) that help pay for some of the costs—medical and nonmedical—associated with a covered hospital stay due to a sickness or accidental injury.

**Plan Features**

- Benefits paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means you may qualify for coverage without answering health questions)
- Premiums paid through convenient payroll deduction
- No pre-existing limitations or waiting period
- Benefits don't reduce as you get older
- Coverage is portable (with certain stipulations)
- Annual Health Screening Benefit is included
- Benefits are paid regardless of any other medical insurance

**Additional Rider Available**

- Waiver of Premium

**Underwriting Guidelines – Guaranteed-Issue**

**Guaranteed-Issue**

Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first and second anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

**Late Enrollee Eligibility**

For late enrollees who are not eligible for guaranteed-issue:

All applicants are required to answer underwriting questions.

**Individual Eligibility**

Issue Ages:

- Employee: 18+
- Spouse or Domestic Partner: 18+
- Children: Under age 26

**Spouse or Domestic Partner Coverage Available**

To apply for spouse or domestic partner coverage, you must also apply and be issued coverage.
***Spouse/Domestic Partner-only coverage is not available.***

**Dependent Children Coverage Available**

Dependent children under the age of 26 can be covered. To apply for dependent child coverage, you must also apply and be issued coverage.

If you do not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, you must apply for coverage for the child and pay any required premium.
***Children-only coverage is not available.***

**Successor Insured Benefit**

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

**Portability**

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

**Group Hospital Indemnity Benefits**

**Hospitalization Benefits – Base Plan**

| Benefits | Low | HIGH |
|---|---|---|
| Hospital Admission (per confinement) – once per covered sickness or accident per calendar year for each insured<br><br>We will pay the amount shown when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident.<br><br>We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. | **$500** | **$1,500** |
| Hospital Confinement (per day) – maximum of 180 days per confinement for each covered sickness or accident for each insured<br><br>We will pay this benefit in the amount shown for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or because of a covered sickness. In order to receive this benefit for accidental injuries received in a covered accident, the insured must be confined to a hospital within six months of the date of the covered accident.<br><br>If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.<br><br>This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness. | **$100** | **$150** |

****Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement only.***

### Health Screening Benefit – once per calendar year for each insured

| Benefit | Benefit Amount |
|---|---|
| Health Screening Benefit | **$50 per calendar year** |

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

### Treatment Benefits

| Benefit | High | Low |
|---|---|---|
| Major Diagnostic Exams – once per covered sickness or accident per calendar year<br><br>We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams:<br>• Computerized Tomography (CT/CAT scan)<br>• Magnetic Resonance Imaging (MRI)<br>• Electroencephalography (EEG) | **$250** | **$125** |

### Surgical Benefits

| Benefits | High | Low |
|---|---|---|
| **Surgical Benefit (per procedure)**<br><br>If an insured has surgery performed by a physician due to an injury or because of a covered sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a hospital (on an inpatient or outpatient basis), in an ambulatory surgical center, or in a physician's office.<br><br>If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations (the operation that is nearest in severity and complexity).<br><br>If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit—the largest—will be provided. | **Up to $1,500** | **Up to $750** |
| **Anesthesia Benefits**<br><br>When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit. | **Up to $375** | **Up to $187.50** |

**Waiver of Premium Rider**

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

Limitations and Exclusions
(applies to all riders unless otherwise noted)

## Exclusions

We will not pay for loss due to:

- War - voluntarily participating in war, any acto of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.

**Notices**

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

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

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

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

Puerto Rico, or the Virgin Islands.

Continental American Insurance Company, Columbia, South Carolina.

## Monthly Rates

| | Low Plan | High Plan |
|---|---|---|
| **Employee** | $20.96 | $42.32 |
| **Employee + Spouse** | $41.92 | $84.96 |
| **Employee + Child(ren)** | $30.96 | $61.76 |
| **Employee + Family** | $51.92 | $104.40 |

# Aflac Group Critical Illness With Cancer

**Plan Features**

• Benefits are paid directly to you, unless otherwise assigned.

• Premiums are paid through convenient payroll deduction.

• Guaranteed-issue coverage available to employee and spouse.

• Each dependent child is covered at 50% of the primary insured amount at no additional charge.

• Benefit amounts are available from $5,000 up to $50,000 for employees and up to $30,000 for spouse.

• An annual Health Screening benefit is included.

• The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).

**Underwriting Guidelines – Guaranteed-Issue**

Guaranteed-issue coverage is available for all eligible employees. The following options are available: Up to [$30,000] for employees and up to [$15,000] for spouses with no participation requirement.

For employee amounts over [$30,000] and spouse amounts over [$15,000]:
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

**Individual Eligibility**

Issue Ages
Employee 18-69
Spouse 18-69
Children under age 26

Benefit-eligible employees, working at least [40] hours or more weekly, with at least [0] days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

**Spouse Coverage Available**

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling [100%] of the employee amount, not to exceed the $30,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $30,000.

**Dependent Children Coverage at No Additional Charge**

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

**Portability**

Coverage is portable with certain stipulations. See certificate for details.

## Group Critical Illness Benefits

**First Occurrence Benefit** – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness; if the date of diagnosis is while coverage is in force, and the certificate does not exclude the illness or condition by name or by specific description. We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

| Critical Illnesses Covered Under Plan | Percentage of Face Amount |
|---|---|
| Cancer (Internal or Invasive) | 100% |
| Heart Attack | 100% |
| Major Organ Transplant | 100% |
| Renal Failure (End Stage) | 100% |
| Stroke | 100% |
| Carcinoma in Situ** | 25% |
| Coronary Artery Bypass** | 25% |

**Separate Diagnosis Benefit** – We will pay benefits for each different critical illness after the first when the following conditions are met: the two dates of diagnosis must be separated by at least 6 months, or if the insured is treatment-free from cancer for at least 6 months, and are not caused by or contributed to by a critical illness for which benefits have been paid.

**Re-occurrence Benefit** - Once benefits have been paid for a critical illness, we will pay additional benefits for that same critical illness when the dates of diagnosis are separated by at least 12 months, or the insured has been treatment-free from cancer for at least 12 months and is currently treatment-free.

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless the insured has been treatment-tree for 12 months and is currently treatment-free.

+ Payment of the partial benefit for carcinoma in situ will reduce by 25% the benefit for internal cancer. Payment of the partial benefit for coronary artery bypass surgery will reduce by 25% the benefit for a heart attack.

*For employees who have chosen the without cancer plan option, these cancer benefits do not apply.

**Health Screening Benefit- $100**

After the Waiting Period, we will pay a maximum of $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year. This benefit is only payable for health screening tests performed as the result of preventative care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

• 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

**Specified Critical Illness Rider**

| Illnesses Covered Under Plan | Percentage of Face Amount |
|---|---|
| Coma | 100% |
| Paralysis | 100% |
| Severe Burns | 100% |
| Loss of Speech | 100% |
| Loss of Sight | 100% |
| Loss of Hearing | 100% |
| Advanced Alzheimer's Disease | 25% |
| Advanced Parkinson's Disease | 25% |
| Benign Brain Tumor | 100% |

We will pay the specified critical illness benefit if the insured is diagnosed with one of the specified critical illnesses shown in the rider schedule if the date of diagnosis is after the waiting period, the date of diagnosis occurs while the rider is in force, and the specified critical illness is not excluded by name or specific description in the rider. We will not pay benefits under the rider if these conditions result from another specified critical illness. For benefits to be payable on multiple specified critical illnesses, the date of loss for each illness must be separated by at least 12 months.

