Mark III
Employee Benefits

Employee
Benefits

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

Arranged and Enrolled by Mark III Brokerage, Inc.

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

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

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Key Points to Remember

PAY DATES

• The first pay date for premium changes to BCBS/Ameritas is June 2nd, due to health care premiums being paid a month in advance.

• The first pay date for premium changes for all voluntary benefits is July 14, 2016. This is for the work period of 6-25-2016 through 7-8-2016.

LAST DAY TO ENROLL IN BCBS PPO/HSA & AMERITAS DENTAL PLANS

• The last day to make annual enrollment changes to your BCBS Health and Ameritas Dental plans is May 6, 2016.

TO ENROLL

• If you need to enroll or make changes to the following benefits, you MUST see a Mark III Benefits Counselor: Aflac Group Critical Illness & Accident, AUL/One America Short & Long Term Disability, Gilsbar Health Care & Dependent Care Flexible Spending Accounts, Humana Cancer, Lincoln Financial Term Life.

BCBS HEALTH CHANGES TO THE PPO PLAN

• Radiology Services: Currently the plan pays 100% of the costs. Effective July 1, 2016, you will pay the deductible plus 20%.

• Emergency Room: Currently you pay a $250 copay. Effective July 1, 2016, you will pay the deductible plus 20%.

NEW BENEFIT: Nationwide Pet Insurance

• The Pet Insurance plan provides coverage for your furry friends. This includes coverage for accidents, common illnesses (rashes, ear infections, etc.), chronic illnesses, wellness services to name a few. You will pay for this benefit directly through VPI. Note a summary about the pet insurance is located in this benefits booklet (refer to the Table of Contents to locate the summary).

GILSBAR FLEXIBLE SPENDING ACCOUNTS

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

ONCE THE ANNUAL ENROLLMENT ENDS

• Remember that elections made during annual enrollment cannot be changed once the enrollment period ends unless you have a qualifying event: 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. Please visit your Human Resources Department to make this change.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnc.com or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- **$1,500** Individual/**$3,000** Family Member/**$3,000** Family Total. Out-of-Network- **$3,000** Individual/**$6,000** Family Member/**$6,000** Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network- **$3,500** Individual/**$5,000** Family Member/**$5,000** Family Total. Out-of-Network- **$7,000** Individual/ **$10,000** Family Member/**$10,000** Family Total.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**

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Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/content/providersearch/index.htm or please call 1-877-275-9787	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	50% Coinsurance	---none---
	Specialist visit	20% Coinsurance	50% Coinsurance	---none---
	Other practitioner office visit	20% Coinsurance/ Chiropractic Visit	50% Coinsurance/ Chiropractic Visit	-Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	50% Coinsurance	-Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	-No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	-Prior authorization may be required for benefits to be provided
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsnc.com/content/services/formulary/presdrugben.htm	Tier 1 Drugs	20% Coinsurance	20% Coinsurance	-No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. -For Infertility dosage limits apply
	Tier 2 Drugs	20% Coinsurance	20% Coinsurance	
	Tier 3 Drugs	20% Coinsurance	20% Coinsurance	
	Tier 4 Drugs	20% Coinsurance	20% Coinsurance	

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	---none---
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	20% Coinsurance	20% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	-Precertification may be required
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance/ outpatient	50% Coinsurance/ outpatient	-Prior Authorization may be required
	Mental/Behavioral health inpatient services	20% Coinsurance	50% Coinsurance	-Precertification required
	Substance use disorder outpatient services	20% Coinsurance/ outpatient	50% Coinsurance/ outpatient	-Prior Authorization may be required
	Substance use disorder inpatient services	20% Coinsurance	50% Coinsurance	-Precertification required
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	50% Coinsurance	-No coverage for maternity for dependent children.
	Delivery and all inpatient services	20% Coinsurance	50% Coinsurance	-Precertification may be required

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	-Prior authorization may be required for benefits to be provided
	Rehabilitation services	20% Coinsurance	50% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy
	Habilitation services	20% Coinsurance	50% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	20% Coinsurance	50% Coinsurance	-Coverage is limited to 60 days per benefit period.-Precertification required
	Durable medical equipment	20% Coinsurance	50% Coinsurance	-Prior authorization may be required for benefits to be provided-Limits may apply
	Hospice services	20% Coinsurance	50% Coinsurance	-Precertification may be required

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Covered	Covered	-Limited to one pair of glasses or contacts per benefit period
	Dental check-up	Not Covered	Not Covered	Excluded Service

*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery and services
- Dental care (Adult)
- Hearing aids
- Long-term care, respite care, rest cures
- Routine Foot Care
- Weight loss programs

*HSA/HRA funds, if available, may be used to cover eligible medical expenses
**Self-funded groups may cover this service; check your benefit booklet for details

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Private duty nursing
- Routine eye care (Adult)

***Self-funded groups may not cover this service; check your benefit booklet for details

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Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable.

Does This Coverage Provide Minimum Essential Coverage?

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

Does This Coverage Meet the Minimum Value Standard?

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

*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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

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About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,840
- **You pay** $2,700

Sample care costs:

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

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$2,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **You pay** $2,300

Sample care costs:

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

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$700
Limits or exclusions	$80
Total	**$2,300**

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Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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A Health Savings Account combines traditional medical coverage with a savings account and investment options. You can make tax-free contributions to the savings account up to the federal limits. With an HSA, you can pay for current health expenses—and save for future qualified medical and retiree health expenses—all on a tax-free basis.

For 2016, your annual contribution is limited to **$3,350 for individuals** and **$6,750 for families.** Limits for future years will be set by the IRS.

If you are age 55 or older, and not enrolled in Medicare, you may make an additional contribution for up to $1,000 to your HSA in 2016 and later years until you are age 65. Please consult with your tax advisor for further information.

Maximum contributions are based upon maintaining enrollment in a qualified HSA medical plan on the 1st of the month for 12 months of the contract year. For enrollment less than 12 months, you may not be eligible for the maximum contribution. Please consult your tax advisor.

HSA dollars can be used to reimburse yourself for qualified healthcare expenses incurred by you, your spouse or eligible dependents. Qualified expenses include **medical, dental and vision expenses as defined under Section 213(d) of the tax code and include expenses that are not covered by your HSA qualified medical plan.** Qualified dependents are children, siblings, parents and others who are considered an exemption under Section 152 of the tax code.

Any dollars remaining in your savings account at the end of the year carry over to the next year. If you change employers or retire, you may take any dollars in your savings account with you.

The plan deductible is the portion of covered medical and pharmacy expenses that you pay before your plan will begin to cover healthcare expenses. Only covered services count toward the plan deductible. Once your plan deductible has been met, your plan begins providing coverage for eligible services as described in the policy. All covered expenses (including those expenses applied to the plan deductible) benefit from negotiated discounts with participating providers and pharmacies.

You can choose how you pay for medical expenses that are submitted through your qualified HSA medical plan:
• You may pay for medical expenses on a claim-by-claim basis using the debit card that comes with your HSA.
• You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for future years.

