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Pre-Tax Benefits

After-Tax Benefits

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:

Mark III
Employee Benefits

Ameritas Dental Plan

Effective Date: July 1, 2017

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 (Per Person).
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!

Ameritas Dental 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, 2017

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	12 Months	Covered in Full	Up to $34.00
Bifocal		Covered in Full	Up to $48.00
Trifocal		Covered in Full	Up to $64.00
Lenticular		Covered in Full	Up to $88.00
Progressive		Covered to providers retail trifocal amount	Up to $64.00
Contact Lenses (per pair)**			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)***	12 Months	Up to $150.00	Up to $100.00
Contact Lense Fitting Fee**			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	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.

Superior Vision 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.

SUPERIOR VISION
See yourself healthy.

Aflac Group Accident Plan

Plan Features

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

Eligibility

Issue Ages
Employee at least age 18
Spouse at least age 18
Children under age 26
The employee may purchase Accident Plus coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

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

Portability

When coverage would otherwise terminate because an employee ends his employment, 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 45 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.

Accident Benefits – High Option

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

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

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

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

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

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown for the affected bone.

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

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

If the dislocation requires open reduction, we will pay 150% of the amount shown.
Dislocation refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.

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

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

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

The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount.
If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

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

The insured is injured,

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

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

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

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

Lacerations	
Up to 2" long	$50
2"–6" long	$200
More than 6" long	$400
Lacerations not requiring stitches	$25

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

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

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

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

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

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

- For treatment received due to injuries from a covered accident **and**
- For each covered accident up to one year after the accident date.

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

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room **and**
- Receives initial treatment within 14 days after the covered accident.

This benefit is payable only once per 24-hour period and only once per covered accident.

We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

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

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, **and**
- Is held in a hospital for observation for at least 24 hours, **and**
- Receives initial treatment within 14 days after the accident.

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

Accident Follow-Up Treatment	$25

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

Physical Therapy	$25

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

Air Ambulance	$500
Ambulance	$100

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

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

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

Blood/Plasma	$100

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

Prosthesis	$500

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

Appliance	$100

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

Family Lodging Benefit (per night) $100

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

Wellness $60

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

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

Hospital Admission $1,000

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

- Is injured,
- Requires hospital confinement, **and**
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.
- We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day) $200

We will pay the amount shown when, because of a covered accident, the insured:
Is injured, **and**
Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.
The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days.
This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.
We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day) $400

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

- Is injured, **and**

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

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

Accidental Death & Dismemberment (within 90 days)			
	Employee	Spouse	Children
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

- Loss of a hand – The hand is cut off at or above the wrist joint; **or**
- Loss of a foot – The foot is cut off at or above the ankle; **or**
- Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**
- Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

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

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

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

Common carrier means:

- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**
- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

LIMITATIONS AND EXCLUSIONS

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

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

• War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service. This does not include terrorism.
• Suicide – committing or attempting to commit suicide, while sane or insane.
• Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness. This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.
• Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
• Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
• Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
• Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
• Sports – participating in any organized sport—professional or semiprofessional.
• Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

TERMINATION OF AN EMPLOYEE'S INSURANCE

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

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

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

1. the date the plan is terminated, for dependents of Class I insureds;
2. the 31st day after the premium due date, if the required premium has not been paid;

3. the date the spouse or dependent child ceases to be a dependent; or
4. the premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

DEFINITIONS

Accidental injury or injuries means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of covered accident.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children are your or your Spouse's natural children, step-children, legally adopted children, foster children or children placed for adoption who are younger than age 26. However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday, but not more frequently than annually.

A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we;

- will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

- will not dis-enroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:

  a. The court or administrative order is no longer in effect; or

  b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

Dismemberment means loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Employee means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

Family member includes your spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.
This includes step-family members and family-members-in-law.

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or prearranged use of X-ray equipment, laboratory, and surgical facilities; maintains permanent medical history records; and a state supported institution even though it may not have an operating room and related equipment for the surgery.
A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Spouse means your legal wife or husband. Coverage may only be issued to your spouse if your spouse is over 18.

Notices

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

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

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

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

AGCM378NC-10-BK R1 IV (4/17)

Aflac Group Accident Rates

Type of Coverage	Monthly
Employee	$16.20
Employee + Spouse	$23.16
Employee + Dependent Child(ren)	$30.90
Employee + Spouse + Dependent Child(ren)	$37.86

Continental American Insurance Company
Columbia, South Carolina
800.433.3036

AGC1603069 IV (10/16)

Allstate Benefits Group Cancer Plan

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.

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*

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

Allstate®
Benefits

Aflac Group Hospital Indemnity Plan

Plan Description
The Group Supplemental Hospital Indemnity Plan provides benefits for inpatient and outpatient services as a result of covered accidents and sicknesses.

Plan Features
- Benefits available for spouse and/or dependent children.
- Pays regardless of any other insurance programs.
- Premiums are paid by convenient payroll deduction.
- Covers both injuries and sicknesses.
- Admission and per day Hospital Confinement Benefits included.
- Surgery and Anesthesia Benefits included.
- The plan is portable with certain stipulations

Individual Eligibility
Issue Ages
Employee 18-64
Spouse 18-64
Children under age 26

Spouse and Dependent Children Coverage Available
The employee may purchase Group Supplemental Hospital Indemnity coverage for their 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. If the employee is eligible then the employee's spouse and dependent children are eligible to participate.