**Heart Event Rider**

| Covered Surgeries and Procedures | Percentage of Face Amount |
|---|---|
| **Category 1** | |
| Coronary Artery Bypass Surgery | 100% |
| Mitral valve replacement or repair | 100% |
| Aortic valve replacement or repair | 100% |
| Surgical Treatment of Abdominal aortic aneurysm | 100% |
| **Category 2**** | |
| AngioJet Clot Busting | 10% |
| Balloon Angioplasty (or Balloon valvuloplasty ) | 10% |
| Laser Angioplasty | 10% |
| Atherectomy | 10% |
| Stent implantation | 10% |
| Cardiac catheterization | 10% |
| Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) | 10% |
| Pacemakers | 10% |

We will pay the applicable category I or category II benefit if the insured is treated with one of the procedures shown on the rider schedule as long as the date of treatment is after the waiting period, treatment occurred while the rider is in force, treatment is recommended by a physician, and it is no excluded by name of specific description in the rider. Benefits are not payable under the rider for loss if these conditions result from another specified critical illness other than heart attack. For Heart Attack, we will pay applicable benefits. Payment of initial, reoccurrence, or separate diagnosis benefits are subject to the Benefit Provisions section of the certificate.

*This 100% represents the combination of total of applicable benefits available in this Rider and benefits available in the Certificate (for the same conditions). When combined, benefits from the Rider **and** Certificate **will not exceed 100%** of the maximum applicable benefit. Note that the 25% Coronary Artery Bypass Surgery (CABS) partial benefit in your base certificate is increased to 100% with this Rider. The CABS benefit in this Rider, combined with the benefit in your base certificate, equal 100% of the maximum benefit—**not 125%**.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Category I and a Category II procedure are performed at the same time, benefits are eligible only at the 100% (higher) event and will not exceed the applicable face amount shown on the Benefit Schedule in the Certificate. You are eligible to receive only one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures.

**Limitations and Exclusions**

This plan contains a 30-day waiting period. This means that we will not pay benefits to an insured who has been diagnosed or had a health screening test performed before his coverage has been in force 30 days from the effective date. If a critical Illness is first Diagnosed during the waiting period, we will

only pay benefits for loss beginning after coverage has been in force for 12 months. Or, the insured may elect to void the certificate from the beginning and receive a full premium refund.

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

**Pre-existing Condition*** is a sickness or physical condition that existed within the 12-month period before the insured's effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured.

We will not pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the 12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after the insured's effective date.

**Benefits are payable for the reoccurrence of a previously diagnosed cancer and/or carcinoma in situ as long as the Insured:*

• *Has been free from signs or symptoms of that cancer for a consecutive 12-month period before the date of diagnosis (for the reoccurrence) and*

• *Has been treatment-free from that cancer for the 12 consecutive months before the date of diagnosis (for the reoccurrence).*

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

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

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

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

• **Participation in Aggressive Conflict of any kind, including:**
    - War (declared or undeclared) or military conflicts (this does not include terrorism)
    - Insurrection or riot
    - Civil commotion or civil state of belligerence

• **Illegal substance abuse, which includes the following**:
    - Abuse of legally-obtained prescription medication
    - Illegal use of non-prescription drugs

**Specified Critical Illness Rider Exclusions:**

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

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

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

**Heart Event Rider Exclusions:**

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

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

The Company will not reduce or deny a claim for benefits for any covered heart procedure that was diagnosed more than 12 months after the effective date of this Rider.

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

Notices

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

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

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Continental American Insurance Company, Columbia, South Carolina.

AGCM320C-NC-BK R2 IV (3/18)

# Aflac Critical Illness with Cancer Monthly Rates

| NONTOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 6.63 | $ 9.76 | $ 12.89 | $ 16.02 | $ 19.15 | $ 22.28 | $ 25.41 | $ 28.54 | $ 31.67 | $ 34.80 |
| 30-39 | $ 8.49 | $ 13.48 | $ 18.46 | $ 23.45 | $ 28.44 | $ 33.43 | $ 38.42 | $ 43.40 | $ 48.39 | $ 53.38 |
| 40-49 | $ 13.86 | $ 24.21 | $ 34.57 | $ 44.93 | $ 55.28 | $ 65.64 | $ 75.99 | $ 86.35 | $ 96.71 | $ 107.06 |
| 50-59 | $ 21.81 | $ 40.12 | $ 58.43 | $ 76.74 | $ 95.05 | $ 113.35 | $ 131.66 | $ 149.97 | $ 168.28 | $ 186.59 |
| 60-69 | $ 37.55 | $ 71.60 | $ 105.65 | $ 139.70 | $ 173.75 | $ 207.80 | $ 241.85 | $ 275.91 | $ 309.96 | $ 344.01 |

| NONTOBACCO - Spouse | | | | | | |
|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 |
| 18-29 | $ 6.63 | $ 9.76 | $ 12.89 | $ 16.02 | $ 19.15 | $ 22.28 |
| 30-39 | $ 8.49 | $ 13.48 | $ 18.46 | $ 23.45 | $ 28.44 | $ 33.43 |
| 40-49 | $ 13.86 | $ 24.21 | $ 34.57 | $ 44.93 | $ 55.28 | $ 65.64 |
| 50-59 | $ 21.81 | $ 40.12 | $ 58.43 | $ 76.74 | $ 95.05 | $ 113.35 |
| 60-69 | $ 37.55 | $ 71.60 | $ 105.65 | $ 139.70 | $ 173.75 | $ 207.80 |

| TOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 8.30 | $ 13.10 | $ 17.89 | $ 22.69 | $ 27.49 | $ 32.29 | $ 37.09 | $ 41.88 | $ 46.68 | $ 51.48 |
| 30-39 | $ 11.67 | $ 19.83 | $ 28.00 | $ 36.16 | $ 44.33 | $ 52.49 | $ 60.66 | $ 68.83 | $ 76.99 | $ 85.16 |
| 40-49 | $ 24.33 | $ 45.15 | $ 65.98 | $ 86.80 | $ 107.63 | $ 128.45 | $ 149.28 | $ 170.10 | $ 190.93 | $ 211.75 |
| 50-59 | $ 38.76 | $ 74.03 | $ 109.29 | $ 144.55 | $ 179.81 | $ 215.08 | $ 250.34 | $ 285.60 | $ 320.86 | $ 356.13 |
| 60-69 | $ 68.90 | $ 134.30 | $ 199.70 | $ 265.11 | $ 330.51 | $ 395.91 | $ 461.31 | $ 526.71 | $ 592.11 | $ 657.51 |

| TOBACCO - Spouse | | | | | | |
|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 |
| 18-29 | $ 8.30 | $ 13.10 | $ 17.89 | $ 22.69 | $ 27.49 | $ 32.29 |
| 30-39 | $ 11.67 | $ 19.83 | $ 28.00 | $ 36.16 | $ 44.33 | $ 52.49 |
| 40-49 | $ 24.33 | $ 45.15 | $ 65.98 | $ 86.80 | $ 107.63 | $ 128.45 |
| 50-59 | $ 38.76 | $ 74.03 | $ 109.29 | $ 144.55 | $ 179.81 | $ 215.08 |
| 60-69 | $ 68.90 | $ 134.30 | $ 199.70 | $ 265.11 | $ 330.51 | $ 395.91 |

*Rates include cancer benefit.*

*Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, Benign Brain Tumor 100%, Advanced Alzheimer's Disease 25%, Advanced Parkinson's Disease 25% Rider, and no additional riders.*

*No benefit reduction at age 70*

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

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# Aflac Group Critical Illness Without Cancer

**Plan Features**

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available from $5,000 up to $50,000 for employees and up to $30,000 for spouse.
- An annual Health Screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).

**Underwriting Guidelines – Guaranteed-Issue**

Guaranteed-issue coverage is available for all eligible employees. The following options are available: Up to $30,000 for employees and up to $15,000 for spouses with no participation requirement.

For employee amounts over $30,000 and spouse amounts over $15,000:
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

**Individual Eligibility**

Issue Ages
Employee 18-69
Spouse 18-69
Children under age 26

Benefit-eligible employees, working at least 30 hours or more weekly, with at least 0 days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age
are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

**Spouse Coverage Available**

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling [100%] of the employee amount, not to exceed the $30,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $30,000.

**Dependent Children Coverage at No Additional Charge**

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

**Portability**

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

**Group Critical Illness Benefits**

**First Occurrence Benefit** – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness; if the date of diagnosis is while coverage is in force, and the certificate does not exclude the illness or condition by name or by specific description.