BCBS PREFERRED PROVIDER ORGANIZATION (HSA) INSURANCE RATES
For Those Participating in the Wellness Program
Effective July 1, 2016 to June 30, 2017 - Deductions begin June 2016

MEDICAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	602.97	0.00	602.97	$0.00	$0.00
Employee/Spouse	1271.20	235.92	1035.28	$117.96	$117.96
Parent/Child/Children	795.46	147.63	647.83	$73.82	$73.81
Family	1463.36	419.43	1043.93	$209.72	$209.71

DENTAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	33.22	$0.00	33.22	$0.00	$0.00
Employee/Spouse	67.49	$23.97	43.52	$11.99	$11.98
Parent/Child/Children	50.08	$17.78	32.30	$8.89	$8.89
Family	94.81	$39.12	55.69	$19.56	$19.56

BCBS PREFERRED PROVIDER ORGANIZATION (HSA) INSURANCE RATES
For Those NOT Participating in the Wellness Program
Effective July 1, 2016 to June 30, 2017 - Deductions begin June 2016

MEDICAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	632.97	$30.00	602.97	$15.00	$15.00
Employee/Spouse	1301.20	$265.92	1035.28	$132.96	$132.96
Parent/Child/Children	825.46	$177.63	647.83	$88.82	$88.81
Family	1493.36	$449.43	1043.93	$224.72	$224.72

DENTAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	33.22	$0.00	33.22	$0.00	$0.00
Employee/Spouse	67.49	$23.97	43.52	$11.99	$11.98
Parent/Child/Children	50.08	$17.78	32.30	$8.89	$8.89
Family	94.81	$39.12	55.69	$19.56	$19.56

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnc.com or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- **$2,000** Individual/**$4,000** Family Total. Out-of-Network- **$4,000** Individual/**$8,000** Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. $150 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network- **$4,000** Individual/**$8,000** Family Total. Out-of-Network- **$8,000** Individual/ **$16,000** Family Total.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans

	content/providersearch/index.htm or please call 1-877-275-9787	use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35/visit	30% Coinsurance	---none---
	Specialist visit	$70/visit	30% Coinsurance	---none---

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	$70/Chiropractic Visit	30% Coinsurance/ Chiropractic Visit	-Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	Not Covered	-Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	-No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsnc.com/content/services/formulary/presdrugben.htm	Tier 1 Drugs	$10/prescription	$10/prescription	-No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. -For Infertility dosage limits apply -Coverage is limited to a 30 day supply -Minimum of $50 in coinsurance but no more than $100 for Tier 4 drugs
	Tier 2 Drugs	$45/prescription	$45/prescription	
	Tier 3 Drugs	$60/prescription	$60/prescription	
	Tier 4 Drugs	25% Coinsurance with min/max copay	25% Coinsurance with min/max copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	---none---

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	$70/visit	$70/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	30% Coinsurance	-Precertification may be required
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$70/office visit; 20% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Mental/Behavioral health inpatient services	20% Coinsurance	30% Coinsurance	-Precertification required
	Substance use disorder outpatient services	$70/office visit; 20% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Substance use disorder inpatient services	20% Coinsurance	30% Coinsurance	-Precertification required
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	30% Coinsurance	-No coverage for maternity for dependent children.
	Delivery and all inpatient services	20% Coinsurance	30% Coinsurance	-Precertification may be required
If you need help recovering or have	Home health care	20% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
other special health needs	Rehabilitation services	20% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy
	Habilitation services	20% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	20% Coinsurance	30% Coinsurance	-Coverage is limited to 60 days per benefit period.-Precertification required
	Durable medical equipment	20% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided-Limits may apply
	Hospice services	20% Coinsurance	30% Coinsurance	-Precertification may be required

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Covered	Covered	-Limited to one pair of glasses or contacts per benefit period
	Dental check-up	Not Covered	Not Covered	Excluded Service

*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery and services
- Dental care (Adult)
- Hearing aids
- Long-term care, respite care, rest cures
- Routine Foot Care
- Weight loss programs

*HSA/HRA funds, if available, may be used to cover eligible medical expenses
**Self-funded groups may cover this service; check your benefit booklet for details

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Private duty nursing
- Routine eye care (Adult)

***Self-funded groups may not cover this service; check your benefit booklet for details

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable.

Does This Coverage Provide Minimum Essential Coverage?

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

Does This Coverage Meet the Minimum Value Standard?

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

*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,340
- **You pay** $3,200

Sample care costs:

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

Patient pa---

Deductib	$2,000
Copays	$50
Coinsurance	$900
Limits or exclusions	$200
Total	**$3,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,700
- **You pay** $1,700

Sample care costs:

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

Patient pays:

Deductibles	$700
Copays	$700
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,700**

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

BCBS PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE RATES
For Those Participating in the Wellness Program
Effective July 1, 2016 to June 30, 2017 - Deductions begin June 2016

MEDICAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	730.28	$59.16	671.12	$29.58	$29.58
Employee/Spouse	1539.30	$387.03	1152.27	$193.52	$193.52
Parent/Child/Children	964.16	$243.12	721.04	$121.56	$121.56
Family	1773.29	$611.39	1161.90	$305.70	$305.69

DENTAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	37.00	$0.00	37.00	$0.00	$0.00
Employee/Spouse	74.76	$26.30	48.46	$13.15	$13.15
Parent/Child/Children	55.71	$19.51	36.20	$9.76	$9.75
Family	104.93	$42.92	62.01	$21.46	$21.46

BCBS PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE RATES
For Those NOT Participating in the Wellness Program
Effective July 1, 2016 to June 30, 2017 - Deductions begin June 2016

MEDICAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	760.28	$89.16	671.12	$44.58	$44.58
Employee/Spouse	1569.30	$417.03	1152.27	$208.52	$208.51
Parent/Child/Children	994.16	$273.12	721.04	$136.56	$136.56
Family	1803.29	$641.39	1161.90	$320.70	$320.69

DENTAL Coverage Only	Total Cost	Employee Cost	County Cost	Bi-Weekly Deductions 1st Payroll	Bi-Weekly Deductions 2nd Payroll
Individual	37.00	$0.00	37.00	$0.00	$0.00
Employee/Spouse	76.26	$26.30	48.46	$13.15	$13.15
Parent/Child/Children	55.71	$19.51	36.20	$9.76	$9.75
Family	104.93	$42.92	62.01	$21.46	$21.46

Gilsbar Health Reimbursement Arrangement (HRA)

Thank you for choosing to participate in the Health Care Reimbursement Account. Your plan is administered by Gilsbar, LLC. **Lincoln County Government's Group Number is S2611.**

Plan year: July 1, 2016 – June 30, 2017

- **HRA Amount: $750**
- **Run-Off Period: 90 days following the end of the plan year to file for services rendered during the plan year.**

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

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

THERE IS A HANDY MOBILE APPLICATION!

