Mark III
Employee Benefits

Employee
Benefits

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

Arranged and Enrolled by Mark III Brokerage, Inc.

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

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

Plan Arranged By:

2016 State Health Plan Comparison

PLAN DESIGN FEATURES	CONSUMER-DIRECTED HEALTH PLAN (CDHP)		ENHANCED 80/20 PLAN		TRADITIONAL 70/30 PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
HRA Starting Balance	$600 Employee $1,200 Employee + 1 $1,800 Employee + 2 or more		N/A		N/A	
Annual Deductible	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family	$700 Individual $2,100 Family	$1,400 Individual $4,200 Family	$1,054 Individual $3,162 Family	$2,108 Individual $6,324 Family
Coinsurance	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum*	N/A	N/A	$3,210 Individual $9,630 Family	$6,420 Individual $19,260 Family	$4,282 Individual $12,846 Family	$8,564 Individual $25,692 Family
Out-of-Pocket Maximum**	$3,500 Individual $10,500 Family	$7,000 Individual $21,000 Family	N/A	N/A	N/A	N/A
Rx Out-of-Pocket Maximum	Included in total out-of-pocket maximum		$2,500		$3,294	
Preventive Care	$0 (covered at 100%)	N/A	$0 (covered at 100%)	N/A	$39 for primary doctor; $92 for specialist	Only certain services are covered
Office Visits	15% after deductible; $25 added to HRA if you use PCP on ID; $20 added to HRA if you use Blue Options Designated specialist	35% after deductible	$30 for primary doctor; $15 if you use PCP on ID card $70 for specialist; $60 if you use Blue Options Designated specialist	40% after deductible	$39 for primary doctor; $92 for specialist	50% after deductible
Inpatient Hospital	15% after deductible; $200 added to HRA if you use Blue Options Designated hospital	35% after deductible	$233 copay, then 20% after deductible; copay not applied if you use a Blue Options Designated hospital	$233 copay, then 40% after deductible	$329 copay, then 30% after deductible	$329 copay, then 50% after deductible
PRESCRIPTION DRUGS						
Tier 1			$12 copay per 30-day supply		$15 copay per 30-day supply	
Tier 2			$40 copay per 30-day supply		$46 copay per 30-day supply	
Tier 3	15% after deductible	35% after deductible	$64 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge	$72 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge
Tier 4			25% up to $100 per 30-day supply		25% up to $100 per 30-day supply	
Tier 5			25% up to $132 per 30-day supply		25% up to $132 per 30-day supply	
ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)	$0 (covered at 100%)	$0 (covered at 100%)	N/A	N/A
CDHP Preventive Medications	15%, no deductible	15%, no deductible	N/A	N/A	N/A	N/A

Note: For the Enhanced 80/20 and Traditional 70/30 Plans, for non-specialty brand-name drugs for which a generic is available, you will pay the generic copay plus the difference between the plan's cost for the brand-name drug and the generic drug, up to $100 per 30-day supply for the brand-name drug.

Ameritas Dental Plan

Effective Date: July 1, 2016

CALENDAR YEAR DEDUCTIBLE

There is a $50.00 In and Out-of-Network deductible, per individual for Type 2 (Basic) and/or Type 3 (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

TYPE 1 - PREVENTIVE AND DIAGNOSTIC

Type 1 benefits are payable at 100% U&C*
No deductible applies.

- Evaluations (Two per year)
- Cleanings (Two per year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- X-rays
- Sealants

TYPE 2 - BASIC PROCEDURES

Type 2 benefits are payable at 80% U&C*
50.00 Deductible In-Network and Out-of-Network.

- Simple Extractions
- Restorative Amalgam & Resin (excluding inlays & crowns)
- Repair and recement crowns
- Limited Exams
- Denture Repair
- Anesthesia

TYPE 3 - MAJOR PROCEDURES

Type 3 Benefits are payable at 50% U&C*
50.00 Deductible In-Network and Out-of-Network.