We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

| Critical Illnesses Covered Under Plan | Percentage of Face Amount |
|---|---|
| Heart Attack | 100% |
| Major Organ Transplant | 100% |
| Renal Failure (End Stage) | 100% |
| Stroke | 100% |
| Coronary Artery Bypass Surgery+ | 25% |

**Separate Diagnosis Benefit** – We will pay benefits for each different critical illness after the first when the following conditions are met: the two dates of diagnosis must be separated by at least 6 months, and are not caused by or contributed to by a critical illness for which benefits have been paid.

**Re-occurrence Benefit** - Once benefits have been paid for a critical illness, we will pay additional benefits for that same critical illness when the dates of diagnosis are separated by at least 12 months.

+ Payment of the partial benefit for coronary artery bypass surgery will reduce by 25% the benefit for a heart attack.

**Health Screening Benefit- $100**

After the Waiting Period, we will pay a maximum of $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year. This benefit is only payable for health screening tests performed as the result of preventative care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

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

**Specified Critical Illness Rider**

| Illnesses Covered Under Plan | Percentage of Face Amount |
|---|---|
| Coma | 100% |
| Paralysis | 100% |
| Severe Burns | 100% |
| Loss of Speech | 100% |
| Loss of Sight | 100% |
| Loss of Hearing | 100% |
| Advanced Alzheimer's Disease | 25% |
| Advanced Parkinson's Disease | 25% |
| Benign Brain Tumor | 100% |

We will pay the specified critical illness benefit if the insured is diagnosed with one of the specified critical illnesses shown in the rider schedule if the date of diagnosis is after the waiting period, the date of diagnosis occurs while the rider is in force, and the specified critical illness is not excluded by name or specific description in the rider. We will not pay benefits under the rider if these conditions result from another specified critical illness. For benefits to be payable on multiple specified critical illnesses, the date of loss for each illness must be separated by at least 12 months.

**Heart Event Rider**

| Covered Surgeries and Procedures | Percentage of Face Amount |
|---|---|
| **Category 1** | |
| Coronary Artery Bypass Surgery | 100% |
| Mitral valve replacement or repair | 100% |
| Aortic valve replacement or repair | 100% |
| Surgical Treatment of Abdominal aortic aneurysm | 100% |
| **Category 2**** | |
| AngioJet Clot Busting | 10% |
| Balloon Angioplasty (or Balloon valvuloplasty ) | 10% |
| Laser Angioplasty | 10% |
| Atherectomy | 10% |
| Stent implantation | 10% |
| Cardiac catheterization | 10% |
| Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) | 10% |
| Pacemakers | 10% |

We will pay the applicable category I or category II benefit if the insured is treated with one of the procedures shown on the rider schedule as long as the date of treatment is after the waiting period, treatment occurred while the rider is in force, treatment is recommended by a physician, and it is no excluded by name of specific description in the rider. Benefits are not payable under the rider for loss if these conditions result from another specified critical illness other than heart attack. For Heart Attack, we will pay applicable benefits. Payment of initial, reoccurrence, or separate diagnosis benefits are subject to the Benefit Provisions section of the certificate.

*This 100% represents the combination of total of applicable benefits available in this Rider and benefits available in the Certificate (for the same conditions). When combined, benefits from the Rider and Certificate will not exceed 100% of the maximum applicable benefit. Note that the 25% Coronary Artery Bypass Surgery (CABS) partial benefit in your base certificate is increased to 100% with this Rider. The CABS benefit in this Rider, combined with the benefit in your base certificate, equal 100% of the maximum benefit—not 125%.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Category I and a Category II procedure are performed at the same time, benefits are eligible only at the 100% (higher) event and will not exceed the applicable face amount shown on the Benefit Schedule in the Certificate. You are eligible to receive only one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures.

**Limitations and Exclusions**

This plan contains a 30-day waiting period. This means that we will not pay benefits to an insured who has been diagnosed or had a health screening test performed before his coverage has been in force 30 days from the effective date.

If a critical Illness is first Diagnosed during the waiting period, we will only pay benefits for loss beginning after coverage has been in force for 12 months. Or, the insured may elect to void the certificate from the beginning and receive a full premium refund.

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

**Pre-existing Condition** is a sickness or physical condition that existed within the 12-month period before the insured's effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured.

We will not pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after the insured's effective date.

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

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

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

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

• Participation in Aggressive Conflict of any kind, including:

  - War (declared or undeclared) or military conflicts (this does not include terrorism)
  - Insurrection or riot
  - Civil commotion or civil state of belligerence

• Illegal substance abuse, which includes the following:

  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

**Specified Critical Illness Rider Exclusions:**

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

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

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

**Heart Event Rider Exclusions:**

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

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

The Company will not reduce or deny a claim for benefits for any covered heart procedure that was diagnosed more than 12 months after the effective date of this Rider.

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

**Notices**

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

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

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Continental American Insurance Company, Columbia, South Carolina.

# Aflac Critical Illness Without Cancer Monthly Rates.

| NONTOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 5.68 | $ 7.86 | $ 10.04 | $ 12.22 | $ 14.40 | $ 16.58 | $ 18.76 | $ 20.94 | $ 23.12 | $ 25.30 |
| 30-39 | $ 7.04 | $ 10.58 | $ 14.11 | $ 17.65 | $ 21.19 | $ 24.73 | $ 28.27 | $ 31.80 | $ 35.34 | $ 38.88 |
| 40-49 | $ 10.56 | $ 17.61 | $ 24.67 | $ 31.73 | $ 38.78 | $ 45.84 | $ 52.89 | $ 59.95 | $ 67.01 | $ 74.06 |
| 50-59 | $ 15.46 | $ 27.42 | $ 39.38 | $ 51.34 | $ 63.30 | $ 75.25 | $ 87.21 | $ 99.17 | $ 111.13 | $ 123.09 |
| 60-69 | $ 25.95 | $ 48.40 | $ 70.85 | $ 93.30 | $ 115.75 | $ 138.20 | $ 160.65 | $ 183.11 | $ 205.56 | $ 228.01 |

| NONTOBACCO - Spouse | | | | | | |
|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 |
| 18-29 | $ 5.68 | $ 7.86 | $ 10.04 | $ 12.22 | $ 14.40 | $ 16.58 |
| 30-39 | $ 7.04 | $ 10.58 | $ 14.11 | $ 17.65 | $ 21.19 | $ 24.73 |
| 40-49 | $ 10.56 | $ 17.61 | $ 24.67 | $ 31.73 | $ 38.78 | $ 45.84 |
| 50-59 | $ 15.46 | $ 27.42 | $ 39.38 | $ 51.34 | $ 63.30 | $ 75.25 |
| 60-69 | $ 25.95 | $ 48.40 | $ 70.85 | $ 93.30 | $ 115.75 | $ 138.20 |

| TOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 6.70 | $ 9.90 | $ 13.09 | $ 16.29 | $ 19.49 | $ 22.69 | $ 25.89 | $ 29.08 | $ 32.28 | $ 35.48 |
| 30-39 | $ 8.92 | $ 14.33 | $ 19.75 | $ 25.16 | $ 30.58 | $ 35.99 | $ 41.41 | $ 46.83 | $ 52.24 | $ 57.66 |
| 40-49 | $ 16.98 | $ 30.45 | $ 43.93 | $ 57.40 | $ 70.88 | $ 84.35 | $ 97.83 | $ 111.30 | $ 124.78 | $ 138.25 |
| 50-59 | $ 26.26 | $ 49.03 | $ 71.79 | $ 94.55 | $ 117.31 | $ 140.08 | $ 162.84 | $ 185.60 | $ 208.36 | $ 231.13 |
| 60-69 | $ 44.75 | $ 86.00 | $ 127.25 | $ 168.51 | $ 209.76 | $ 251.01 | $ 292.26 | $ 333.51 | $ 374.76 | $ 416.01 |

| TOBACCO - Spouse | | | | | | |
|---|---|---|---|---|---|---|
| Issue Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 |
| 18-29 | $ 6.70 | $ 9.90 | $ 13.09 | $ 16.29 | $ 19.49 | $ 22.69 |
| 30-39 | $ 8.92 | $ 14.33 | $ 19.75 | $ 25.16 | $ 30.58 | $ 35.99 |
| 40-49 | $ 16.98 | $ 30.45 | $ 43.93 | $ 57.40 | $ 70.88 | $ 84.35 |
| 50-59 | $ 26.26 | $ 49.03 | $ 71.79 | $ 94.55 | $ 117.31 | $ 140.08 |
| 60-69 | $ 44.75 | $ 86.00 | $ 127.25 | $ 168.51 | $ 209.76 | $ 251.01 |

*Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, Benign Brain Tumor 100%, Advanced Alzheimer's Disease 25%, Advanced Parkinson's Disease 25% Rider, and no additional riders.*

*No benefit reduction at age 70*

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


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## THE NEED FOR DISABILITY INSURANCE

# Protect your paycheck

You insure your home, car and other valuable possessions, so why not also protect what pays for all those things? Your income. Without it, think about how your mortgage/rent, groceries or credit card bills would get paid. That's where disability insurance can help.

