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For Your Reference

Plan Arranged By:

Mark III Employee Benefits

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsnc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-877-275-9787 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- $2,000 Individual/$4,000 Family Total. Out-of-Network- $4,000 Individual/$8,000 Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services.	For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $150 for prescription drug coverage. There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network- $5,000 Individual/$10,000 Family Total. Out-of-Network- $10,000 Individual/$20,000 Family Total.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40/visit	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	Not Covered	-You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Tier 1 Drugs	$4/prescription	$4/prescription	- * See Prescription Drug section. - For Infertility dosage limits apply -
	Tier 2 Drugs	$45/prescription	$45/prescription	

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/rxinfo	Tier 3 Drugs	$60/prescription	$60/prescription	Minimum of $50 in coinsurance but no more than $100 for tier 4 drugs
	Tier 4 Drugs	25% coinsurance	25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral	Outpatient services	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services	Inpatient services	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
If you are pregnant	Office visits	$40/visit	30% coinsurance	-*See Family planning section. -Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	20% coinsurance	30% coinsurance	-*See Therapies section -30 visits/ benefit period includes PT/OT/ Chiropractic Care. -30 visits/benefit period Speech Therapy - $40,000 max/benefit period for Adaptive Behavior Treatment (18 and younger)
	Habilitation services	20% coinsurance	30% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	30% coinsurance	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered
	Durable medical equipment	20% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	Hospice services	20% coinsurance	30% coinsurance	-Precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	-Limits may apply
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BCBSNC at 1-877-258-3334 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost $12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost $7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost $1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-275-9787.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsnc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-877-275-9787 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- $1,500 Individual/$3,000 Family Member/$3,000 Family Total. Out-of-Network- $3,000 Individual/ $6,000 Family Member/$6,000 Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductibleplan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive services.	For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network- $3,500 Individual/$5,000 Family Member/$5,000 Family Total. Out-of-Network- $7,000 Individual/ $10,000 Family Member/$10,000 Family Total.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-

	www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	-You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
	Tier 1 Drugs	20% coinsurance	20% coinsurance	- * See Prescription Drug section. -For Infertility dosage limits apply
	Tier 2 Drugs	20% coinsurance	20% coinsurance	

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/rxinfo	Tier 3 Drugs	20% coinsurance	20% coinsurance	
	Tier 4 Drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral	Outpatient services	20% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services	Inpatient services	20% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	-*See Family planning section. -Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	20% coinsurance	50% coinsurance	-*See Therapies section -30 visits/ benefit period includes PT/OT/ Chiropractic Care. -30 visits/benefit period Speech Therapy - $40,000 max/benefit period for Adaptive Behavior Treatment (18 and younger)
	Habilitation services	20% coinsurance	50% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	50% coinsurance	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered
	Durable medical equipment	20% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	Hospice services	20% coinsurance	50% coinsurance	-Precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	-Limits may apply
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BCBSNC at 1-877-258-3334 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

*For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com

CGS

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost $12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,600**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost $7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost $1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-275-9787.

The plan would be responsible for the other costs of these EXAMPLE covered services.

CGS

May 1, 2017

Dear Onslow County Colleague:

For years, Onslow County and **all** employees have accepted the responsibility for increasing healthcare costs regardless of the efforts taken by individual employees to manage, maintain, and improve health and wellness outcomes. These increased healthcare costs have come in the form of increased deductibles and co-insurance, and increased premiums paid by the county on behalf of employees. This has created some significant challenges for the Onslow County budget as costs have steadily increased over the last few years. In addition, the lack of accountability for maintaining a healthy lifestyle has created some undue burdens on employees who work hard to manage health and wellness at the expense of employees who are not accepting responsibility for managing their health. In fiscal year 2015, Onslow County experienced an increase in healthcare costs of 16%. **A significant portion of these increases is directly related to the health and wellness of our employee population**. Simply put, a large portion of our employees are not taking care of themselves and as a result the cost of healthcare for everyone is increasing. And, all of these costs add to the county budget and take away resources and funds that could be used to incentivize our employees which include improving salary and benefits. This type of behavior does not stand up to the responsibility we have as a government organization and our obligation to be accountable for the tax dollars we spend of the citizens of Onslow County.

Therefore, beginning in the plan year beginning July 1, 2016, Onslow County implemented Accountability Improvement Measures (AIM) as part of our healthcare plan. These measures are designed to help us reduce cost and shift the accountability and responsibility for managing our health and wellness to you and me – the employee. As a result, you will begin experiencing some changes in your healthcare and in our management of the plan in the coming months and years.