- Restorative - Crowns
- Prosthodontics - Fixed Pontics or Abutments
- Prosthodontics - Removable Dentures, Partials
- Endodontics (Root Canal)
- Complex Oral Surgery
- Periodontics (Gum Disease)

ORTHODONTIA - CHILD(REN) UP TO AGE 26

Paid at 50% U&C* with a $1,000 lifetime maximum.
No deductible applies.

Late Entrant Provision

There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

** Usual & Customary charge*

ANNUAL MAXIMUM BENEFIT

- Type 1, Type 2, and Type 3 Procedures - $1,000 per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person.

***This plan includes a maximum carryover for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $750.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year and there is a $100 PPO Bonus available. In future years if you have benefits paid of less than $750, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000.

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 employees Date of Hire to determine the 36 month period). This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES

You are eligible for insurance if you are a full-time active employee working at least 40 hours per week.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up 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 brochure is for general information only.

SECTION 125

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

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.

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.

AMERITAS MANAGED CARE PRODUCTS

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

PASSIVE PPO

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

COMMONLY ASKED PPO QUESTIONS

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?
By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at 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?
For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area: Martin County Government wants employees to have options regarding their choice of providers.

In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. However, the amount Ameritas allows for each procedure for non-panel provider utilizes 85th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 8.5 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure. In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

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 on the Ameritas web site, OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

Monthly Rates	
Employee Only	**$0.00**
Employee + Spouse	**$43.04**
Employee + Child	**$27.44**
Employee +Children	**$36.88**
Employee + Family	**$67.96**

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

This insurance is underwritten by Ameritas Life Insurance Corp.

Superior Vision Plan

Effective Date: July 1, 2016

Outline of Benefits – Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)

Copayment: $10.00 Exam Copayment
$25.00 Contact Lens Fitting Fee
$10.00 Materials Copayment

HOW TO USE THE PLAN

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to **www.superiorvision.com** and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

Benefits	Frequency	In-Network*	Non-Network*
Comprehensive Exam (by an Ophthalmologist)	12 Months	Covered in Full	Up to $44.00
Comprehensive Exam (by an Optometrist)	12 Months	Covered in Full	Up to $39.00
Lenses (Standard) per pair Single Vision Bifocal Trifocal Lenticular Progressive	12 Months	Covered in Full Covered in Full Covered in Full Covered in Full Covered to providers retail trifocal amount	Up to $34.00 Up to $48.00 Up to $64.00 Up to $88.00 Up to $64.00
Contact Lenses (per pair)** Medically Necessary Cosmetic (Elective)***	 12 Months 12 Months	 Covered in Full Up to $150.00	 Up to $210.00 Up to $100.00
Contact Lense Fitting Fee**** Standard Specialty	 12 Months 12 Months	 Covered in Full Up to $50.00	 Not Covered Not Covered
Frames (Standard)*	24 Months	Up to $150.00	Up to $77.00

All in-network and out-of-network allowances are at the retail value.

**Contact lenses are in lieu of eyeglass lenses and frames benefits.

***The insured is responsible for paying any charges in excess of this allowance

****Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

DISCOUNT FEATURES

Look for providers in the Provider Directory who accepts discounts; please verify their discounts prior to service.

Discounts on Covered Materials	
Frames	20% off amount over allowance
Lens	20% off retail
Progressives	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums* on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

Maximum Member Out-of-Pocket		
	Single Vision	**Bifocal & Trifocal**
Scratch Coat	$13	$13
Ultraviolet Coat	$15	$15
Tints, solid, or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High-Index 1.6	$55	20% off retail
Photochromic	$80	20% off retail
Glass Coloring	$35	20% off retail

Discounts on Non-Covered Exam and Materials
Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

Discounts on Non-Covered Exam & Materials	
Exams, Frames and prescription lenses	30% off retail
Lens options, contacts, other prescription materials	20% off retail
Disposable contact lenses	10% off retail

Refractive Surgery
Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

* Discounts & maximums may vary by lens type. Please check with your provider.
* Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Monthly Rates	
Employee Only	**$9.70**
Employee + One Dependent	**$18.80**
Employee + Family	**$27.60**

Customer Service
800-507-3800
916-852-2277 fax

Explanation of benefits
Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
Grievance issues

Customer Service/Corporate Office
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claims Administration
P.O. Box 967
Rancho Cordova, CA 95741

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

The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life.