A disability can happen to anyone at any time and it can last for a short or long period of time. Purchasing disability insurance through your workplace is a way to replace a portion of your pre-disability earnings if you get sick or hurt and are unable to work. Being prepared can help ease the financial burden for you.

Things to think about
A severe injury or illness can leave you unable to work for years. Workers' compensation only covers injuries that happen on the job and, to qualify for coverage, you must meet certain eligibility requirements.
Additionally, medical insurance will only help cover your medical costs.

You might be able to dip into savings or borrow money from loved ones, but if you don't have these options,can you really afford not to have disability insurance?

Protect yourself and your income with disability insurance.

**Disability insurance can provide you with the income protection you need. Consider purchasing it today.**

**Note:** Products issues and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company

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Let's figure it out Everyone's circumstances are different. This calculator can help you figure out how much you need to protect your lifestyle and the lifestyles of those you love if you become disabled.

**Estimate your essential monthly expenses**

| Living Expenses | Amount |
|---|---|
| Monthly housing (e.g., mortgage, rent, insurance, taxes) | |
| Utilities (e.g., telephone, electricity, gas, oil, cable, TV, internet) | |
| Food | |
| Transportation (e.g., car payments, gasoline, insurance) | |
| **Subtotal =** | |
| Debt expenses | |
| Education (e.g., tuition, books, supplies) | |
| Health care (e.g., out-of-pocket costs, insurance premiums) | |
| Debt payments (e.g., credit cards, other debt) | |
| **Subtotal =** | |
| Other expenses | |
| Dependent care | |
| Life insurance premiums | |
| **Subtotal =** | |
| **Minimum monthly amount to cover with disability insurance.** | **$** |

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

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

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

**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 maximum STD benefit duration, if continually disabled, is thirteen (13) weeks.

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

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

**STD Pre-Existing Condition Exclusion**
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/ OneAmerica from the prior carrier and will be Actively at work on the effective date.

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

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

**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

**Benefit Duration*: 13 Weeks***

| Monthly Benefit | Monthly Premium |
|---|---|
| $500 | $10.36 |
| $600 | $12.43 |
| $700 | $14.50 |
| $800 | $16.57 |
| $900 | $18.64 |
| $1,000 | $20.71 |
| $1,100 | $22.78 |
| $1,200 | $24.85 |
| $1,300 | $26.92 |
| $1,400 | $28.99 |
| $1,500 | $31.07 |
| $1,600 | $33.14 |
| $1,700 | $35.21 |
| $1,800 | $37.28 |
| $1,900 | $39.35 |
| $2,000 | $41.42 |

**American United Life Insurance Company**

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200 / South Portland, ME  04106

Fax: 1-844-287-9499

OneAmerica.claims@customdisability.com

Toll Free Phone 1-855-517-6365

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

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

# AUL Long Term Disability

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

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

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

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

| Age When Total Disability Begins | Maximum Period Benefits are Payable |
|---|---|
| Prior to Age 61 | 5 Years |
| 61 | Lesser of 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 |

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

**Mental & Nervous / Drug & Alcohol**
Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments 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.

**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/ from the prior carrier and will be Actively at work on the effective date if the AULcoverage is replacing coverage under a Franchise Plan of Benefits.

**Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period**
This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit IF:

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and
2. The Person changes from one AUL short term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period. The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

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

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

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

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

***** Please note, annual increases are not available for LTD coverage.**

**Exclusions and Limitations**
This plan will not cover any disability resulting from certain events or conditions such as but not limited to war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. Additional exclusions and limitations may apply.

# *Voluntary Long Term Disability*

| Benefit Amount | Monthly Deduction |
|---|---|
| $500 | $8.15 |
| $1,000 | $16.30 |
| $1,500 | $24.45 |
| $2,000 | $32.60 |

**Customer Service**
800-553-5318

**Disability Claims**

American United Life Insurance Company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
OneAmerica.claims@customdisability.com
Toll Free Phone 1-855-517-6365

**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.

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

# MetLife Term Life

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

**OPTIONAL EMPLOYEE LIFE INSURANCE**
Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. 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 optional portion of your program to go along with any personal insurance coverage you may have.

**OPTIONAL DEPENDENT LIFE INSURANCE**
Provides coverage on:
- Your Spouse
- Child(ren) up to age 26.

Handicapped children can continue to be covered with no age limit, as long as the child is covered prior to age 26.

***It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child reaches maximum age limit.***

**FEATURES**
The plan features easy eligibility and simple enrollment procedures. AND...There is no need for a medical exam if you sign up during the enrollment period. 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 System absorbs the cost of administering the program which is underwritten by Metropolitan Life - 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 election card 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. You are automatically the beneficiary under Dependent Life.

**WHEN YOUR INSURANCE STARTS**

Your Basic Employee Life 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.

In order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have been "hospitalized " in the last three months prior to your enrollment date. The term "hospitalized" includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term "hospitalized".

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

**If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to Metropolitan Life.**

**REDUCTIONS AT AGE 70 & OVER**

If you remain in active service beyond age 70 your combined amount of Basic and Optional Employee Life Insurance will reduce as follows:

| Attained | Percent of Original |
|---|---|
| 70 | 65% |
| 75 | 45% |
| 80 | 30% |

| Age | Amount |
|---|---|

**TERMINATION OF COVERAGE**

All insurance under this 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, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

**DISABILITY**

Your insurance may be continued during your disability provided the Board of Education continues premium payments on your behalf. However, your insurance will be subject to reduction as shown under "Reductions at ages 70 & Over" above.

## PORTABILITY

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance only.

**Qualifying Events Include:**

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is $10,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

## 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 Metropolitan Life in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

## SUICIDE EXCLUSION

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage.

## THE ACCELERATED BENEFIT OPTION (ABO)

Metropolitan 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.

## BASIC EMPLOYEE LIFE INSURANCE

All Eligible Employees $5,000* (No cost to you)

## OPTIONAL EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:
$250,000, $240,000, $230,000, $220,000, $210,00, $200,000, $190,000, $180,000, $170,000, $160,000, **$150,000, $140,000, $130,000, $120,000, $110,000, $100,000, $90,000, $80,000, $70,000, $60,000, $50,000, $40,000, $30,000, $20,000, $10,000

*See “Reductions at age 70 & Over.”