- Access available account balances on your iPhone®, iPod Touch®, iPad®, or Android®-powered device
  - Submit claims and receipts using your device's camera
  - Receive selected alerts via text message on any mobile device

IT'S EASY TO GET STARTED:

STEP 1: **After your effective date, go to www.myGilsbar.com and register as a new participant.** You will complete a brief registration form, and you will need a valid e-mail address and your **Group Number, S2611.**

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 Account 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.**

A Health Reimbursement Arrangement (HRA) is a type of health plan that uses only **Employer** contributions to pay Employee and Dependent health care expenses. Basically all types of medical, dental, vision, deductibles, copayments, coinsurance and other healthcare related expenses may be reimbursed by the HRA as defined by Code Section 213(d). In order to be an eligible **premium expense** under an HRA, the premium must qualify as a medical expense under Code Section 213(d).

Other qualified medical expenses from your HRA include the following:

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage.
- Amounts that are not covered under another health plan.

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

Amounts that remain at the end of the year can be carried over to the next year and Lincoln County has not set a limit on the amount that you can rollover.

Your Employer is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses.

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

SUBMIT YOUR CLAIMS:	CONTACT US:
For fastest processing, fax claims and receipts to: (866) 635-1329 Mail claims and receipts to: Claims Processing Center P.O. Box 965 Covington, LA 70434 *(Please keep the original documents for your records.)*	**Customer Contact Center** **Phone: (800) 445-7227 ext. 1883** **Email: flex@gilsbar.com** **7:00 a.m.-7:00 p.m. CST** *(Please do not email claims/receipts.)*

Gilsbar

2100 Covington Centre • Covington, LA • 70433
800.445.7227 • www.gilsbar.com

Gilsbar Health & Dependent Care Flexible Spending Accounts

•Plan Year: July 1, 2016 - June 30, 2017
•Health Care Spending Account minimum: $0
•FSA is not available for Health Savings Account Participants

Gilsbar Flexible Spending Accounts
Lincoln County

Medical Reimbursement Plan Maximum: $2,550

Dependent Care Account Maximum: $5,000

Claims Filing Limit: All claims for reimbursement must be submitted within 90 days following the end of the grace period, or if earlier, 90 days following the date you cease to parti*cipate in the Plan, or* the claims will be denied.

Thank you for choosing to participate in the Health Care or Dependent Care FSA or HRA. Your plans are administered by Gilsbar, LLC. **Your group number is S2600.**

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

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

IT'S EASY TO GET STARTED:

STEP 1: After your effective date, go to www.myGilsbar.com and register as a new participant. You will complete a brief registration form, and you will need a valid email address and your group number, S2600.

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

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

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

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

SUBMIT YOUR CLAIMS:	CONTACT US:
For fastest processing, fax claims and receipts to: (866) 635-1329 Mail claims and receipts to: Claims Processing Center P.O. Box 965 Covington, LA 70434 *(Please keep the original documents for your records.)*	**Customer Contact Center** **Phone: (800) 445-7227 ext. 1883** **Email: flex@gilsbar.com** **7:00 a.m.-7:00 p.m. CST** *(Please do not email claims/receipts.)*

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

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

HOW DOES THE HEALTHCARE FSA WORK?

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

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

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

HOW DOES THE HEALTHCARE FSA SAVE ME MONEY?

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

	With FSA	Without FSA
Salary:	$1000.00	$1000.00
Less Pre-Taxed Dollars:		
Healthcare Reimbursement	-$100.00	$0.00
Taxable Income	$900.00	$1000.00
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
Net Take Home Pay:	$651.15	$723.50
Less Healthcare Expenses	-$0.00	-$100.00
Net After Expenses:	**$651.15**	**$623.50**

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

HOW EASY IS IT TO USE MY HEALTHCARE FSA?

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

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

CAN I CHANGE MY CONTRIBUTION AMOUNT?

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

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

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

HEALTHCARE FSA EXPENSE WORKSHEET

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

HOW WILL HEALTHCARE REFORM AFFECT MY FSA?

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

HEALTHCARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:	
Deductibles (medical and dental)	$ _____
Benefit percentage/co-insurance (The amount NOT paid by your insurance)	$ _____
Amounts paid over plan limits	
Over reasonable and customary allowance	$ _____
Over psychiatric limits	$ _____
Over private room allowance	$ _____
Expenses NOT covered by your insurance plan	
Physicals	$ _____
Prescription Drugs	$ _____
Vision Care	$ _____
Hearing Expenses	$ _____
Psychiatric Care	$ _____
Dental and Orthodontic Care	$ _____
Assistance for the Handicapped	$ _____
Therapy / Treatments	$ _____
Physician's Fees / Services	$ _____
Medical Equipment	$ _____
Miscellaneous Charges	$ _____
My out-of-pocket healthcare expenses last year	TOTAL $ _____
Compare last year's typical expenses to those eligible under your Healthcare FSA and budget accordingly for the upcoming year.	

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

WHERE CAN I USE MY FSA DEBIT CARD?

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

WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

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

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

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

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

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

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

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

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

HOW DOES THE DEPENDENT CARE FSA WORK?

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

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

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

HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

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

	With FSA	Without FSA
Salary	$1000.00	$1000.00
Less Pre-Taxed Dollars		
Dependent Day Care Reimbursement	-$192.00	$0.00
Taxable Income	$808.00	$1000.00
Less:		
Federal Income Tax (15%*)	-$121.20	-$150.00
State Income Tax (5%*)	-$40.40	-$50.00
Social Security (7.65%*)	-$61.81	-$76.50
Net Take Home Pay	$584.59	$723.50
Less Dependent Care Expenses	-$0.00	-$192
Net After Expenses	**$584.59**	**$531.50**

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

HOW EASY IS IT TO USE THE DEPENDENT CARE FSA?

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

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

WHAT EXPENSES ARE COVERED?

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

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

HOW DO I GET REIMBURSED?

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

CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?

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

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

DEPENDENT CARE FSA EXPENSE WORKSHEET

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

DEPENDENT CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:	
Costs of Child or Adult Care Facilities*	
Day Care Center / Nursery School	$ _____
Family Day Care / Adult Day Care Centers**	$ _____
Wages paid to a nanny or in home care provider***	$ _____
Other dependent care expenses considered eligible by the IRS	$ _____
TOTAL ESTIMATED DEPENDENT CARE EXPENSES	$ _____
Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.	

* The facility must follow all local and state laws.

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

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

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 www.myGilsbar.com to electronically upload any required receipts.

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

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

WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?

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

ARE PROVIDERS, PHARMACIES, HOSPITALS, ETC. REQUIRED TO PROVIDE A RECEIPT WITH SERVICE?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

SHOULD I KEEP COPIES OF MY RECEIPTS?