Aflac Group Accident Insurance

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

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

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

Many families don't budget for 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
- Casts
- Emergency room use
- Wheelchairs
- Surgery and Anesthesia
- Crutches
- Stitches
- Bandages

These costs add up- fast. While major medical insurance can help with the cost 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?

- No limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Benefits available for spouse and/or dependent children.
- Provides 24-hour protection (on and off-the-job)
- Benefits for both inpatient and outpatient treatment of covered accidents.
- Guaranteed Issue (which means you may qualify for coverage without having to answer health questions).
- Payroll Deduction - Premiums are paid by convenient payroll deduction.
- Coverage will be effective the date you sign the enrollment form.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers

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What is guaranteed-issue coverage?

Guarantee-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 age 18;
- Are a full-time, benefit-eligible employee;
- Are working at least **30** hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be age 18 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does Aflac accident plan feature?

- **Accident Benefits**

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

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

- **Medical Fees Benefit**

  You may receive this benefit 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 of 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 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**

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

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

- **Hospital Admission Benefit**

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

- **Hospital Confinement Benefit (per day)**

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

- **Hospital Intensive Care (per day)**

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

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

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

You should know that the plan includes:

- A **pre-existing condition limitation.** 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:
- 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.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits
- for any related medical/surgical treatment or diagnostic procedures for such illness.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica except under the Accidental Common Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participating in any organized sport, professional or semi-professional.
- Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
- Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.

Monthly Premium Rates

Employee	$16.20
Employee and Spouse	$23.16
Employee and Dependent Children	$30.90
Employee, Spouse, and Dependent Child(ren)	$37.86

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

Continental American Insurance Company • Columbia, South Carolina
1-800-433-3036 toll-free • 1-866-849-2970 fax • www.aflacgroupinsurance.com

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

Allstate Benefits Group Cancer Plan

In the United States, about 1,665,540 new cancer cases were expected to be diagnosed in 2014. [1]

Group Voluntary Cancer

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

Meeting Your Needs:

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

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

Benefit Coverage Highlights

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

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

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

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

Your Benefit Coverage

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

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires Disease (confirmation by culture or sputum), Addison's Disease, Hansen's

**Primary insured only*

***List of covered diseases on page 37-38*

1 Cancer Facts & Figures, American Cancer Society, 2014

Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

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

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

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

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

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

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

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

Radiation/Chemotherapy for Cancer
Up to a $10,000 (Low) or $20,000 (High) benefit will be paid per 12 month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period.

Anti-Nausea Benefit
Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician. This benefit does not pay for medication administered while the covered person is an inpatient.

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

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

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

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

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

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

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

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

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

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

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

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

Hospice Care
A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:
1. Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
2. Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

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

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

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

Family Member Lodging and Transportation

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

1. Lodging-This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.
2. Transportation-Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

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

*Bone Marrow or Stem Cell Transplant**

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

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

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

ADDITIONAL BENEFITS

Wellness

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

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

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

*Intensive Care***

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

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

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

***This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.**
****This benefit is not disease specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**
C. **Ambulance - Allstate Benefits pays the actual charges** for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

Issue Ages: 18 and older while Actively at Work.

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

Eligibility - Family members eligible for coverage include: you, your spouse or domestic partner; and children under age 26.

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

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision, the date you are no longer in an eligible class, or the date your class is no longer eligible.

Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

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

Limits, Exclusions, and Exceptions - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn, adopted or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement.

A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

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

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

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

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than January 15, 2018. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

For newly eligible employees, or those hired in the last twelve months, the High and Low Options are offered with Guaranteed Issue. For all other employees, Evidence of Insurability will be required, meaning that a few health questions must be answered.

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

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

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

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

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

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

Customer Care Center: 1.800.521.3535
www.allstate.com or allstatebenefits.com

Aflac Group Hospital Indemnity Plan

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

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 3 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.