**OPTIONAL DEPENDENT LIFE INSURANCE**
Your choice of the following amounts:*

- $50,000, $40,000, $30,000, $20,000 or $10,000 on your spouse
- $20,000, $15,000, $10,000 or $5,000 on each of your eligible children

You choose either: Family, Spouse or Child(ren) coverage

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance. You must choose the same amount of optional employee life insurance or more on yourself in order to purchase optional dependent life insurance on your dependents.
** All amounts up to and including this coverage amount are guaranteed issue as defined in When Your Insurance Starts.

| Employee Monthly Rates | | | |
|---|---|---|---|
| **Coverage Amount** | **Monthly Premium** | **Coverage Amount** | **Monthly Premium** |
| $250,000 | $50.00 | $120,000 | $24.00 |
| $240,000 | $48.00 | $110,000 | $22.00 |
| $230,000 | $46.00 | $100,000 | $20.00 |
| $220,000 | $44.00 | $90,000 | $18.00 |
| $210,000 | $42.00 | $80,000 | $16.00 |
| $200,000 | $40.00 | $70,000 | $14.00 |
| $190,000 | $38.00 | $60,000 | $12.00 |
| $180,000 | $36.00 | $50,000 | $10.00 |
| $170,000 | $34.00 | $40,000 | $8.00 |
| $160,000 | $32.00 | $30,000 | $6.00 |
| $150,000** | $30.00 | $20,000 | $4.00 |
| $140,000 | $28.00 | $10,000 | $2.00 |
| $130,000 | $26.00 | | |
| **Spouse Monthly Rates** | | | |
| $50,000 | $25.50 | $ 20,000 | $10.20 |
| $40,000 | $20.40 | $10,000 | $5.10 |
| $30,000** | $15.30 | | |
| **Child Monthly Rates** | | | |
| $20,000** | $5.10 | $10,000 | $2.55 |
| $15,000 | $3.83 | $5,000 | $1.28 |

** All amounts up to and including this coverage amount are guaranteed issue as defined in When Your Insurance Starts.

**PLAN SPONSOR**

Guilford County Schools
P.O. Box 880
712 N. Eugene Street
Greensboro, NC 27402-0880
(336) 370-8352 or (336)370-8996

**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.

***If you have any questions regarding your statement of health or life insurance claim, please call (800)638-6420.***

This insurance is underwritten by Metropolitan Life Insurance Company, New York, New York 10010.

MetLife

*This information has been prepared to give you the highlights of additional coverage now being offered by your School Board to meet your insurance needs. For details please ask your personnel office or refer to the certificate of insurance that you will receive after you have signed up for protection.*

## MetLife Enhancements:

### *Will Preparation Service:*

**Having an up-to-date will is one of the most important things you can do for your family.**

Like life insurance, a carefully prepared will is important. With a will, you can define your most important decisions such as who will care for your children or inherit your property. The Will Preparation Service also includes the preparation of living wills and power of attorney. By enrolling for Supplemental Life coverage, you will have access to Hyatt Legal Plans' network of more than 13,000 participating attorneys for preparing or updating these documents at no additional cost to you if you use a Hyatt Legal Plan's participating attorney.

*Who is eligible to participate in the Will Preparation service?*

Employees who participate in MetLife's Group Variable Universal Life, Group Universal Life or Supplemental Term Life Plans are eligible.

Highlights include:

• Full-service options to prepare and update wills, including complex wills andcodicils, living wills and powers of attorney, for both you and your spouses / domestic partners.

• Face-to-face and telephone consultations with a Hyatt Legal Plans' participating plan attorney.

• Unlimited access to update a will for as long as you continue to participate in the MetLife Group Life Plan.

Plus:

• Convenient access to a local attorney.

• Hyatt's network of over 13,000 participating plan attorneys.

• Hyatt's award-winning Client Service Center to assist in locating an attorney.

### *Funeral Planning Guide:*

Grieving family members and friends may be confronted with dozens of funeral planning decisions — all of which must be made quickly, and typically under great emotional duress. What kind of funeral should it be? What funeral provider should you use? Should you bury or cremate the body? What other arrangements should you plan? Whom should you notify? And, as unpleasant as it may sound, how much is it all going to cost and where will the money come from to pay for it? Knowing and following your wishes can alleviate the decision-making stress, and allow your survivors to focus on their emotional needs and on other family matters that may arise during difficult times. Following the funeral, your financial affairs will need to be finalized, and the information you provide for your survivors will be invaluable in completing this task.

The Guide also provides you and/or your survivors with information on funeral planning and on estate settlement, as well as descriptions of MetLife benefits that may be available to you or your beneficiaries, and a list of additional resources you may need.

Once you have completed the Funeral Planning Guide, it can be saved to your computer. As a backup, we recommend printing it out to keep with your other important papers. You may want to use the guide to initiate conversations with your family about other end-of-life issues, as well. In any event, be sure to let ***your family know where this information can be found, should they need it.****

***Estate Resolution Services:***

ERS gives estate representatives access to Hyatt Legal Plans network of more than 13,000 participating attorneys for face-to-face or telephone consultation at no additional cost. Estate representatives can get the legal help they need with this great benefit that provides:

• Face-to-face consultations: estate representatives can meet with an attorney to discuss matters relating to probating your and your spouse's/domestic partner's estates.

• Preparation and representation: document preparation and representation needed at court proceedings is available to execute the transfer of probate assets from the deceased's estate to the heirs.

• Correspondence and tax filings: any correspondence needed to transfer non-probate assets may be completed by an attorney, as well as any associated filings.

• Coverage for attorney fees: Estate Resolution Services offers great financial value, since all participating attorney fees for included services are covered through the plan.

Beneficiaries can also use this benefit to consult an attorney to discuss general questions about the probate process. Individuals have the option to use the out-of-network reimbursement feature to retain an attorney who does not participate in Hyatt Legal Plans network of plan attorneys. If a non-network attorney is chosen, the individual will be responsible for any attorneys' fees that exceed the reimbursed amount.

*Who is eligible to participate in the Will Preparation service?*

Employees who participate in MetLife's Group Variable Universal Life, Group Universal Life or Supplemental Term Life Plans are eligible.

Beneficiaries and/or executors/administrators call a toll-free telephone number, 1-800-821-6400 to speak to a Hyatt Legal Plans' Client Service Representative.

***Special Needs Planning:***

MetLife has focused substantial resources on the financial concerns of families with dependents with special needs. As part of the PlanSmart® Financial Education Series, MetLife offers comprehensive planning assistance to help you understand the legal and financial complexities of special needs planning. As a nationally known leader in special needs planning, our program is designed to help you secure a lifetime of care and ensure quality of life and financial freedom for your family member with special needs—as well as peace of mind for you, the caregiver. ***This is a complimentary service offered by your company.***

MetLife Special Needs Planners provide practical information and guidance.

Many of our Special Needs Planners have a dependent or close relative with special needs and all receive extensive ongoing training for special needs planning. In addition, our Planners can provide referrals to experts that provide support and service in your local special needs community.

Special Needs Planning from MetLife can help you address the following critical issues:

• Protecting eligibility for government benefits such as Supplemental Security Income (SSI) and Medicaid

• Providing lifetime care with special needs trusts while still preserving government benefit eligibility

• Selecting appropriate funding vehicles to fund special needs trusts, including life insurance, and choosing a trustee, guardian or conservator

For more information on the special needs planning resources available to you visit www.metlife.com/special needs or call 1-877-638-3375.

For more information regarding any of the MetLife enhancements, you can access the full brochure by going to: ***www.markiiibrokerage.com/guilfordcountyschoolsnc or you can contact Metlife direct.***

# Texas Life Whole Life Insurance – SOLUTIONS 121

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

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

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

Why Voluntary Coverage?

- Most employees typically depend on group term life insurance.
- Adults covered by both group and Individual life insurance replace more of their income upon death than adults having group term alone.[3]
- Term policies are created to last for a finite period of time that will likely end before you die.[4]
- When do you want a life insurance policy in force? --Answer: When you die.
- Term is for IF you die, permanent is for WHEN you die.

The SOLUTIONS Advantage

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

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

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

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

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

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

(Policy Form ICC-ULABR-11 or Form Series ULABR-11)

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

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

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

**Sample Rates**

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

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

**SOLUTIONS Review**

- Permanent and yours to keep when you change jobs or retire, as long as you pay premiums due
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit 1
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness on all policies
- Waiver of Premium included for ages 17-59
- If desired, you may apply for higher amounts of coverage by answering additional underwriting questions
- Coverage available for spouse, children and grandchildren2

1 Guarantees are subject to product terms, exclusions and limitations.

2 Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships. Accordingly, we will treat each party to a civil union or domestic partnership that is recognized and valid under applicable state law as a spouse. Coverage not available on children and grandchildren in Washington.