It is important that you remember the following information:

- Participation in wellness activities and in biometric screening is optional. However, if you choose not to participate, you will lose premium savings offered by Onslow County.
- The health risk assessment conducted in June 2014 set the baseline for existing employees. For employees hired after June 2014, their baseline will be set when they participate in their first health risk assessment.
- In subsequent years, you will need to maintain or see improvement in four out of the five biometric indicators listed below. Employees who meet these measures will receive a $50.00 per month discount towards their health insurance premiums during fiscal year 2018. These measures are tracked and analyzed by our health risk assessment provider.
    - Waist Circumference (less than 40” for males and less than 35” for females or improve by 10%)
    - Blood Pressure (less than 140/90 or lose 10/5 mmHg)
    - Cholesterol Ratio (less than 5.5 or improve by 10%)
    - Glucose (Hemoglobin A1c less than 7.0)
    - Tobacco free – you do not smoke, dip, or consume tobacco products (including e-cigarettes) as a stimulant (this will be certified through an attestation form that you will sign and we will maintain on file annually)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the County Clinic and they will work with you (or, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Onslow County is committed to having healthy employees. The Commissioners and county administration have taken significant steps to provide a free wellness clinic, wellness and fitness classes and educational opportunities, and fitness competitions to help you stay on track. We know that a healthy workforce is a competitive and effective workforce and we need your help to take responsibility for your health and help to be good stewards of the benefits we receive.

PPO Monthly Premium

	Not Participating in Health Assessment and/or not meeting health measures	Participating in Health Assessment
Employee Only	$75.00	$25.00
Employee and Spouse	$500.12	$450.12
Employee and Child	$238.82	$188.76
Employee and Children	$353.82	$303.82
Employee and Family	$506.08	$456.08

HSA Monthly Premium

(Employer HSA Contribution - $750)

	Not Participating in Health Assessment and/or not meeting health measures	Participating in Health Assessment
Employee Only	$50.00	$0.00
Employee and Spouse	$475.12	$425.12
Employee and Child	$213.76	$163.76
Employee and Children	$328.82	$278.82
Employee and Family	$481.08	$431.08

For Customer Service needs and questions, please call BCBSNC at 877-275-9787.

BlueCross BlueShield Association

Onslow County Health and Wellness Center

- There is no co-pay for services provided by the Health & Wellness Center to eligible County
- Employees and the dependents covered by the County Health Insurance.
- Employees who are seen during the workday at the Center will not have to use sick or comp time provided they return to work the same day.
- The top generic prescriptions based on our group's usage will be prescribed free of charge at the Center through Johnson Drug. They have 3 convenient locations in Jacksonville. All other prescriptions may be filled at the pharmacy of your choosing.
- All diagnostic services (x-rays, MRI, etc.) ordered at the Center will be free of charge through Coastal Diagnostic Imaging which is located on Henderson Drive.
- All personal medical services are confidential and the records will be securely maintained by the clinician.
- The services to be offered at the Wellness Center include (but are not limited to) the following:
  - Primary Care Needs
  - Routine Medical Needs
  - Episodic Care
  - Preventative health care education
  - Routine Lab Work ordered by the clinic practitioner
  - First Aid
  - Fitness for Duty exams
  - Wellness Checks
  - Disease Management Program (for those who wish to receive this service)
  - Education on Healthy Lifestyles
- The Health and Wellness Center is located at 3085 Richlands Highway, Suite 4, Jacksonville
- Services are provided by QuickER Care Clinic
  - Phone: 910-939-4848
  - Fax: 910-455-0616
- Office Hours are 8AM to 6PM Monday through Friday and 9AM to 3PM Saturday
- Appointments may be made by calling the Health & Wellness Center directly.

Gilsbar Health Reimbursement Account (HRA)

Effective Date: July 1, 2017

- ***Health Reimbursement Annual Employer Contribution: $750***
- ***Waiting Period: When insurance becomes effective***
- ***Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year***

The Health Reimbursement Account (HRA) is an Employer-sponsored plan that can be used to reimburse a portion of you and your eligible family member's out-of-pocket medical expenses, such as deductibles, coinsurance and pharmacy expenses. The HRA is not an insurance program, but a financial reimbursement plan funded entirely by the County. A Health Reimbursement Account (HRA) gives you the opportunity to manage your health care expenses in partnership with the County.

Basically all types of medical, dental, vision, deductibles, copayments, coinsurance and other healthcare related expenses may be reimbursed by the HRA as defined by Code Section 213(d). In order to be an eligible **premium expense** under an HRA, the premium must qualify as a medical expense under Code Section 213(d).