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

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.

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 the following:

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

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.

Monthly Premium Rates

	High Option	*Low Option*
Employee	$30.96	$15.69
Employee and Spouse	$61.17	$31.03
Employee and Dependent Child(ren)	$42.91	$21.50
Employee and Family	$73.12	$36.84

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.

Continental American Insurance Company (CAIC) is a wholly-owned subsidiary of Aflac Inc. CAIC underwrites group coverage but is not licensed to solicit business in Guam, Puerto Rico, or the Virgin Islands. In California, group coverage is underwritten by Continental American Life Insurance Company, and in New York group coverage in underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company

Columbia, South Carolina

1-800-433-3036 toll-free

1-866-849-2970 fax

Aflacgroupinsurance.com

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

Aflac Group Critical Illness Insurance

Effective Date: July 1, 2016

Guaranteed Issue Amounts: Employee- $10,000 / Spouse- $5,000

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:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week;
- 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:

- Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- Mitral valve replacement or repair
- Aortic valve replacement or repair
- Surgical treatment of abdominal aortic aneurysm
- AnjioJet clot busting*
- Balloon angioplasty (or balloon valvuloplasty)*
- Laser angioplasty*
- Atherectomy*
- Stent implantation*
- Cardiac catherization*
- Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- 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: This 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. Aflac 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. Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatmentfree for that cancer for 12 consecutive months.

Certain Exceptiions. No benefits are payable for loss resulting from:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; or
- Diagnosis and/or treatment received outside the United States.

GROUP CRITICAL ILLNESS

North Carolina - Monthly (12pp/yr)

NON-TOBACCO - Employee

AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 5.35	$ 7.20	$ 9.05	$ 10.90	$ 12.75	$ 14.60	$ 16.45	$ 18.30	$ 20.15	$ 22.00
30-39	$ 6.55	$ 9.60	$ 12.65	$ 15.70	$ 18.75	$ 21.80	$ 24.85	$ 27.90	$ 30.95	$ 34.00
40-49	$ 9.70	$ 15.90	$ 22.10	$ 28.30	$ 34.50	$ 40.70	$ 46.90	$ 53.10	$ 59.30	$ 65.50
50-59	$ 13.45	$ 23.40	$ 33.35	$ 43.30	$ 53.25	$ 63.20	$ 73.15	$ 83.10	$ 93.05	$ 103.00
60-69	$ 19.50	$ 35.50	$ 51.50	$ 67.50	$ 83.50	$ 99.50	$ 115.50	$ 131.50	$ 147.50	$ 163.50

NON-TOBACCO - Spouse

AGES	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 5.35	$ 6.28	$ 7.20	$ 8.13	$ 9.05	$ 9.98	$ 10.90	$ 11.83	$ 12.75
30-39	$ 6.55	$ 8.08	$ 9.60	$ 11.13	$ 12.65	$ 14.18	$ 15.70	$ 17.23	$ 18.75
40-49	$ 9.70	$ 12.80	$ 15.90	$ 19.00	$ 22.10	$ 25.20	$ 28.30	$ 31.40	$ 34.50
50-59	$ 13.45	$ 18.43	$ 23.40	$ 28.38	$ 33.35	$ 38.33	$ 43.30	$ 48.28	$ 53.25
60-69	$ 19.50	$ 27.50	$ 35.50	$ 43.50	$ 51.50	$ 59.50	$ 67.50	$ 75.50	$ 83.50

TOBACCO - Employee

AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 6.30	$ 9.10	$ 11.90	$ 14.70	$ 17.50	$ 20.30	$ 23.10	$ 25.90	$ 28.70	$ 31.50
30-39	$ 8.35	$ 13.20	$ 18.05	$ 22.90	$ 27.75	$ 32.60	$ 37.45	$ 42.30	$ 47.15	$ 52.00
40-49	$ 15.80	$ 28.10	$ 40.40	$ 52.70	$ 65.00	$ 77.30	$ 89.60	$ 101.90	$ 114.20	$ 126.50
50-59	$ 23.15	$ 42.80	$ 62.45	$ 82.10	$ 101.75	$ 121.40	$ 141.05	$ 160.70	$ 180.35	$ 200.00
60-69	$ 34.10	$ 64.70	$ 95.30	$ 125.90	$ 156.50	$ 187.10	$ 217.70	$ 248.30	$ 278.90	$ 309.50