3 LIMRA; Life Insurance Ownership Focus – 2016

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

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

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

# Texas Life SOLUTIONS Series 121

**MONTHLY – WAIVER & CHRONIC ILLNESS**

## Tier 1/Tier 2 Combo — monthly premiums

| | Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages) | | | | | | | | PAID UP |
|---|---|---|---|---|---|---|---|---|---|
| IFA* ⇒ | $ 10,000 | | $ 15,000 | | $ 25,000 | | $ 30,000 | | For UFA* |
| UFA*⇒ | $ 10,000 | | $ 15,000 | | $ 25,000 | | $ 30,000 | | At Attained |
| (ALB) | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | Age |
| 17 | 9.67 | 11.21 | 12.86 | 15.16 | 19.23 | 23.07 | 22.42 | 27.02 | 65 |
| 18 | 10.03 | 11.56 | 13.39 | 15.69 | 20.12 | 23.95 | 23.48 | 28.08 | 65 |
| 19 | 10.03 | 11.68 | 13.39 | 15.87 | 20.12 | 24.25 | 23.48 | 28.43 | 65 |
| 20 | 10.26 | 12.03 | 13.75 | 16.40 | 20.71 | 25.13 | 24.19 | 29.50 | 65 |
| 21 | 10.38 | 12.27 | 13.92 | 16.75 | 21.00 | 25.72 | 24.54 | 30.20 | 65 |
| 22 | 10.62 | 12.50 | 14.27 | 17.11 | 21.59 | 26.31 | 25.25 | 30.91 | 65 |
| 23 | 10.97 | 12.86 | 14.81 | 17.64 | 22.48 | 27.20 | 26.31 | 31.97 | 65 |
| 24 | 11.09 | 13.21 | 14.98 | 18.17 | 22.77 | 28.08 | 26.66 | 33.04 | 65 |
| 25 | 11.32 | 13.57 | 15.34 | 18.70 | 23.36 | 28.97 | 27.37 | 34.10 | 65 |
| 26 | 11.80 | 13.92 | 16.04 | 19.23 | 24.54 | 29.85 | 28.79 | 35.16 | 65 |
| 27 | 12.15 | 14.39 | 16.58 | 19.94 | 25.43 | 31.03 | 29.85 | 36.58 | 65 |
| 28 | 12.62 | 14.86 | 17.29 | 20.65 | 26.61 | 32.21 | 31.27 | 37.99 | 65 |
| 29 | 13.09 | 15.45 | 18.00 | 21.54 | 27.79 | 33.69 | 32.68 | 39.76 | 65 |
| 30 | 13.33 | 16.04 | 18.35 | 22.42 | 28.38 | 35.16 | 33.39 | 41.53 | 65 |
| 31 | 14.04 | 16.75 | 19.41 | 23.48 | 30.15 | 36.93 | 35.51 | 43.66 | 65 |
| 32 | 14.75 | 17.46 | 20.47 | 24.54 | 31.92 | 38.70 | 37.64 | 45.78 | 65 |
| 33 | 15.34 | 18.29 | 21.35 | 25.78 | 33.39 | 40.77 | 39.41 | 48.26 | 65 |
| 34 | 15.69 | 18.99 | 21.89 | 26.85 | 34.28 | 42.54 | 40.47 | 50.38 | 65 |
| 35 | 16.28 | 19.94 | 22.77 | 28.26 | 35.75 | 44.90 | 42.24 | 53.21 | 65 |
| 36 | 17.11 | 20.88 | 24.01 | 29.68 | 37.82 | 47.26 | 44.72 | 56.05 | 65 |
| 37 | 18.05 | 21.94 | 25.43 | 31.27 | 40.18 | 49.91 | 47.55 | 59.23 | 65 |
| 38 | 18.88 | 23.12 | 26.66 | 33.04 | 42.24 | 52.86 | 50.03 | 62.77 | 65 |
| 39 | 20.29 | 24.54 | 28.79 | 35.16 | 45.78 | 56.40 | 54.28 | 67.02 | 65 |
| 40 | 21.00 | 25.72 | 29.85 | 36.93 | 47.55 | 59.35 | 56.40 | 70.56 | 65 |
| 41 | 22.18 | 27.25 | 31.62 | 39.24 | 50.50 | 63.19 | 59.94 | 75.16 | 65 |
| 42 | 23.24 | 28.91 | 33.22 | 41.71 | 53.16 | 67.32 | 63.13 | 80.12 | 65 |
| 43 | 24.42 | 30.68 | 34.99 | 44.36 | 56.11 | 71.74 | 66.67 | 85.43 | 65 |
| 44 | 26.07 | 32.80 | 37.47 | 47.55 | 60.24 | 77.05 | 71.62 | 91.80 | 65 |
| 45 | 27.73 | 35.04 | 39.94 | 50.92 | 64.37 | 82.66 | 76.58 | 98.53 | 65 |
| 46 | 28.79 | 36.58 | 41.53 | 53.21 | 67.02 | 86.49 | 79.76 | 103.13 | 66 |
| 47 | 29.97 | 38.11 | 43.30 | 55.52 | 69.97 | 90.33 | 83.30 | 107.73 | 67 |
| 48 | 31.27 | 39.76 | 45.25 | 58.00 | 73.22 | 94.46 | 87.20 | 112.69 | 68 |
| 49 | 32.68 | 41.41 | 47.38 | 60.48 | 76.76 | 98.59 | 91.45 | 117.64 | 69 |
| 50 | 33.74 | 42.12 | 48.97 | 61.54 | 79.41 | 100.36 | 94.63 | 119.77 | 70 |
| 51 | 35.04 | 44.01 | 50.92 | 64.37 | 82.66 | 105.08 | 98.53 | 125.43 | 71 |
| 52 | 36.46 | 45.78 | 53.04 | 67.02 | 86.20 | 109.50 | 102.77 | 130.74 | 72 |
| 53 | 37.99 | 47.79 | 55.34 | 70.03 | 90.03 | 114.52 | 107.38 | 136.76 | 73 |
| 54 | 39.64 | 50.03 | 57.82 | 73.39 | 94.16 | 120.12 | 112.33 | 143.48 | 74 |
| 55 | 40.35 | 51.33 | 58.88 | 75.34 | 95.93 | 123.37 | 114.46 | 147.38 | 75 |
| 56 | 41.77 | 53.33 | 61.00 | 78.35 | 99.47 | 128.38 | 118.70 | 153.40 | 76 |
| 57 | 44.01 | 55.46 | 64.37 | 81.53 | 105.08 | 133.69 | 125.43 | 159.77 | 77 |
| 58 | 46.02 | 58.05 | 67.37 | 85.43 | 110.09 | 140.18 | 131.45 | 167.56 | 78 |
| 59 | 47.67 | 60.88 | 69.85 | 89.68 | 114.22 | 147.26 | 136.40 | 176.05 | 79 |
| 60 | 46.20 | 58.84 | 67.80 | 86.75 | 111.00 | 142.59 | 132.60 | 170.51 | 80 |
| 61 | 48.68 | 61.86 | 71.53 | 91.29 | 117.21 | 150.15 | 140.05 | 179.58 | 81 |
| 62 | 51.06 | 65.42 | 75.09 | 96.64 | 123.15 | 159.06 | 147.18 | 190.27 | 82 |
| 63 | 53.33 | 69.20 | 78.49 | 102.31 | 128.82 | 168.51 | 153.98 | 201.61 | 83 |
| 64 | 56.46 | 72.98 | 83.19 | 107.98 | 136.65 | 177.96 | 163.38 | 212.95 | 84 |
| 65 | 59.27 | 77.09 | 87.40 | 114.13 | 143.67 | 188.22 | 171.80 | 225.26 | 85 |
| 66 | 63.05 | 81.95 | 93.07 | 121.42 | 153.12 | 200.37 | 183.14 | 239.84 | 86 |
| 67 | 66.83 | 86.81 | 98.74 | 128.71 | 162.57 | 212.52 | 194.48 | 254.42 | 87 |
| 68 | 71.26 | 92.10 | 105.38 | 136.65 | 173.64 | 225.75 | 207.77 | 270.30 | 88 |
| 69 | 76.01 | 98.47 | 112.51 | 146.21 | 185.52 | 241.68 | 222.02 | 289.42 | 89 |
| 70 | 81.19 | 105.28 | 120.29 | 156.41 | 198.48 | 258.69 | 237.58 | 309.83 | 90 |

*IFA = Initial Face Amount. UFA = Ultimate Face Amount. Gray areas require Tier 2 Underwriting.
Underwriting requirements will vary depending on plan year, participation rates and other factors.
For more information see Group Enrollment Guide.