Other qualified medical expenses from your HRA include the following:

- Amounts paid for health insurance premiums during continuation of coverage provisions during unemployment.
- Amounts paid for qualified long-term care coverage.

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

Balances that remain at the end of the year can be carried over to the next year and $3,000 is the total amount that you can rollover. The County is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses.

If you terminate your employment you will be able to spend down the balance in your account **IF** you elect COBRA.

Gilsbar's Customer Contact Center - 1.800.445.7227, ext. 1883
Website: www.myGilsbar.com

GILSBAR Our Ingenuity. Your Opportunity.

Gilsbar Flexible Spending Accounts

Plan Year: July 1, 2017 - June 30, 2018
Health Care Flexible Spending Account Maximum: $2,500.00
Dependent Care Account Maximum: $5,000.00

Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your plan is administered by Gilsbar, LLC. **Your group number is S2644**

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

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

THERE IS A HANDY MOBILE APPLICATION!

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

IT'S EASY TO GET STARTED:

STEP 1: **After your effective date, go to www.myGilsbar.com and register as a new participant.** You will complete a brief registration form, and you will need a valid e-mail address and your group number, **S2644**

STEP 2: **Once logged in, choose the *FSAs and HRAs* link in the left navigation bar.**

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

SUBMIT YOUR CLAIMS:	*CONTACT US:*
For fastest processing, upload your claims online. You may also fax claims and receipts to: (866) 635-1329 Mail claims and receipts to: Gilsbar, LLC Attn: Flex PO Box 965 Covington, LA 70434 *(Please keep the original documents for your records.)*	***Customer Contact Center*** ***Phone: (800) 445-7227 ext. 1883*** ***Email: flex@gilsbar.com*** ***7:00 a.m. – 7:00 p.m. CST***

Your Healthcare FSA

WHAT IS A HEALTHCARE FSA?

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

HOW DOES THE HEALTHCARE FSA WORK?

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

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

HOW EASY IS IT TO MANAGE MY HEALTHCARE FSA?

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

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

HOW DOES THE FSA SAVE ME MONEY?

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

	With FSA	Without FSA
Salary:	$1000.00	$1000.00
Less Pre-Taxed Dollars:		
Healthcare Reimbursement	-$100.00	$0.00
Taxable Income	$900.00	$1000.00
Less:		
Federal Income Tax (15%*)	-$135.00	-$150.00
State Income Tax (5%*)	-$45.00	-$50.00
Social Security (7.65%*)	-$68.85	-$76.50
Net Take Home Pay:	$651.15	$723.50
Less Healthcare Expenses	-$0.00	-$100.00
Net After Expenses:	**$651.15**	**$623.50**

Your income tax rates will vary based on your income and the state in which you reside

CAN I CHANGE MY CONTRIBUTION AMOUNT?

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

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

MOST COMMON ELIGIBLE EXPENSES

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

HEALTHCARE FSA EXPENSE WORKSHEET

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

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

Conveniently manage your FSA at www.myGilsbar.com!

FSA Debit Card
what you need to know

HOW DOES THE FSA DEBIT CARD WORK?

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

IF I USE MY FSA DEBIT CARD, IS VERIFICATION OF CLAIMS STILL REQUIRED?

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

HOW CAN I PROVIDE SUPPORTING DOCUMENTATION?

If you receive a substantiation request letter please go to www.myGilsbar.com to electronically upload any required receipts.

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

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

WHERE CAN I USE MY FSA DEBIT CARD?

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

WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

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

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

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

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

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

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

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

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

Your Dependent Care FSA

WHAT IS A DEPENDENT CARE FSA?

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

HOW DOES THE DEPENDENT CARE FSA WORK?

With an Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from your pay each pay period. To estimate your dependent care expenses, consider your expenses from last year. Please use the provided expense worksheet to help you determine the amount of money to allocate for your Dependent Care FSA. The IRS requires that all money in your account be used during the plan year. An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself
- Is your spouse and is physically or mentally incapable of caring for himself or herself
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself

HOW EASY IS IT TO MANAGE THE DEPENDENT CARE FSA?

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

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

HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

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

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

Your income tax rates will vary based on your income and the state in which you reside

WHAT EXPENSES ARE COVERED?

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

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

Conveniently manage your FSA at www.myGilsbar.com!

HOW DO I GET REIMBURSED?

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

CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?

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

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

DEPENDENT CARE FSA EXPENSE WORKSHEET

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

DEPENDENT CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:	
Costs of Child or Adult Care Facilities*	
Day Care Center / Nursery School	$ _____
Family Day Care / Adult Day Care Centers**	$ _____
Wages paid to a nanny or in home care provider***	$ _____
* The facility must follow all local and state laws. ** These costs are eligible only if the adult dependent spends at least eight hours per day at your home. *** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.	
Other dependent care expenses considered eligible by the IRS	$ _____
TOTAL ESTIMATED DEPENDENT CARE EXPENSES	$ _____
Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.	