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

FSA/HRA Employee Portal

Quickstart Guide

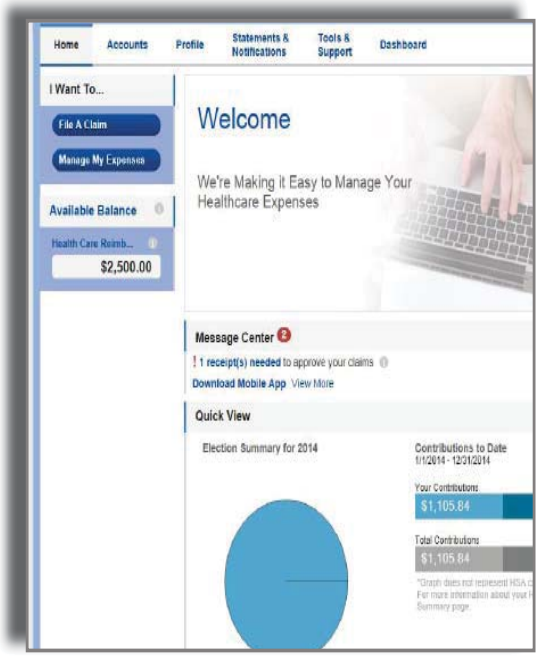
Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA). If applicable, it enables you to:

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

ACCESSING YOUR PORTAL

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

NAVIGATING THE HOME PAGE



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

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

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

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

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

HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

1. On the Home Page under the Accounts tab, click File Claims on the drop-down menu.
2. Enter your claim information and upload the receipt. You may also enter your mileage reimbursement information at this time. Once you have completed the form, click Add Claim.
3. You will be directed to your Claims Basket. You may choose to Add Another Claim or submit the claim(s) listed.
4. When all of your claims are added to the Claims Basket, check the box to confirm that you have read and agree to the Terms and Conditions.
5. Click Submit to send your claims for processing. The Claim Confirmation page will display. You may print the Claim Confirmation Form as a record of your submission.

FSA/HRA Mobile App

Manage Your Accounts On-The-Go

Gilsbar is pleased to announce the release of our FSA & HRA mobile app for your iPhone, Android, and tablet devices.

With the mobile app, you can:

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

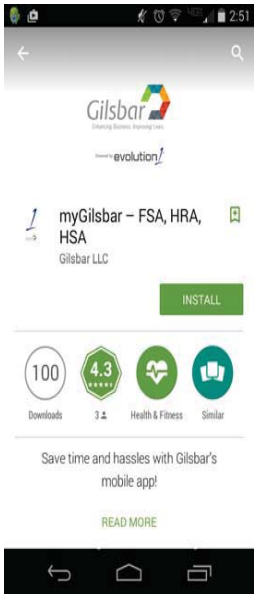
DOWNLOADING THE APP

For Apple Devices:

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

For Android Devices:

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



LOGGING INTO THE MOBILE APP

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

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

- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).
- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

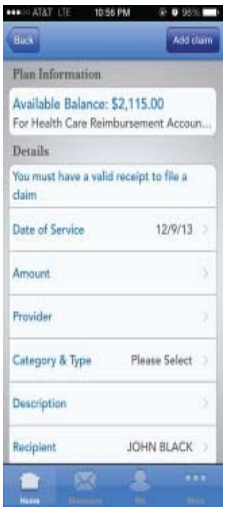
If you would like assistance installing
or logging in to the mobile app,
please contact our Customer Contact Center!
1-800-445-7227, ext 1883 • flex@gilsbar.com

INSIDE THE MOBILE APP

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

view account balances & activity

file new claims



upload & manage receipts

Ameritas Dental (Standard)

Effective Date: July 1, 2016

CALENDAR YEAR DEDUCTIBLE
$50.00 per individual for Type II (Basic) and Type III (Major) Procedures
$150/Family

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

- Routine Exam (Two per benefit period)
- Bitewing X-rays (One per benefit period)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Fluoride for Children (18 and under) (2 per benefit period)
- Cleanings (Two per benefit period)
- Sealants (Age 15 and under)
- Periapical X-rays

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

- Restorative Composites
- Simple Extractions
- Complex Extractions
- Endodontics (Surgical & Nonsurgical)
- Anesthesia
- Restorative Amalgams
- Oral Surgery

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

- Inlays
- Onlays
- Prosthodontics (1 in 8 years)
- Denture Repair
- Periodontics (Surgical & Nonsurgical)
- Crowns (1 crown per tooth every 8 years)
- Crown Repair
- Partials & Dentures

ORTHODONTIA (For Children through age 18)
Paid at 50% U&C*. No deductible applies.

Usual & Customary (U&C)

ANNUAL MAXIMUM BENEFIT
- **Type I, II and Type III Procedures**: $1,000 per calendar year per person.
- **Orthodontia Procedures:** $1,000 Lifetime per person.

LATE ENTRANT

If you or your dependents do not elect to participate in the dental plan when first eligible, you will be considered a Late Entrant and you must wait 12 months for most procedures. For a Late Entrant, benefits will be limited to ***exams, cleanings, and child fluoride***. The late entrant provision is waived if you and or dependents come on the plan as a result of a qualifying event.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employee's Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded.

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES

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

NOTE: Please inquire with your Human Resources Department if you are not sure if you qualify for dental coverage.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children to age 26

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE
The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan.

This is only a partial description of the dental benefits available under this policy. Consult your certificate booklet for details.

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

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

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

NOTES: You are required to pay for the dental plan with pre-tax dollars. No changes are allowed during the 12 month plan year unless there is a change in family status.

Your Dental id card will be shipped to the mailing address on file and will be identified as, Dental Coverage ID Card.

For Claims/Customer Service Questions call Ameritas at 1.800.487.5553
This plan is underwritten by Ameritas Life Insurance Corporation

AMERITAS
LIFE INSURANCE CORP.

Ameritas Dental (PPO)

Effective Date: July 1, 2016

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

CALENDAR YEAR DEDUCTIBLE
$50.00 per individual for Type II (Basic) and Type III (Major) Procedures
$150/Family

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

- Routine Exam (Two per benefit period)
- Bitewing X-rays (One per benefit period)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Fluoride for Children (18 and under) (2 per benefit period)
- Cleanings (Two per benefit period)
- Sealants (Age 15 and under)
- Periapical X-rays

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

- Restorative Composites
- Simple Extractions
- Complex Extractions
- Endodontics (Surgical & Nonsurgical)
- Anesthesia
- Restorative Amalgams
- Oral Surgery

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

- Inlays
- Onlays
- Prosthodontics (1 in 8 years)
- Denture Repair
- Periodontics (Surgical & Nonsurgical)
- Crowns) (1 crown per tooth every 8 years)
- Crown Repair
- Partials & Dentures

ORTHODONTIA (For Children through age 18)
Paid at 50% **MAC***. No deductible applies.

Maximum Allowable Charge (MAC)

ANNUAL MAXIMUM BENEFIT

- **Type I, II and Type III Procedures**: $1,250 per calendar year per person.
- **Orthodontia Procedures:** $1,000 Lifetime per person.

LATE ENTRANT

If you or your dependents do not elect to participate in the dental plan when first eligible, you will be considered a Late Entrant and you must wait 12 months for most procedures. For a Late Entrant, benefits will be limited to ***exams, cleanings, and child fluoride***. The late entrant provision is waived if you and or dependents come on the plan as a result of a qualifying event.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employee's Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded.