TEXASLIFE
INSURANCE COMPANY

*Form: 11M035-1 (B2) B-M-3WS*

## Tier 1/Tier 2 Combo — monthly premiums

| | Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages) | | | | | | | | PAID UP |
|---|---|---|---|---|---|---|---|---|---|
| IFA* ⇒ | $ 50,000 | | $ 75,000 | | $ 100,000 | | $ 150,000 | | For UFA* |
| UFA*⇒ | $ 50,000 | | $ 75,000 | | $ 100,000 | | $ 150,000 | | At Attained |
| (ALB) | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | *Non-Tobacco* | *Tobacco* | Age |
| 17 | 35.16 | 42.83 | 51.09 | 62.60 | 67.02 | 82.36 | 98.88 | 121.89 | 65 |
| 18 | 36.93 | 44.60 | 53.75 | 65.25 | 70.56 | 85.90 | 104.19 | 127.20 | 65 |
| 19 | 36.93 | 45.19 | 53.75 | 66.14 | 70.56 | 87.08 | 104.19 | 128.97 | 65 |
| 20 | 38.11 | 46.96 | 55.52 | 68.79 | 72.92 | 90.62 | 107.73 | 134.28 | 65 |
| 21 | 38.70 | 48.14 | 56.40 | 70.56 | 74.10 | 92.98 | 109.50 | 137.82 | 65 |
| 22 | 39.88 | 49.32 | 58.17 | 72.33 | 76.46 | 95.34 | 113.04 | 141.36 | 65 |
| 23 | 41.65 | 51.09 | 60.83 | 74.99 | 80.00 | 98.88 | 118.35 | 146.67 | 65 |
| 24 | 42.24 | 52.86 | 61.71 | 77.64 | 81.18 | 102.42 | 120.12 | 151.98 | 65 |
| 25 | 43.42 | 54.63 | 63.48 | 80.30 | 83.54 | 105.96 | 123.66 | 157.29 | 65 |
| 26 | 45.78 | 56.40 | 67.02 | 82.95 | 88.26 | 109.50 | 130.74 | 162.60 | 65 |
| 27 | 47.55 | 58.76 | 69.68 | 86.49 | 91.80 | 114.22 | 136.05 | 169.68 | 65 |
| 28 | 49.91 | 61.12 | 73.22 | 90.03 | 96.52 | 118.94 | 143.13 | 176.76 | 65 |
| 29 | 52.27 | 64.07 | 76.76 | 94.46 | 101.24 | 124.84 | 150.21 | 185.61 | 65 |
| 30 | 53.45 | 67.02 | 78.53 | 98.88 | 103.60 | 130.74 | 153.75 | 194.46 | 65 |
| 31 | 56.99 | 70.56 | 83.84 | 104.19 | 110.68 | 137.82 | 164.37 | 205.08 | 65 |
| 32 | 60.53 | 74.10 | 89.15 | 109.50 | 117.76 | 144.90 | 174.99 | 215.70 | 65 |
| 33 | 63.48 | 78.23 | 93.57 | 115.70 | 123.66 | 153.16 | 183.84 | 228.09 | 65 |
| 34 | 65.25 | 81.77 | 96.23 | 121.01 | 127.20 | 160.24 | 189.15 | 238.71 | 65 |
| 35 | 68.20 | 86.49 | 100.65 | 128.09 | 133.10 | 169.68 | 198.00 | 252.87 | 65 |
| 36 | 72.33 | 91.21 | 106.85 | 135.17 | 141.36 | 179.12 | 210.39 | 267.03 | 65 |
| 37 | 77.05 | 96.52 | 113.93 | 143.13 | 150.80 | 189.74 | 224.55 | 282.96 | 65 |
| 38 | 81.18 | 102.42 | 120.12 | 151.98 | 159.06 | 201.54 | 236.94 | 300.66 | 65 |
| 39 | 88.26 | 109.50 | 130.74 | 162.60 | 173.22 | 215.70 | 258.18 | 321.90 | 65 |
| 40 | 91.80 | 115.40 | 136.05 | 171.45 | 180.30 | 227.50 | | | 65 |
| 41 | 97.70 | 123.07 | 144.90 | 182.96 | 192.10 | 242.84 | | | 65 |
| 42 | 103.01 | 131.33 | 152.87 | 195.35 | 202.72 | 259.36 | | | 65 |
| 43 | 108.91 | 140.18 | 161.72 | 208.62 | 214.52 | 277.06 | | | 65 |
| 44 | 117.17 | 150.80 | 174.11 | 224.55 | 231.04 | 298.30 | | | 65 |
| 45 | 125.43 | 162.01 | 186.50 | 241.37 | 247.56 | 320.72 | | | 65 |
| 46 | 130.74 | 169.68 | 194.46 | 252.87 | 258.18 | 336.06 | | | 66 |
| 47 | 136.64 | 177.35 | 203.31 | 264.38 | 269.98 | 351.40 | | | 67 |
| 48 | 143.13 | 185.61 | 213.05 | 276.77 | 282.96 | 367.92 | | | 68 |
| 49 | 150.21 | 193.87 | 223.67 | 289.16 | 297.12 | 384.44 | | | 69 |
| 50 | 155.52 | 197.41 | | | | | | | 70 |
| 51 | 162.01 | 206.85 | | | | | | | 71 |
| 52 | 169.09 | 215.70 | | | | | | | 72 |
| 53 | 176.76 | 225.73 | | | | | | | 73 |
| 54 | 185.02 | 236.94 | | | | | | | 74 |
| 55 | 188.56 | 243.43 | | | | | | | 75 |
| 56 | 195.64 | 253.46 | | | | | | | 76 |
| 57 | 206.85 | 264.08 | | | | | | | 77 |
| 58 | 216.88 | 277.06 | | | | | | | 78 |
| 59 | 225.14 | 291.22 | | | | | | | 79 |

*IFA = Initial Face Amount. UFA = Ultimate Face Amount.
Gray areas require Tier 2 Underwriting.
Underwriting requirements will vary depending on plan year, participation rates and other factors. For more information see Group Enrollment Guide.

## Rates for Individual Policies for Children and Grandchildren[1]

### Monthly Premiums for Life Insurance Coverages Shown

| Issue Age | $10,000 | $25,000 | Policy is Paid Up at Attained Age | Issue Age | $10,000 | $25,000 | Policy is Paid Up at Attained Age |
|---|---|---|---|---|---|---|---|
| 15d-1 | $6.35 | $11.37 | 65 | 9 | $7.21 | $13.53 | 65 |
| 2 | $6.35 | $11.37 | 65 | 10 | $7.32 | $13.80 | 65 |
| 3 | $6.46 | $11.64 | 65 | 11 | $7.54 | $14.34 | 65 |
| 4 | $6.56 | $11.91 | 65 | 12 | $7.75 | $14.88 | 65 |
| 5 | $6.67 | $12.18 | 65 | 13 | $7.97 | $15.42 | 65 |
| 6 | $6.78 | $12.45 | 65 | 14 | $8.18 | $15.96 | 65 |
| 7 | $6.89 | $12.72 | 65 | 15 | $8.40 | $16.50 | 65 |
| 8 | $7.00 | $12.99 | 65 | 16 | $8.62 | $17.04 | 65 |

[1]In WA coverage is not available for children or grandchildren. Policies on children and grandchildren require Tier 2 underwriting.