FSA Substantiation

proof of eligible debit card purchases

IRS REGULATIONS ON FSA DEBIT CARDS

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

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

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

These methods are:

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

WHY DOES THE IRS HAVE THESE RULES? ISN'T IT MY MONEY?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

WHAT SHOULD I DO IF I RECEIVE A SUBSTANTIATION REQUEST?

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

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

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

WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?

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

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

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

SHOULD I KEEP COPIES OF MY RECEIPTS?

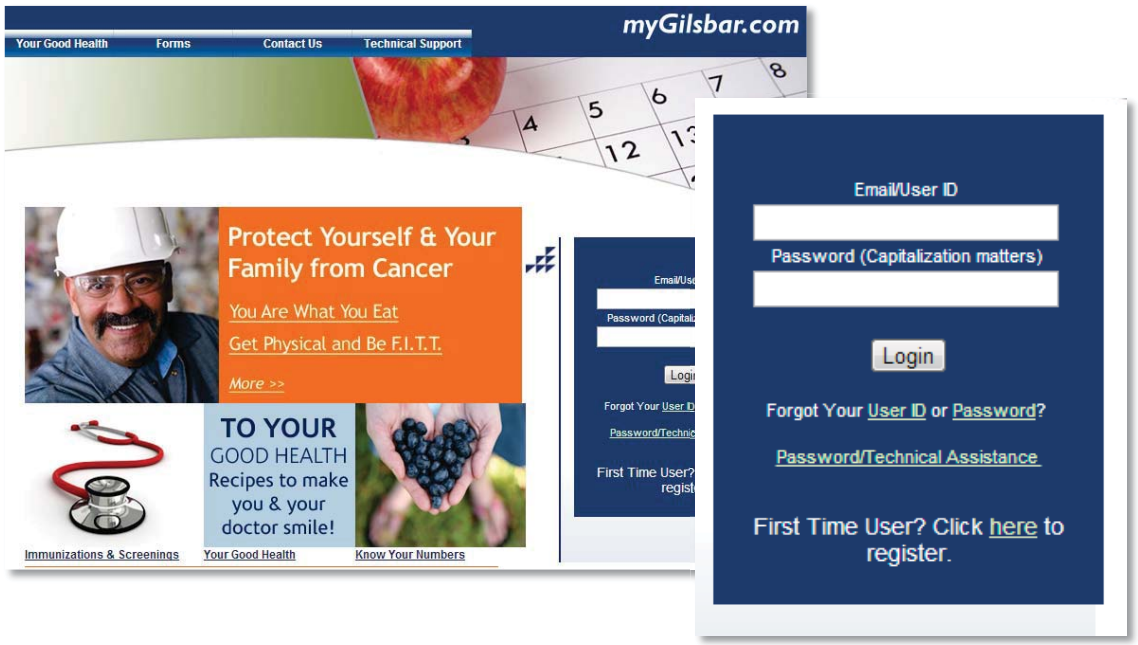
Yes, because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records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

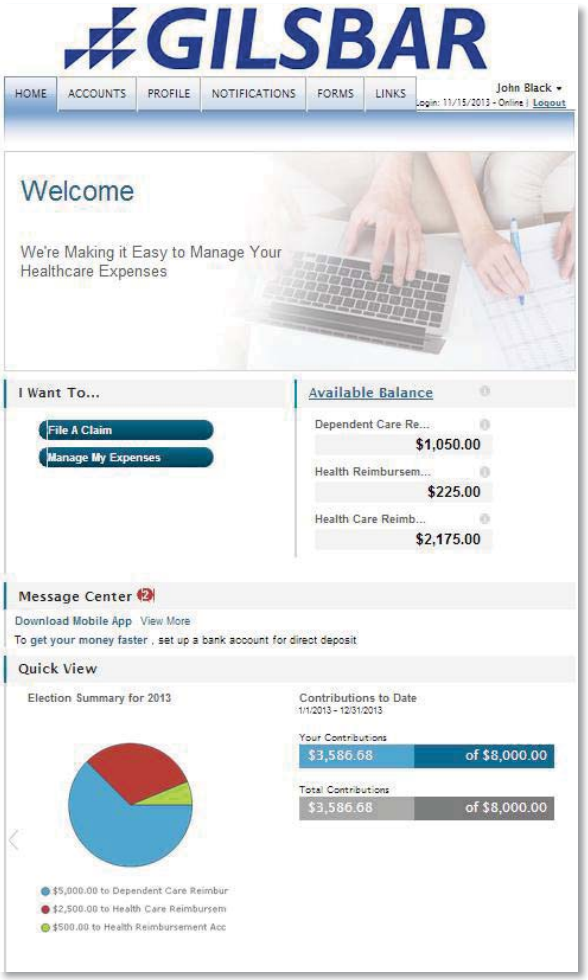
Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA), if applicable. It enables you to:

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

ACCESSING YOUR PORTAL

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





NAVIGATING THE HOME PAGE

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

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

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

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

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

HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

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

FSA/HRA Mobile App

manage your accounts on-the-go

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

With the mobile app, you can:

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

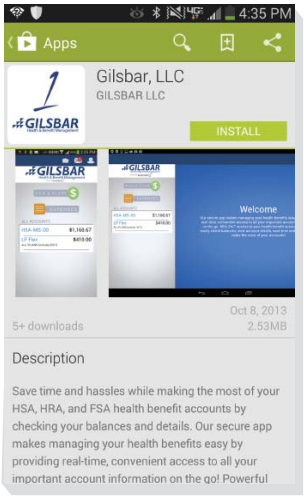
DOWNLOADING THE APP

For Apple Devices:

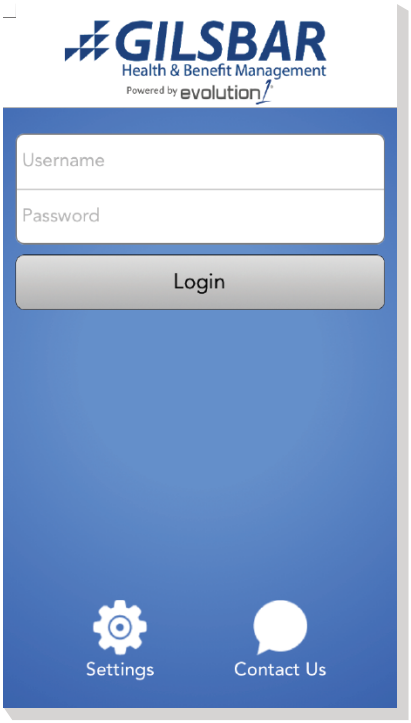
- Open the App store and search for "Gilsbar FSA HRA."
- Tap "Free" and then "Install." You will be prompted for your apple ID log in information. Enter it and select "OK."
- Once the app is downloaded, tap its icon to open it on your device.

For Android Devices:

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

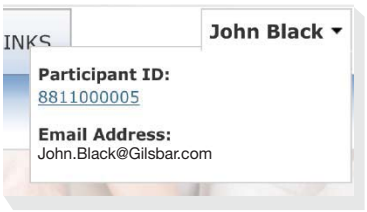


LOGGING IN TO THE MOBILE APP



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

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



- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).

- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

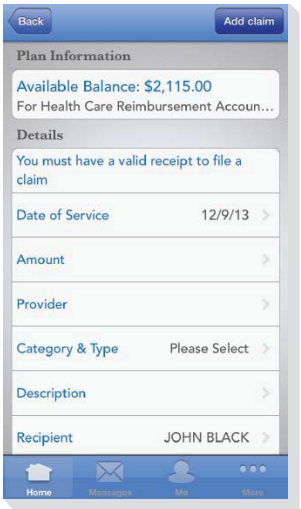
If you would like assistance installing or logging in to the mobile app, please contact our Customer Contact Center!
1-800-445-7227, ext 1883 • flex@gilsbar.com

INSIDE THE MOBILE APP

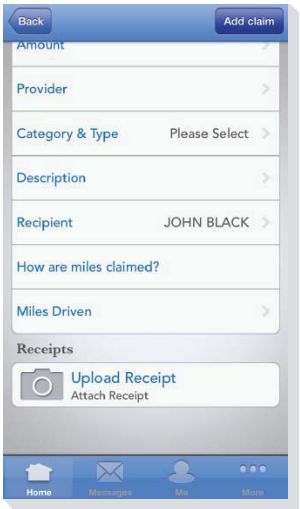
Once you're logged in to the app, you're seconds away from managing your FSA & HRA accounts from your phone.

view account balances & activity

file new claims



upload & manage receipts



Ameritas Dental PPO Plan

Effective Date: July 1, 2017

Calendar Year Deductible

A $25.00 In-Network and a $75.00 Out-of-Network, 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 benefit period)
- Cleanings (Two per benefit period)
- Bitewings (Two per benefit period)
- Space Maintainers
- Fluoride for Children (Under age 19)
- Radiographs (X-rays)

Type 2 - Basic Procedures

Type 2 benefits are payable at 80% U&C* $25.00 Deductible In-Network. $75.00 Deductible Out-of-Network.