TOBACCO - Spouse

AGES	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 6.30	$ 7.70	$ 9.10	$ 10.50	$ 11.90	$ 13.30	$ 14.70	$ 16.10	$ 17.50
30-39	$ 8.35	$ 10.78	$ 13.20	$ 15.63	$ 18.05	$ 20.48	$ 22.90	$ 25.33	$ 27.75
40-49	$ 15.80	$ 21.95	$ 28.10	$ 34.25	$ 40.40	$ 46.55	$ 52.70	$ 58.85	$ 65.00
50-59	$ 23.15	$ 32.98	$ 42.80	$ 52.63	$ 62.45	$ 72.28	$ 82.10	$ 91.93	$ 101.75
60-69	$ 34.10	$ 49.40	$ 64.70	$ 80.00	$ 95.30	$ 110.60	$ 125.90	$ 141.20	$ 156.50

Rates do not include cancer benefit.

Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

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

We've got you under our wing.
aflacgroupinsurance.com | 1.800.433.3036

Underwritten by:
Continental American Insurance Company
2801 Devine Street | Columbia, South Carolina 29205

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.

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

Continental American Insurance Company • Columbia, South Carolina

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.

800.433.3036 | aflacgroupinsurance.com

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

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.

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.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Continental American Insurance Company | Columbia, South Carolina

1500186 R1

IV (1/16)

AUL Short Term Disability

Effective Date: July 1, 2016

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

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

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

Advantages of shopping at work include:

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

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

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycan happen.org/research/CDA_LTD_ Claims_Survey_2011.asp

90% of disabilities are caused by illness.

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

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

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

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

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

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 an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000.

Elimination Period

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

Benefit Duration

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) 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.

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.

Annual Enrollment

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

Employees who elect to increase their Benefit Duration may do so only during the annual enrollment period subject to the pre-existing exclusion. The pre-existing exclusion will apply to the increased benefit duration.

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 if insurability.

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).

You have 31 days from your date of termination to submit an application to port your coverage.

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

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

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200

South Portland, ME 04106

Fax: 1-844-287-9499

OneAmerica.claims@customdisability.com

Toll Free Phone 1-855-517-6365

American United Life Insurance Company®
a OneAmerica® *company*

AUL Life Short-Term Disability Monthly Rates

Benefit Duration: 13 Weeks

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

Benefit Duration: 26 Weeks

Monthly Benefit	*Monthly Premium*
$500	$15.00
$600	$18.00
$700	$21.00
$800	$24.00
$900	$27.00
$1,000	$30.00
$1,100	$33.00
$1,200	$36.00
$1,300	$39.00
$1,400	$42.00
$1,500	$45.00
$1,600	$48.00
$1,700	$51.00
$1,800	$54.00
$1,900	$57.00
$2,000	$60.00

Benefit Duration: 52 Weeks

Monthly Benefit	*Monthly Premium*
$500	$19.72
$600	$23.66
$700	$27.60
$800	$31.54
$900	$35.49
$1,000	$39.43
$1,100	$43.37
$1,200	$47.32
$1,300	$51.26
$1,400	$55.20
$1,500	$59.15
$1,600	$63.09
$1,700	$67.03
$1,800	$70.97
$1,900	$74.92
$2,000	$78.86

Fort Dearborn Term Life Plan

Basic Employee Life Insurance

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

Optional Employee Life Insurance

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

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

Optional Dependent Life Insurance

Provides coverage on:

- Your Spouse
- Unmarried child(ren) from 15 days of age to age 18 (to age 23 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.

It is your responsibility to notify Human Resources when a spouse or dependent child is no longer eligible for coverage. (ie. divorce, child no longer full-time college student, etc.)