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES

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

NOTE: Please inquire with your Human Resources Department if you are not sure if you qualify for dental coverage.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children to age 26

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE
The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan.

This is only a partial description of the dental benefits available under this policy. Consult your certificate booklet for details.

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

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

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

NOTES: You are required to pay for the dental plan with pre-tax dollars. No changes are allowed during the 12 month plan year unless there is a change in family status.

Your Dental id card will be shipped to the mailing address on file and will be identified as, Ameritas PPO Dental Network.

For Claims/Customer Service Questions call Ameritas at 1.800.487.5553
This plan is underwritten by Ameritas Life Insurance Corporation

AMERITAS
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Commonly Asked PPO Questions

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

Do I have to use an Ameritas PPO provider?

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

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

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

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

As noted above, you have a choice of enrolling in the PPO plan or the Standard plan. If you elect to enroll in the PPO option, it is strongly advised that you and your covered dependents utilize one of the many available network providers when seeking dental services. Members enrolling in the PPO plan should absolutely utilize a participating provider for all procedures and services in order to benefit from the plan and the Maximum Allowable Charge (MAC) reimbursement tied to the PPO option.

For members enrolling in the Standard option, you can choose to visit any provider. Non-panel providers will charge their standard fees and Ameritas will reimburse based on the 90th U&C. The 90th U&C reimbursement means that 9 out of 10 dentists in an area are within our reimbursement allowance. The 90th U&C is the highest in the industry and does provide a strong reimbursement. That said, unlike the Ameritas PPO providers: Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing.

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

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

Or, visit the Ameritas website at:
www.Ameritas.com

AMERITAS
LIFE INSURANCE CORP.

Humana Group Cancer & Specified Disease

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

Group Cancer and Specified Disease Insurance

POLICY FORM HIC-GP-CAN-POL-NC 6/09
Underwritten by Humana Insurance Company

Plan Features

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

Benefit	Low	High
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	$2,500	$5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Actual Charges	Actual Charges
Non-Local Transportation. Payable for transportation to a Hospital, clinic, treatment center, or from one medical facility to another which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. Ambulance benefits shall include transportation from one medical facility to another. No Lifetime Maximum	Actual Charges	Actual Charges
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following expenses incurred by the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual Charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	(a) $200 per day (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to $50 per day	(a) $200 per day (b) Actual charges for round trip coach fare;or personal automobile expense of 50 cents per mile. (c) Actual charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Actual charges to a combined lifetime maximum of $15,000	Actual charges to a combined lifetime maximum of $15,000

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

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

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

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

Other Specified Diseases Covered:

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

Payment of Benefits

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

Pre-Existing Condition Limitation

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

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

Exceptions and Other Limitations

The Policy pays benefits only for diagnoses resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:

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

Termination of Coverage

A Covered Person's insurance under the Policy will automatically terminate on the earliest of the following dates:

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

Portability

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

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

a. the Named Insured; or
b. any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
c. any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
d. a newborn child (as described in the Eligibility Section).

Child (Children)

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

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

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

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

Benefits

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

Hospital Intensive Care Confinement Benefit

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

Double Benefits

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

Emergency Hospitalization and Subsequent Transfer to an ICU

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

Step Down Unit

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

Exceptions and Other Limitations

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

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company. This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected. Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact:

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

HUMANA

- **Toll Free: 800.845.7519**
- **Fax: 512.275.9350**
- **Mailing Address:**

  Bay Bridge Administrators, LLC

  P.O. Box 161690, Austin, Texas 78716
- **Website: www.bbadmin.com**

Humana Base Cancer Plan - Low & High Options

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

Semi- Monthly Premium (24 pay)

	Option 1- Low	Option 2- High
Employee Only	$11.69	$15.45
Employee & Children	$16.60	$21.68
Employee & Spouse	$23.80	$31.44
Employee & Family	$28.72	$37.67

Aflac Accident ~ High Plan

Effective Date: July 1, 2016

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

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

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

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

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

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

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

- There's no limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Spouse and dependent child coverage is available.

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A proud member of the Aflac family of insurers

• The plan provides 24-hour protection.

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

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

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

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

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

What is guaranteed-issue coverage? Am I eligible?

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

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

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

• Are between the ages of 18 and 69;

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

• Are working at least 30 hours per week;

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

• Are not a seasonal or temporary employee.

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

What core benefits does the Aflac accident plan feature?

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

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

• **Medical Fees Benefit**
You may receive this benefit per covered accident for physician charges, emergency room services and supplies, and X-rays.

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

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

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

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

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

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

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

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

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

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

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

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

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

• **Accidental-Death and-Dismemberment Benefit**

o Accidental Death

o Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)

o Dismemberment

o Loss of One or More Fingers and Toes

o Partial Amputation of Fingers or Toes

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

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

• **Certain exceptions.** No benefits are payable for loss resulting from:

o Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.

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

o Participating or attempting to participate in an illegal activity or working at an illegal job.

o Committing or attempting to commit suicide, while sane or insane.

o Injuring or attempting to injure yourself intentionally.

o Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica (except under the Accidental Common Carrier Death Benefit).

o Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

o Participating in any organized sport, professional or semi-professional.

o Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.

o Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

o Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.

o Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.

o Having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

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

Semi-Monthly Premium (24 pay)

24 Hour Coverage	High Option
Employee	$9.40
Employee and Spouse	$12.91
Employee and Dependent Child(ren)	$15.71
Employee & Family	$19.22

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.
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Aflac Critical Illness Insurance (without cancer)

Effective Date: July 1, 2016

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

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

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

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

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

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

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers

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

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

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

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

What core benefits does the Aflac critical illness plan feature?

- **First Occurrence Benefit**

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

- **Additional Occurrence Benefit**

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

- **Reoccurrence Benefit**

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

- **Heart Benefit**

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

- o Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- o Mitral valve replacement or repair
- o Aortic valve replacement or repair
- o Surgical treatment of abdominal aortic aneurysm
- o AnjioJet clot busting*
- o Balloon angioplasty (or balloon valvuloplasty)*
- o Laser angioplasty*
- o Atherectomy*
- o Stent implantation*
- o Cardiac catherization*
- o Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- o Pacemaker insertion*

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

- **Health Screening Benefit**

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

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

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

You should know that the plan includes:

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

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

- **Certain exclusions**. No benefits are payable for loss resulting from:
    - o Intentionally self-inflicted injury or action;
    - o Suicide or attempted suicide while sane or insane;
    - o Illegal activities or participation in an illegal occupation;
    - o War whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
    - o Substance abuse; or
    - o Diagnosis and/or treatment received outside the United States

Aflac Group Critical Illness Plan (without cancer)
Employee and Spouse (24-Pay Rates)

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

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

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

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

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

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Columbia, South Carolina 800.433.3036
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Aflac Hospital Indemnity

Effective Date: July 1, 2016

Plan Features

- Benefits are available for spouse and/or dependent children.
- Premiums are paid by convenient payroll deduction.
- The plan covers injuries and sickness.
- Admission and per-day hospital confinement benefits are included.
- Wellness benefit is included.
- Surgery and anesthesia benefits are included.
- High or Low Plan Options; employee may only choose one option

Issue Ages

- Employee: 18–64
- Spouse: 18–64
- Children: under age 26
- Full-time, benefit-eligible employees working at least **30 hours per week** are eligible to apply. Employees must be actively at work on the date of application and the effective date of coverage. Seasonal and temporary employees are not eligible.