- Sealants (Under 17)
- Denture Repair
- Oral Surgery - Simple and Complex Extractions
- Restorative Amalgam & Resin (excluding inlays & crowns)

Type 3 - Major Procedures

Type 3 Benefits are payable at 50% U&C* $25.00 Deductible In-Network. $75.00 Deductible Out-of-Network.

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

Orthodontia

Paid at 50% U&C** with a $1,000 lifetime maximum. No deductible applies.
Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

***Important Note: Late Entrant Notice*: There is a 12 month waiting period on all procedures except cleanings, exams, and fluoride treatments, unless the employee (and/or dependents) enrolled in the plan when they were FIRST eligible to participate.**

** Percentage Paid based on Usual and Customary Charges

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 (carryover doesn't apply)

*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 each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements, you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1,000. This benefit allows you to accumulate up to a $2,000 annual dental maximum!

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 30 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-Deductible Reduction

Deductible Reduction continues the difference of in-network and out-of-network claim allowance and allows a reduced deductible for those who visit an in-network 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.ameritasgroup.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:

Onslow 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 in the Benefit's Department or on 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!

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.AmeritasGroup.com

Ameritas Dental Rates

Employee Only	$0.00 (paid by the County)
Employee/Spouse	$32.44
Employee/Child(ren)	$24.54
Employee/Family	$59.20

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan Full Services Plan

Effective Date: July 1, 2017
Outline of Benefits – Gold Preferred Plan with Materials Discount
Copayment: ***$10.00 Exam Copayment***
$10.00 Materials Copayment
$25.00 Contact Lens Fitting Fee

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[1]*	*Out-of-Network[1]*
Comprehensive Eye Exam			
Ophthalmologist	12 Months	Covered in Full	Up to $44.00
Optometrist	12 Months	Covered in Full	Up to $39.00
Standard Lenses (Per Pair):			
Single Vision	12 Months	Covered in Full	Up to $34.00
Bifocal	12 Months	Covered in Full	Up to $48.00
Trifocal	12 Months	Covered in Full	Up to $64.00
Lenticular	12 Months	Covered in Full	Up to $88.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames-Standard[3]	24 Months	Up to $150.00	Up to $77.00

[1] All in-network and out-of-network allowances are at the retail value.
[2] Contact lenses are in lieu of eyeglass lenses and frames benefits.
[3] The insured is responsible for paying any charges in excess of this allowance.
[4] 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 accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

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

The following options have out-of-pocket maximums[5] on standard 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

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.

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.

[5] Discounts and 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.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. **Please confirm the details of your employer's plan prior to seeking services.**

Monthly Rates Full Services Plan

Employee Only	$9.70
Employee + One	$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.

Superior Vision Plan 2 - Materials Only Plan

Effective Date: July 1, 2017
Outline of Benefits – Platinum Preferred Materials Only Plan
Plan Copayment: $10.00 Materials Copayment
$25 Contact Lens Fitting Exam

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.

Benefits	***Frequency***	***In-Network[1]***	***Out-of-Network[1]***
Eye Exam		No Benefit	No Benefit
Standard Lenses (Per Pair):			
Single Vision	12 Months	Covered in Full	Up to $34.00
Bifocal	12 Months	Covered in Full	Up to $48.00
Trifocal	12 Months	Covered in Full	Up to $64.00
Lenticular	12 Months	Covered in Full	Up to $88.00
Progressive	12 Months	Covered to provider's retail trifocal amount	Up to $64.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Standard Contact Lens Fitting Exam[4]	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Exam[4]	12 Months	Up to $50.00	Not Covered
Frames-Standard[3]	24 Months	Up to $150.00	Up to $77.00

[1] All in-network and out-of-network allowances are at the retail value.
[2] Contact lenses are in lieu of eyeglass lenses and frames benefits.
[3] The insured is responsible for paying any charges in excess of this allowance.
[4] 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.

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Photochromic	$80	20% off retail

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Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

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*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. **Please confirm the details of your employer's plan prior to seeking services.**

Monthly Rates - Materials Only Plan

Employee Only	$6.90
Employee + One	$13.38
Employee + Family	$19.64

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
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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

Effective Date: July 1, 2017

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*
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	$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 200% 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 200% of the benefit amount for the fractured bone which has the highest dollar amount.