Guaranteed-Issue
During the initial enrollment, coverage is guaranteed-issue, which means you may not have to answer health questions to be eligible for coverage. Subsequent to the initial enrollment, evidence of insurability may be required.

Portability
When coverage would otherwise terminate because an employee ends his employment, 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 45 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)	
Plan I	$100
Plan II	$150

We will pay the amount shown when an insured is confined to a hospital as a resident bed patient as the result of an 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)	
Plan I	$500
Plan II	$1,500

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

We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment.
We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

This benefit option will be based on the insured's current major medical plan's deductible to assist the insured in meeting the out-of-pocket liability.

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

Surgical Benefit (per procedure)	
Plan I	Up to $750
Plan II	Up to $1,500

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	
Plan I	Up to $188
Plan II	Up to $375

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 (per calendar year)	
Plan I & II	$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.

Limitations and Exclusions

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 caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above).

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

Insurance for dependents will terminate on the earliest of the following:
1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

Definitions

Injury or Injuries – Accidental bodily injury or injuries caused solely by or as the result of a covered accident.

Covered Accident – An accident, which occurs on or after the insured's effective date, while the insured's certificate is in force, and which is not specifically excluded.

Sickness – An illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an injury.

Covered Person - means the insured if the certificate is issued as Individual coverage.
If the certificate is issued as:
1. Employee/Spouse coverage Covered Person means the insured and the insured's legal spouse;
2. Single Parent Family coverage Covered Person means the insured and insured's covered dependent children as defined in the applicable rider that have been accepted for coverage;
3. Family coverage Covered Person means the insured, the insured's spouse, and the insured's covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

Covered Sickness – An illness, infection, disease or any other abnormal physical condition which is not caused solely by or the result of any injury which:
1. Occurs while the insured's coverage is in force; and
2. Was not treated or for which the insured did not receive advice within 12 months before the insured's effective date; and
3. Is not excluded by name or specific description in the plan.

Doctor or Physician – A person, other than the insured, or a member of the insured's immediate family, who:

Is licensed by the state to practice a healing art;
Performs services which are allowed by his or her license; and
Performs services for which benefits are provided by the Plan.

A **hospital** is not:

A nursing home;
An extended-care facility;
A convalescent home;
A rest home or a home for the aged;
A place for alcoholics or drug addicts; or
A mental institution.

Hospital includes any duly licensed state tax supported institution, including those community health centers and other health clinics which are certified as Medicaid providers.

Effective Date – The date as shown in the certificate schedule if you are on that date actively at work for the policyholder. If not, the certificate will become effective on the next date you are actively at work as an eligible employee. The certificate will remain in effect for the period for which the premium has been paid. The certificate may be continued for further periods as stated in the plan. The certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application will be attached and made a part of the certificate. The certificate, on its effective date, automatically replaces any certificate or certificates previously issued to you under the plan.

Dependent Children – means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.
a. Coverage on Dependent Children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, and not more frequently than annually from then forward.

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

i. Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
ii. Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical

Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

iv. Will not impose pre-ex limitations or waiting periods.

If Dependent Children are covered under the plan, Dependent Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Spouse – An employee's legal spouse who is between the ages of 18–64 and who is named on the enrollment application.

Treatment – Consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Notices

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

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

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

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

AGCM385NC-HL-BK IV (1/17)

Monthly Premium Rates

	High Option Plan II	Low Option Plan I
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

Continental American Insurance Company

Columbia, South Carolina

1-800-433-3036 toll-free

1-866-849-2970 fax

Aflacgroupinsurance.com

Aflac Group Critical Illness Insurance

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available from $5,000 up to $50,000 for employees and up to $25,000 for spouse.
- An annual Health Screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- Includes an Additional Benefits Rider with benefits for the following:
    - Coma
    - Paralysis
    - Severe Burn
    - Loss of Sight
    - Loss of Hearing
    - Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-issue coverage is offered during the initial enrollment and for new hires.
Up to **$10,000** for employees and up **to $5,000** for spouses with no participation requirement.

For employee amounts over **$10,000** and spouse amounts over **$5,000:**
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

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

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

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.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling 50% of the employee amount, not to exceed the $25,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $25,000.

Dependent Children Coverage at No Additional Charge

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

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.

Terminations

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

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

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

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Termination of the insurance on any insured will not prejudice his rights regarding any claim arising prior to termination.

Group Critical Illness Benefits

First Occurrence Benefit – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

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

Additional Occurrence Benefit – We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

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

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

Health Screening Benefit- $100
After the Waiting Period, an Insured may receive a maximum of **$100** for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

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

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe Burns	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

Heart Event Rider

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

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

EXCEPTIONS, REDUCTIONS AND TERMS YOU NEED TO KNOW

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

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

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

Benefits will not be paid for loss due to:

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

No benefits will be paid for loss which occurred prior to the Effective Date.
No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation and Exceptions

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

Terms You Need to Know

The **Effective Date** of your insurance will be the date shown on the certificate schedule.