Class I

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

Class II

- A Class I primary insured is eligible for Class II coverage if he:
- Was previously insured under Class I; and
- Is no longer employed by the policyholder.
- The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate. Only dependents covered under Class I coverage are eligible for continued coverage under Class II.
- Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.
- The employee may purchase supplemental hospital indemnity 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.

- A spouse is the person married to the employee on the effective date of this coverage. A spouse means the legal spouse who is between the ages of 18 and 64. A spouse must not be hospitalized or unable to perform his or her normal duties or activities on the date of application and the effective date of coverage.

- Dependent child means natural children, stepchildren, foster children, legally adopted children, or children placed for adoption who are under age 26.

Guaranteed-Issue

- During the first three years of the Plan being in-force, employees coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12- month period.

Portability

- When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.
- The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.
- The employee may continue the coverage until the earlier of:
- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.
- Coverage may not be continued:
- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Benefits

Hospital Confinement (per day)	***High Option***	***Low Option***
	$150	***$100***

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

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

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

Hospital Admission (per confinement)	***High Option***	***Low Option***
	$1,500	***$500***

We will pay the amount shown when an insured is admitted to a hospital and confined as a resident bed patient because of an injury or because of a covered sickness. To receive this benefit for injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident. We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment.

We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again. This benefit option will be based on the insured's current major medical plan's deductible to assist the insured in meeting the out-of-pocket liability.

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

Surgical Benefit (per procedure)	***High Option***	***Low Option***
	Up to $1,500	***Up to $750***

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

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

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

Anesthesia Benefits	*High Option*	*Low Option*
	Up to $375	*Up to $187.50*

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

Wellness Benefit	*High Option*	*Low Option*
	$50	*$50*

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

Pre-Existing Condition Limitation

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

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

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

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

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

Exclusions

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

1. War – Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.
2. Suicide – Committing or attempting to commit suicide, while sane or insane.
3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.
4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.

6. Aviation – Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those, which are not motor–driven.
7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts – Participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports – Participating in any organized sport: professional or semi–professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

Terminations

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

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

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

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.
5. Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

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

Semi-Monthly Rates (24 pay)

	High Option	***Low Option***
Employee	$15.48	$7.85
Employee and Spouse	$30.59	$15.52
Employee and Dependent Child(ren)	$21.46	$10.76
Employee and Family	$36.57	$18.43

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

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Continental American Insurance Company

Columbia, South Carolina

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Aflac Value Added Services

NOTE: If you currently have the Aflac Accident, Critical Illness or Hospital Indemnity plans, you automatically have access to the benefits provided in this summary at no extra cost to you. If you apply for either of these benefits, you will have access to the value added services listed.

Need help with healthcare?

We've got your lifeline.

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

We've enhanced your plan without adding cost.

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

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

SERVICES AVAILABLE STARTING JANUARY 1, 2016

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

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

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

DID YOU KNOW?

You can also use Health Advocate's Health Advocacy and Medical Bill Saver™ services for your spouse, dependent children, parents and parents-in-law, while Telemedicine is available for you and your family.

HealthAdvocate MeMD Aflac

Get more without spending more.

More than just peace of mind.

Health Advocacy from Health Advocate

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

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

More than just cash benefits.

Medical Bill Saver™ from Health Advocate

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

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

More than just care.

Telemedicine from MeMD

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

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

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

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

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IV (1/16)

AUL Short Term Disability

Effective Date: July 1, 2016

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

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

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.[1]
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.[1]
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.[1]

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

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.[2]
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

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

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

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

1 National Safety Council, Injury Facts, 2003 Edition
2 American Cancer Society, Cancer Facts & Figures 2004
3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update
4 American Lung Association, Lung Disease Data 2003
5 National Underwriter, May 2002

Class Description

All Full-Time Eligible Employees working a minimum of 40 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 your covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum benefit is $500.***

Elimination Period

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

Benefit Duration

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

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

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

Recurrent Disability

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

Exclusions and Limitations

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

Portability

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

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

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

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 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.

Customer Service
1.800.553.5318
Website: www.employeebenefits.aul.com

Disability Claims
American United Life Insurance Company

c/o Custom Disability Solutions

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

Toll Free ~ **855.517.6365** Fax ~ **844.287.9499**

OneAmerica.claims@customdisability.com

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

AUL Life Short-Term Disability
Semi-Monthly Rates

Benefit Duration*:*
13 Weeks

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

AUL Long Term Disability

Effective Date: July 1, 2016

LTD Class Description

All Full-Time Eligible Employees working a minimum of 40 hours per week, electing to participate in the Voluntary Long-Term Disability.

LTD Monthly Benefit

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

LTD Elimination Period

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

LTD Benefit Duration

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

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

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

LTD Mental & Nervous / Drug & Alcohol:

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

Special Conditions

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

Other income Offsets

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

Waiver of Premium

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

Pre-Existing Condition Exclusion

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

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

Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period

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

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and

2. The Person changes from one AUL short-term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period.

The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short-term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.
The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short-term disability plan's Pre-Existing Condition Limitation.

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

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

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

Annual Enrollment
Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly LTD benefit without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.
.
Exclusions and Limitations
This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

Voluntary Long Term Disability

Monthly Benefit Amount	Semi-Monthly Deduction
$500	$3.20
$1,000	$6.40
$1,500	$9.60
$2,000	$12.80

Customer Service
1.800.553.5318
Website: www.employeebenefits.aul.com

Disability Claims
American United Life Insurance Company

c/o Custom Disability Solutions

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

Toll Free~ **855.517.6365** Fax~ **844.287.9499**

OneAmerica.claims@customdisability.com

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

Lincoln Financial Group Term Life

Effective Date: (pending underwriting approval)

VOLUNTARY EMPLOYEE LIFE INSURANCE
You now have the opportunity to elect group term life insurance coverage at low group rates and through payroll deductions.

VOLUNTARY DEPENDENT LIFE INSURANCE
Provides coverage on:

- Your Spouse
- Unmarried child(ren) from age 1 day through age 21 (through age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit upon approval from Lincoln Financial. 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 graduates from college.

FLEXIBILITY
Simply choose the amount of coverage that suits your needs from the selection provided.

FEATURES
The plan features easy eligibility and simple enrollment procedures. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

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

ELIGIBILITY
You will be eligible for this plan if you are an active full-time employee, working 40 or more hours per week.

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. Medical underwriting is necessary for late entrants and increases.

BENEFICIARY
You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update the beneficiary designation as necessary.