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

The maximum amount payable for the Fracture Benefit per covered accident is 200% of 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 200% 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 200% 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 200% 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 200% of 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
Over 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)	
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
Other Injuries	
Concussion (A concussion *or Mild Traumatic Brain Injury (MTB)* is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: *Concussion and MTB* 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 (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 this benefit 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 your 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 this benefit for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness — $60

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

- Annual physical exams
- Blood screenings
- Eye Examinations
- Immunizations
- Flexible Sigmoidoscopies
- Ultrasounds
- Mammograms
- Pap smears
- PSA tests

Hospital Admission — $1,000

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

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

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

Hospital Confinement (per day) — $200

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

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

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

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

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

Hospital Intensive Care (per day)	$400

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

- Is injured, **and**
- Those injuries cause confinement to a hospital intensive care unit.

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

Accidental Death & 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 and 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 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 on the next page. 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 which 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, or participating in the armed forces or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service. 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 under the influence of any narcotic, unless taken under the direction of a physician. 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.

Aflac Accident Semi-Monthly Rates	
Employee	$8.10
Employee and Spouse	$11.58
Employee and Dependent Child(ren)	$15.45
Employee, Spouse, and Dependent Child(ren)	$18.93

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Continental American Insurance Company
Columbia, South Carolina

Customer Service 800.433.3036

AGCM378NC-200-25-BK R1 IV (4/17)

Aflac Group Hospital Indemnity Plan

Effective Date: July 1, 2017

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)	High Option	Low Option
	$150	$100

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

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

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

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

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

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

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

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

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

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

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

Anesthesia Benefits	High Option	Low Option
	Up to $375	Up to $188

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

Wellness Benefit	High Option	Low Option
	$50	$50

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

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 crew member on, or jumping or falling from any aircraft, including those, which are not motor–driven.

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

Terminations

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

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.

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.

Semi-Monthly Premium Rates

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

Continental American Insurance Company, Columbia, South Carolina.

Customer Service 800.433.3036

Aflac®

We've got you under our wing.®

AGCM385NC-HL-BK IV (1/17)

Aflac Group Critical Illness Plan
Lump Sum Single Payment Policy/First Occurrence

Effective Date: July 1, 2017

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:
    - o Coma
    - o Paralysis
    - o Severe Burn
    - o Loss of Sight
    - o Loss of Hearing
    - o 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. The following options are available for guaranteed-issue for the first three years:

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

Employees - 18-69
Spouses - 18-69
Children under age 26

Benefit-eligible employees working at least 19 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 or her 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%
Stroke	100%
Major Organ Transplant	100%
Kidney Failure (End Stage)	100%
Coronary Artery Bypass**	25%

*If diagnosis occurs after age 70, benefits are reduced by 50%.

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 in force. 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%

*If diagnosis occurs after age 70, benefits are reduced by 50%.

Heart Event Rider

Illnesses Covered Under Plan	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%

*If diagnosis occurs after age 70, benefits are reduced by 50%.

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%.

Additional Benefit Rider Exceptions

If diagnosis occurs after age 70, benefits are reduced by 50%.

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.

Heart Event Rider Exceptions

If diagnosis occurs after age 70, benefits are reduced by 50%.

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.

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.

Customer Service 800.433.3036

AGCM328-NC-BK IV (1/17)

Semi-Monthly Rates for Employee and Spouse

NON - TOBACCO - EMPLOYEE SEMI-MONTHLY

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

NON-TOBACCO - SPOUSE SEMI-MONTHLY

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

TOBACCO - EMPLOYEE SEMI-MONTHLY

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

TOBACCO - SPOUSE SEMI-MONTHLY

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

Aflac Group Critical Illness Plan
Lump Sum Single Payment Policy/First Occurrence

Effective Date: July 1, 2017

Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $25,000 for spouses.
- Dependent children are covered at 50% of the primary insured's amount at no additional charge.
- Guaranteed-issue coverage is available (which means you may qualify for coverage without having to answer health questions).
- Premiums are paid through convenient payroll deduction.
- Coverage is portable, with certain stipulations.
- 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

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

Up to **$10,000** for employees and **$5,000** for spouses with no participation requirement.

Individual Eligibility

Issue Ages

Employees - 18-69
Spouses - 18-69
Children under age 26

Benefit-eligible employees working at least 19 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 or her 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. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

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

*At age 70, benefits are reduced by 50%.

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

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

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

**Payment of the partial benefit for Carcinoma in Situ will reduce by 25% the benefit for Internal Cancer. Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.

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 in force. 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%

*At age 70, benefits are reduced by 50%.

Heart Event Rider

Illnesses Covered Under Plan	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%

*****At age 70, benefits are reduced by 50%.

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% Coronary Artery Bypass partial benefit in your certificate is increased to 100%. That means the Coronary Artery Bypass Surgery 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.