Features

The plan features easy eligibility and simple enrollment procedures. There is no need for a medical exam if you sign up during the enrollment period.

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

Low Cost

Your cost is lower than for comparable insurance on an individual basis due to the “wholesale” economies inherent in group insurance. Additionally, the System absorbs the cost of administering the program which is underwritten by Fort Dearborn, a leader in the field of group coverage.

Eligibility

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

Enrollment

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

Statement Of Health

Increases in coverage, a re-entry in the plan, amounts over the guaranteed issue limits, and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to Fort Dearborn.

Beneficiary

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

When Your Insurance Starts

Your Basic Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

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

Reductions At Age 65 & Over

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

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

(The above age reduction also applies to dependent spouse.)

Termination Of Coverage

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

Waiver Of Premium

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

Your employee Supplemental Life Insurance may be continued provided you remit the applicable premium to your employer.

Conversion

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Fort Dearborn in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

Portability

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

The Accelerated Benefit Option (ABO)

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

Group Policy

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

Plan Sponsor

Martin County Government
PO Box 668
Williamston, NC 27892
(252) 789-4330

Claims Procedure

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

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

SCHEDULE OF BENEFITS

Basic Employee Life & AD&D Insurance

Eligible Employees $10,000

Optional Employee Life & Insurance

Your choice of the following amounts:

$250,000/$200,000/$150,000/$100,000/$90,000/$80,000/$70,000/$60,000/
$50,000/$40,000/$30,000/$20,000/$10,000

- Employees under age 60 must furnish evidence of insurability for amounts over $100,000
- Employees age 60-69 must furnish evidence of insurability for amounts over $20,000
- Employees age 70 and over must furnish evidence of insurability for all amounts of coverages.

Optional Dependent Life Insurance

$10,000/$20,000/$30,000/$40,000/$50,000 on your spouse

- To be eligible for $20,000 coverage and above, your spouse must furnish medical evidence of insurability and you must elect an equal or greater amount of Employee Optional Life Insurance.

$10,000/$5,000 on each of your eligible children

YOUR MONTHLY COST FOR EMPLOYEE SUPPLEMENTAL LIFE INSURANCE

(Spouse coverage based on spouse's age)

Your Age	Rate Per $1,000
Less than 35	.08
35-39	.12
40-44	.19
45-49	.28
50-54	.48
55-59	.82
60-64	1.29
65-69	2.03
70-74	3.23
75+	5.72

Texas Life Whole Life Plan- Solutions 121

Common Issue Date: August 1, 2016

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. (Policy Form ICC07-ULCL-WP-07 and Form Series ULCL-WP-07).

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

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

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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 for both non-tobacco and tobacco users, and include the cost for Waiver of Premium and the Accelerated Death for Chronic Illness benefit.

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

SOLUTIONS Review

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

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

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

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

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

TEXASLIFE INSURANCE COMPANY

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

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

Continuing Your Benefits Upon Termination of Employment

Vision and Dental Plans

Under the group vision, and dental plans, you and your covered dependents are eligible to continue 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. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA.

For more Cobra information, call Donna Zube at **252-789-4335**

AUL Short-Term Disability

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 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).

To Continue Other Policies

You may continue your Aflac Group Accident Plan, Aflac Group Critical Illness Plan, Allstate Benefits Cancer, and Texas Life Whole Life policies by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home.

For more information, contact

Allstate Benefits at **800-521-3535**

Aflac Group at **800-433-3036**

Texas Life at **800-283-9233**

Contact Information for Questions and Claims

Ameritas Dental
Customer Service
800-487-5553
www.ameritasgroup.com

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

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

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

Aflac Group
PO Box 427
Columbia, SC 29202

Customer Service
1-800-433-3036
www.aflacgroupinsurance.com

Texas Life Insurance Company
PO Box 830
Waco, TX 76703-0830
800-283-9233

Fort Dearborn
Martin County Government-Plan Sponsor
PO Box 668
Williamston, NC 27892
(252) 789-4330

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

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

or scan:

Mark III
Employee Benefits
211 Greenwich Road
Charlotte, NC 28211

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