WHEN YOUR INSURANCE STARTS

If you enroll for Voluntary Employee Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you are not actively at work, your insurance will not be effective until you return to active full-time work.

WHEN YOUR DEPENDENT INSURANCE STARTS

Your dependents are eligible for coverage on the date you are eligible to be insured or the date you acquire an eligible dependent.

REDUCTIONS AT AGE 65 & OVER

If you remain in active service beyond age 65 your Voluntary Employee Life Insurance will reduce as follows:

Attained Age	Percent of Original Amount
65	65%
70	50%
75	35%

TERMINATION OF COVERAGE

All insurance under the plan will terminate upon the earlier of retirement, termination of employment, when the plan ceases or when you withdraw from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to your beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account will be paid to you.

WAIVER OF PREMIUM PROVISION

If you become totally disabled **prior to age 60** and remain totally disabled for 180 days, your amount of life insurance will be continued without payment of premium provided proof of your continued total disability is provided annually. The insurance terminates at age 65 or retirement, whichever is earlier.

PORTABILITY

If you terminate your employment, the portability provision allows you to take your voluntary life coverage with you, subject to the following provisions.

- You must apply for coverage within 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 coverage.
- Must be under age 65 and insured under the policy for at least 12 months before termination.
- Available to spouse and child(ren)

Please refer to the Group Certificate for details.

ACCELERATED BENEFITS OPTION

Lincoln Financial 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. ***This option applies to Voluntary Employee Life coverage only. Please refer to the Group Certificate for details.***

GROUP POLICY AND CERTIFICATE

The insurance briefly described in this booklet is subject to the terms and conditions of the Group Policy issued by Lincoln Financial Insurance Company. If you become insured, you will receive a certificate outlining your benefits under the policy. Unless otherwise stated, we follow all applicable state & federal laws.

SCHEDULE OF BENEFITS

VOLUNTARY EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:*
$10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000

***Employee must take coverage on self to apply for dependent coverage.**

VOLUNTARY SPOUSE LIFE INSURANCE

Your choice of the following amounts: $5,000, $10,000, $15,000, $20,000, $25,000

VOLUNTARY CHILD(REN) LIFE INSURANCE

$10,000 (***per child, regardless of the number of children)***

- ***All late applications and requests for coverage increases are subject to medical underwriting approval.***
- ***See "Reductions at age 65 and Over."***
- ***Optional Dependent coverage is not a pre-tax item per IRS Section 125 regulations.***

PLAN SPONSORED BY

Lincoln County Government
115 West Main St.
Lincolnton, NC 28092
704.736.8493

This information is only a brief description of the group insurance policy sponsored by Lincoln County Government. The controlling provisions will be in the group policy issued by Lincoln Financial. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when Lincoln Financial and the employer may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for employees who become insured according to its terms. For costs and more complete details of coverage, contact your Human Resources representative.

Semi-Monthly Costs

VOLUNTARY EMPLOYEE TERM LIFE

	Less than 30	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$10,000	0.30	0.40	0.45	0.55	0.85	1.40	2.40	3.35	6.35	10.30
$20,000	0.60	0.80	0.90	1.10	1.70	2.80	4.80	6.70	12.70	20.60
$30,000	0.90	1.20	1.35	1.65	2.55	4.20	7.20	10.05	19.05	30.90
$40,000	1.20	1.60	1.80	2.20	3.40	5.60	9.60	13.40	25.40	41.20
$50,000	1.50	2.00	2.25	2.75	4.25	7.00	12.00	16.75	31.75	51.50
$60,000	1.80	2.40	2.70	3.30	5.10	8.40	14.40	20.10	38.10	61.80
$70,000	2.10	2.80	3.15	3.85	5.95	9.80	16.80	23.45	44.45	72.10
$80,000	2.40	3.20	3.60	4.40	6.80	11.20	19.20	26.80	50.80	82.40
$90,000	2.70	3.60	4.05	4.95	7.65	12.60	21.60	30.15	57.15	92.70
$100,000	3.00	4.00	4.50	5.50	8.50	14.00	24.00	33.50	63.50	103.00

VOLUNTARY SPOUSE TERM LIFE

	Less than 30	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$5,000	0.15	0.20	0.225	.275	0.425	0.70	1.20	1.675	3.175	5.15
$10,000	0.30	0.40	0.45	0.55	0.85	1.40	2.40	3.35	6.35	10.30
$15,000	0.45	0.60	0.675	0.825	1.275	2.10	3.60	5.025	9.525	15.45
$20,000	0.60	0.80	0.90	1.10	1.70	2.80	4.80	6.70	12.70	20.60
$25,000	0.75	1.00	1.125	1.375	2.125	3.50	6.00	8.375	15.875	25.75

• Spouse costs is based on employee's age

VOLUNTARY CHILD TERM LIFE - $10,000*	$0.25*

**** Costs is the total amount for all children covered under the plan, not per child***

Texas Life Whole Life ~ Solutions 121

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

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

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

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

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

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

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

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

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

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

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

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

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

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

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Sample Rates

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

SOLUTIONS 121

Age	**Face Amount**	Monthly Premium **Non-Tobacco** Chronic Illness, & Waiver	Monthly Premium **Tobacco** Chronic Illness, & Waiver	**P a i d - u p Age**
20	$50,000	$38.11	$46.96	**65**
25	$50,000	$43.42	$54.63	**65**
30	$50,000	$53.45	$67.02	**65**
35	$50,000	$68.20	$86.49	**65**
40	$50,000	$91.80	$115.40	**65**
45	$50,000	$125.43	$162.01	**65**

SOLUTIONS REVIEW

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

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

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

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

If you have any questions regarding your Texas Life policy, please call 800.283.9233, prompt 2

TEXASLIFE INSURANCE COMPANY

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

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Nationwide Pet Insurance

- ***Note that the costs listed are based on a monthly pay schedule***

Choose a pet health plan to fit your needs

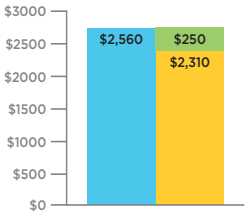
From Nationwide®, the #1 choice in America for pet insurance^

Prices include 5% discount!**

	Major Medical Plan comprehensive℠ + Pet Wellness Plan Plus◊ everyday care℠	Major Medical Plan comprehensive℠	Pet Wellness Plan Plus◊ everyday care℠
	Starting at $22/paycheck*	Starting at $13/paycheck*	Starting at $10/paycheck*
Use any vet	✓	✓	✓
Accidents, including poisonings, cuts and broken bones	✓	✓	
Common illnesses, including ear infections, rashes, vomiting and diarrhea	✓	✓	
Serious/chronic illnesses†, including cancer, diabetes and allergies	✓	✓	
Hereditary conditions‡	✓	✓	
Procedures/services, including surgeries, Rx meds and hospitalization	✓	✓	
Wellness services, including exams, vaccinations and flea/heartworm preventives	✓		✓
Annual deductible	$250 for medical claims $0 for wellness claims	$250	$0

Sample reimbursement

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



Exam, X-rays, surgery, treatment
1-yr-old mixed breed, California

- Veterinary fee
- Reimbursed by Nationwide
- Annual deductible

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

vethelpline℠ | Members have **free, 24/7 access** to a veterinary professional through **Vet Helpline** ($170 value) for any pet question. Only from Nationwide.