Employee means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband.

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26. Coverage on dependent children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent(s) for support, the above age 26 shall not apply. Proof of such incapacity and dependency must be furnished to us within 31 days following such 26th birthday, and not more frequently than annually from then forward.

Your newborn children and newborn adopted children are automatically covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in your home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

a. Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
b. Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
c. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
d. Will not impose pre-ex limitations or waiting periods.

If your children are covered under the plan, children born or placed in your home after the effective date of this rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria:1. New and serial eletrocardiographic (EKG) findings consistent with myocardial infarction; 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after the coverage effective date. Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia. We will pay a benefit for stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable

waiting period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

End-Stage Renal Failure means the end-stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The kidney failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a critical illness. It doesn't include an insured or their family member.

Licensed Health Care Practitioner means an individual who has successfully completed a prescribed program of study in a variety of health fields and who has obtained a license or certificate indicating his or her competence to practice in that field.

Additional Benefit Rider Exceptions

All limitations and exclusions that apply to the Critical Illness plan also apply to the rider. The Waiting Period and Pre-existing condition limitation apply from the date the rider is effective.

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

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

The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months.

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

Additional Benefit Rider Definitions

Coma means a state of unconsciousness for 30 consecutive days with:

- No reaction to external stimuli;
- No reaction to internal needs; and
- The use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician.

A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.

Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

Heart Event Rider Exceptions

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

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

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

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

PRE-EXISTING CONDITIONS EXCEPTION

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

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

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

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

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

EXCEPTIONS

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

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

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

Heart Rider Definitions

Category I – Specified Surgeries of the Heart

Open Heart Surgery means undergoing open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations.

Benefits are paid for the following open heart surgery procedures only:

Coronary Artery Bypass Surgery (also coronary artery bypass graft surgery, or bypass surgery) is a surgical procedure performed to relieve angina and to reduce the risk of death from coronary artery disease.

Off-Pump Coronary Artery Bypass (OPCAB) is a form of bypass surgery that does not stop the heart or use the heart-lung machine.

Coronary Artery Bypass Grafting (CABG) is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under the rider.

Mitral Valve Replacement or Repair is a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.

Aortic Valve Replacement or Repair is a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.

Surgical Treatment of Abdominal Aortic Aneurysm is a procedure performed to prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stent implantation, or other surgical and nonsurgical procedures.

Category II Benefits (Invasive, Procedures and Techniques of the Heart) are paid for the following procedures only:

AngioJet Clot Busting is used to clear blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up, and simultaneously drawing it out.

Balloon Angioplasty (or Balloon Valvuloplasty) is used to open a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

Laser Angioplasty is similar to Balloon Angioplasty. A laser tip is used to burn/break down plaque in the clogged blood vessel.

Atherectomy is used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Stent Implantation is where a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.

Cardiac Catheterization (also Heart Catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest, where it monitors the
heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

Pacemakers refers to the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when a heart's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Subject to the Reoccurrence Benefit in the base plan, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II benefits exclude all procedures not specifically listed above.

GROUP CRITICAL ILLNESS

CI G

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.*

Aflac
We've got you under our wing.®

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

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

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

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

AGCM328-NC-BK IV (1/17)

Need help with healthcare?

We've got your lifeline.

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

We've enhanced your plan without adding cost.

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

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

SERVICES AVAILABLE AS SOON AS YOUR COVERAGE STARTS

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

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD when your coverage begins.

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

DID YOU KNOW?

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

HealthAdvocate™ MeMD™ Aflac®

Get more without spending more.

More than just peace of mind.

Health Advocacy from Health Advocate

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

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

More than just cash benefits.

Medical Bill Saver™ from Health Advocate

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

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

More than just care.

Telemedicine from MeMD

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

- Create your account at www.MeMD.me/Aflac
- When you have a health issue, log on and request a provider consultation
- You can request consultations via webcam, app or phone
- Get ePrescriptions,* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- $25.00 per visit!

Questions? Call 855-423-8585

Aflac

Value Added Services
Value Added Services are not available to residents of Idaho. State availability may vary.

Telemedicine
Due to Arkansas state regulations, insureds physically located in Arkansas at the time of a telemedicine session may only receive consultation services from physicians. Physicians are prohibited from providing diagnoses or prescribing drugs to persons located in Arkansas at the time of service.

Medical Bill Saver
Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

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

This offering may not supersede the terms and conditions of any existing contract the client has with Health Advocate. Health Advocate reserves the right to refuse any client group through Aflac if the client group cancels a pre-existing contract with Health Advocate prior to expiration date of the contract.

aflacgroupinsurance.com | 1.800.433.3036

AGC1500186 R5

IV (3/17)

AUL Short Term Disability

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

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.

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

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

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, 2017

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.

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).

Sample Rates

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

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

SOLUTIONS Review

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

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

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

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

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

TEXASLIFE INSURANCE COMPANY

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

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

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

Continuing Your 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