# Legal Shield Group Legal Plan and Identity Theft Plan

*LegalShield, Inc.* gives you the ability to talk to a top-rated attorney on any matter without worrying about hourly costs. For one flat monthly fee, you can access legal advice, no matter the issue.

**1. Legal Plan**: Covers you, your spouse or significant other, never married children under age 26 living at home, or never married and under age 26 who are full-time college students, children under age 18 for whom the Member acts as legal guardian, or any dependent child, regardless of age, who is mentally or physically disabled, for whom the Member is primarily responsible.

The **Legal Plan** offers nationwide coverage under your monthly rate for:

a. Toll-free phone consultations
b. Phone calls and letters on your behalf
c. Contract /document review up to 15 pages
d. Mortgage document assistance
e. Uncontested separation+
f. Uncontested divorce+
g. Uncontested name change+
h. Health care power of attorney
i. Living will
j. Standard Will preparation
k. Routine moving traffic matters++
l. Trial defense services
m. IRS audit legal services
n. Preferred member discount of 25% for matters not fully covered
o. 24-hour attorney access if you are questioned, detained, or arrested

+Available after 90 consecutive days of membership ++Available after 15 days of membership

**(Above waiting periods do not apply to current Legal Shield Members who are upgrading to new Plan)**

The plan is easy to use with simple, direct, toll-free access to your Provider Law Firm. There are no claim forms or deductibles. Members have toll-free access to attorneys and trained professional customer service staff for coverage questions, change of address, or additional information.

**2. Identity Theft Plan:** Protects you and your spouse or significant other and up to 8 children up to age of 18 against identity theft. The plan offers:

a. Free Credit Reports – 24/7 Credit Monitoring
b. Identity Restoration

If you become a victim of identity theft, trained experts from Kroll, Inc. will provide restoration services for you.

**Other**: (1) One rate includes family members as noted; (2) coverage at the discounted group GCS rates is portable; (3) the Plan Document provides details on limitations and exclusions regarding both the Legal Plan and the ID Theft Plan; and (4) a Mobile Phone Application is available for quick and easy access to your *Legal Shield* Provider.

**The GCS discounted rates are as follows:**

| Deduction Schedule | Legal Plan* | Legal Plan + ID Theft Plan* | ID Theft Plan* |
|---|---|---|---|
| 24 month employee | 7.98 | 12.95 | 7.48 |
| 19 month employee | 10.08 | 16.36 | 9.45 |
| 12 month employee | 15.95 | 25.90 | 14.95 |
| 11 month employee | 17.40 | 28.26 | 16.31 |
| 10 month employee | 19.14 | 31.08 | 17.94 |

**Coverage becomes effective January 1, 2019.*

FOR MORE INFORMATION CONTACT:

Glen Gullie
3521 Arrowwood Drive, Raleigh, NC 27604
1-877-487-2837 or gullie@legalshieldassociate.com

Aaron N. Clinard, JD
PO Box 6414, High Point, NC 27262
336-870-5132 or aclinard2@triad.rr.com

**ALLSTATE BENEFITS CANCER PLAN**
When you leave your employment, you may continue your coverage by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. For billing options, please call Allstate Benefits at 800.521.3535

**AFLAC GROUP HOSPITAL INDEMNITY, ACCIDENT AND CRITICAL ILLNESS PLANS**
When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **Aflac Group at 800.433.3036.**

**AMERITAS DENTAL PLAN & DIRECT REIMBURSEMENT DENTAL PLAN**
Under the Ameritas & Direct Reimbursement dental plans, 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 after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. You will receive notification from Benefit Plan Services with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact Alan Peters at Benefit Plan Services 336.889.2003.

**AUL / ONEAMERICA SHORT-TERM & LONG-TERM DISABILITY PLANS**
When you leave employment you may continue your coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. The portability option is not available to retirees. Employees can arrange portability by contacting AUL at 800.553.5318

**GILSBAR HEALTH CARE & DEPENDENT REIMBURSEMENT ACCOUNTS**
If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year.

If you want to remain in the Plan, you can do so by selecting one of the COBRA options listed on the Health Care Reimbursement Agreement Upon Termination Form. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call IMS at 800.426.8739.

**METLIFE TERM LIFE**
**Conversion:** If your employment terminates while you and/or your dependents are covered under the plan or when your Extended Death Benefit period is over, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your or your dependents' coverage terminates.

To get information and rates for converting coverage, please contact Metlife Home Office at 877.275.6387 / ***solutions@metlife.com or the*** MetLife Local Office at 336.553.6330.

**Portability:** If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates
- You must be ACTIVELY at work prior to employment termination
- You may only port up to your current coverage amount. You cannot increase or add dependents
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 26 if a full-time student.

To get information and rates for porting coverage, please contact MetLife direct at 866.492.6983, 877.275.6387 or email at: ***solutions@metlife.com***.

**SUPERIOR VISION PLAN**

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. You will receive notification from Interactive Medical Systems (IMS) with premium and continuation options shortly following your termination of employment. If you should have any questions, please call 800.426.8739.

**TEXAS LIFE WHOLE LIFE:**

When you leave employment you may continue your coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You can arrange this by contacting Texas Life at 800.283.9233 prompt #2.

**RETIREES:**

**METLIFE DENTAL & SUPERIOR VISION INSURANCE PLANS FOR RETIREES OF STATE OR LOCAL GOVERNMENT OFFERED THROUGH NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES' ASSOCIATION, INC.**

With over 54,000 members, the North Carolina Retired Governmental Employees' Association is the largest single group representing retirees before the N.C. General Assembly, the Retirement Systems Boards of Trustees, and the State Health Plan trustees. For retirees or future retirees of state or local governments in North Carolina (including teachers, legislators, National Guard, and judicial), NCRGEA is your voice for sustaining and increasing your benefits after retirement.

Additionally, there are many benefits included with membership at no additional cost ($10,000 AD&D Insurance, bimonthly newsletter, weekly electronic legislative updates while the General Assembly is in session, a toll-free number to call for information and assistance, hearing assistance and vision care discount programs, and free district meetings).

The Association also offers optional MetLife Dental Insurance and Superior Vision Insurance plans for our members. Those premiums are conveniently deducted from your retirement benefit check monthly. Please contact us at NCRGEA, PO Box 10561, Raleigh, NC 27605, 1-800-356-1190, www.info@ncrgea.com or go to our website, www.ncrgea.com, for further information.

# Contacts

Aflac Group Accident, Hospital Indemnity and Critical Illness - 800.433.3036

Allstate Benefits Cancer Plan - 800.521.3535

Ameritas PPO and Standard Dental Plans - 800.487.5553

AUL/OneAmerica STD and LTD Plans - 800.553.5318

Benefit Plan Services COBRA (Dental Only) - 336.889.2003

Direct Reimbursement Dental Plan - 336.889.2003

Gilsbar Medical and Dependent Care Accounts- 800.445.7227 ext. 883

Interactive Medical Systems (IMS) COBRA - 800.426.8739

Mark III Brokerage, Inc. - 800.532.1044, ext. 210

MetLife Term Life Portability - 866.492.6983

MetLife Term Life Conversions:

- Home Office: 877.275.6387 or solutions@metlife.com.
- Local Office, please contact:

JC Aller at 336 553-6330

1801 Stanley Rd. Suite 425

Greensboro, NC 27407

Superior Full Service and Materials Only Vision Plans - 800.507.3800

Texas Life Whole Life Plan - 800.283.9233, prompt #2

## View Benefit Information & Download Forms at:

www.markiiibrokerage.com/guilfordcountyschoolsnc

# OR

## scan this QR with your smartphone!*

*-3rd party iOS or Android app required

*Arranged and Enrolled by Mark III Brokerage, Inc.*

Mark III
Employee Benefits

211 Greenwich Road
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*learn more at: www.markiiieb.com*