Enroll now and receive your discount.

PetsNationwide.com • 877-738-7874

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

Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Such terms and availability may vary by state and exclusions may apply. Insurance plans are offered and administered by Veterinary Pet Insurance Company in California and DVM Insurance Agency in all other states. Underwritten by Veterinary Pet Insurance Company (CA), Brea, CA, an A.M. Best A rated company (2013); National Casualty Company (all other states), Madison, WI, an A.M. Best A+ rated company (2014). Nationwide, the Nationwide N and Eagle, and Nationwide is On Your Side are service marks of Nationwide Mutual Insurance Company. ©2015 Nationwide. 15GRP3656_Payroll_Static

Nationwide® is on your side

Get cash back on the everyday care your pet needs to stay healthy.

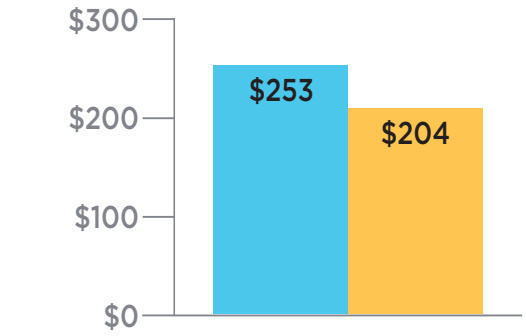
Pet Wellness Plan Plus◊ everyday care℠

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

Duke got a clean bill of health

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

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



Wellness exam, vaccinations, tests, heartworm preventive
1-yr-old Cavalier King Charles spaniel, Minnesota

Veterinary bill | Reimbursed by Nationwide | This plan has no deductible

Using your Nationwide policy is quick and easy.

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

vethelpline℠

Live veterinary guidance about your pet's health, from general questions to identifying urgent care needs. **Free to all members** ($170 value). Only from Nationwide.

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

Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Such terms and availability may vary by state and exclusions may apply. Insurance plans are offered and administered by Veterinary Pet Insurance Company in California and DVM Insurance Agency in all other states. Underwritten by Veterinary Pet Insurance Company (CA), Brea, CA, an A.M. Best A rated company (2013); National Casualty Company (all other states), Madison, WI, an A.M. Best A+ rated company (2014). Nationwide, the Nationwide N and Eagle, and Nationwide Is On Your Side are service marks of Nationwide Mutual Insurance Company. ©2015 Nationwide. 15GRP3656_Payroll_Static

Nationwide® is on your side

Liberty Mutual Auto & Homeowners

You're part of an exclusive group that has partnered with Liberty Mutual to save you money. And the best part- you receive knowledgeable support, immediate claims assistance and the latest information to keep you and your family safe.

Savings you can count on.

As a Lincoln County Government employee, you could save hundreds of dollars a year on car and home insurance with Liberty Mutual.

Here's how.[1]

- Get exclusive group savings off our already competitive rates
- Add extra savings on your home insurance when you insure both your car and home.
- Obtain additional discounts based on your driving experience, car and home safety features and more

[1]Discounts and savings are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.

Service and support when and where you need it

- **We're here for you**: With 24-Hour Claims Assistance, 24-Hour Emergency Home Repair and our optional 24-Hour Roadside Assistance*, we have you covered
- **Service your way**: Interact the way you want with a local licensed sales representative, online, in person, by phone or via your mobile device
- **Choose the payment option best for you**: We offer direct billing, online payment, or automatic deductions from your bank account or credit card

Need additional coverage? Our representatives explain your options in clear terms and recommend the best match for you- whether you need to protect your **car, home, watercraft or motorcycle**. You can also obtain personal liability (umbrella), flood, renters and identity theft insurance.

Micah Dison

149 Plantation Drive, Mooresville, NC 28117

www.LibertyMutual.com/MicahDison ~ Micah.dison@libertymutual.com

Office - 704-360-1840 x59963 ~ Cell - 704.450.4373 ~ Fax - 888-233-7993

Continuation of Benefits If You Leave Employment

AFLAC GROUP CRITICAL ILLNESS, ACCIDENT AND HOSPITAL INDEMNITY

When you leave employment, you may continue your Critical Illness, Accident and Hospital Indemnity by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. You may contact **Aflac at 1.800.433.3036.**

AUL SHORT & LONG TERM DISABILITY

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

BCBS MEDICAL AND AMERITAS DENTAL Under the group medical plans, you and your covered dependents are eligible to continue medical coverage through COBRA if you experience certain "qualifying events".

If you and your dependents are enrolled in these plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plans, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA. For more Cobra information, contact your **Human Resources Department at 704.736.8493.**

GILSBAR HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

If you have a balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Flexible Account at the time of your termination, you will forfeit that balance. For information about your Health Care Spending Account, you may contact your **Human Resources Department at 704.736.8493.**

HUMANA CANCER

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

LIBERTY MUTUAL AUTO & HOMEOWNERS

When you leave employment, you may continue the coverage that you have with Liberty Mutual. If you have questions you may **contact Liberty Mutual at 704.360.1840 x.59976.**

LINCOLN FINANCIAL (TERM LIFE)

If you terminate employment, the portability provision allows you to take your Supplemental Term Life coverage with you, subject to the following provisions:

- You must apply for coverage within 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 your coverage.
- Must be under age 65 and insured under the policy for at least 12 months before termination.
- Available to spouse and child(ren)

For additional information, you may contact **Lincoln Financial at 1.800.423.2765.**

TEXAS LIFE WHOLE LIFE~ SOLUTIONS 121

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may contact **Texas Life at 1.800.283.9233 prompt #2.**

This benefit is no longer enrolled, but remains on payroll deduction:

ASSURITY CANCER

When you leave employment you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may contact **Assurity at 1.866.289.7337.**

DISCLAIMER

This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only.

Phone Directory

- Aflac Group Critical Illness, Accident & Hospital Indemnity - 800.433.3036
- Ameritas Dental - 800.776.9446
- AUL Short & Long Term Disability - 800.553.5318
- Blue Cross Blue Shield - 877.258.3334
- Gilsbar - 800.445.7227
- Humana Cancer - 800.845.7519
- Liberty Mutual Auto & Homeowners - 704.360.1840 x.59963
- Lincoln County Human Resources Department - 704.736.8493
- Lincoln Financial Term Life - 800.423.2765
- Mark III Brokerage, Inc. - 800.532.1044
- Texas Life Whole ~ Solutions 121 - 800.283.9233 (prompt 2)
- Nationwide Pet Insurance - 877.738.7874

View Benefit Information & Download Forms at:

www.markiiibrokerage.com/lincolncountync

or scan:

Mark III
Employee Benefits

211 Greenwich Road
Charlotte, NC 28211
(800) 532-1044
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