If diagnosis occurs after age 70, benefits are reduced by 50%.

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.

Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment free for that cancer for 12 consecutive months.

Additional Benefit Rider Exceptions

If diagnosis occurs after age 70, benefits are reduced by 50%.

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

If diagnosis occurs after age 70, benefits are reduced by 50%.

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.

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.

Customer Service 800.433.3036

AGCM328C-NC-BK IV (1/17)

Semi-Monthly Rates for Employee and Spouse

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON- TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.13	$4.50	$5.88	$7.25	$8.63	$10.00	$11.38	$12.75	$14.13	$15.50
30-39	$3.98	$6.20	$8.43	$10.65	$12.88	$15.10	$17.33	$19.55	$21.78	$24.00
40-49	$6.43	$11.10	$15.78	$20.45	$25.13	$29.80	$34.48	$39.15	$43.83	$48.50
50-59	$9.58	$17.42	$25.25	$33.08	$40.92	$48.75	$56.58	$64.42	$72.25	$80.08
60-69	$14.25	$26.75	$39.25	$51.75	$64.25	$76.75	$89.25	$101.75	$114.25	$126.75

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON-TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.13	$3.81	$4.50	$5.19	$5.88	$6.56	$7.25	$7.94	$8.63
30-39	$3.98	$5.09	$6.20	$7.31	$8.43	$9.54	$10.65	$11.76	$12.88
40-49	$6.43	$8.76	$11.10	$13.44	$15.78	$18.11	$20.45	$22.79	$25.13
50-59	$9.58	$13.50	$17.42	$21.33	$25.25	$29.17	$33.08	$37.00	$40.92
60-69	$14.25	$20.50	$26.75	$33.00	$39.25	$45.50	$51.75	$58.00	$64.25

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.93	$6.10	$8.28	$10.45	$12.63	$14.80	$16.98	$19.15	$21.33	$23.50
30-39	$5.48	$9.20	$12.93	$16.65	$20.38	$24.10	$27.83	$31.55	$35.28	$39.00
40-49	$11.40	$21.05	$30.70	$40.35	$50.00	$59.65	$69.30	$78.95	$88.60	$98.25
50-59	$17.20	$32.65	$48.10	$63.55	$79.00	$94.45	$109.90	$125.35	$140.80	$156.25
60-69	$26.43	$51.10	$75.78	$100.45	$125.13	$149.80	$174.48	$199.15	$223.83	$248.50

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.93	$5.01	$6.10	$7.19	$8.28	$9.36	$10.45	$11.54	$12.63
30-39	$5.48	$7.34	$9.20	$11.06	$12.93	$14.79	$16.65	$18.51	$20.38
40-49	$11.40	$16.23	$21.05	$25.88	$30.70	$35.53	$40.35	$45.18	$50.00
50-59	$17.20	$24.93	$32.65	$40.38	$48.10	$55.83	$63.55	$71.28	$79.00
60-69	$26.43	$38.76	$51.10	$63.44	$75.78	$88.11	$100.45	$112.79	$125.13

Rates include cancer benefit.

Rates include $100 Health Screening Benefit.

USAble Voluntary Term Life Insurance Plan

Effective Date: July 1, 2017

Schedule of Benefits

Amount of Life and AD&D

All Active Full-time Employees:	Life: $22,500
	AD&D: $22,500

Employees must be actively at work and working on a full time basis in order to be eligible for coverage.

Benefit Amount

Spouse:	$5,000.00
Child (each) over 14 days but less than 6 months:	$500.00
6 months but less than 19 years and students less than 26 years:	$5,000.00

Reductions and Terminations

Life benefits and Accidental Death and Dismemberment benefits will reduce by 50% at age 70 and benefits terminate at retirement. Dependent Life Coverage for the employee's spouse will be reduced by 50% when the spouse reaches age 65.

Beneficiary

Each employee may name anyone he desires, except the employer, as the beneficiary or beneficiaries to whom the insurance is to be paid. This designation may be changed by the employee at any time.

Right of Conversion

The employee's life insurance automatically ceases 31 days after termination of employment. During this 31 day period and subject to the terms of the group policy, he may convert his group life insurance without evidence of insurability to an individual life insurance policy (except term insurance) without disability benefits.

Total Disability Benefit (Waiver of Premium)

We will continue the insured employee's group life insurance in force without premium payment if he becomes totally disabled provided:

1. The Employee is insured under this plan and is actively at work on or after the effective date of the plan; and
2. The Employee's total disability begins before age 60; and
3. Total disability has continued without interruption for at least six (6) months during which time premiums have been paid; and

4. The Employee provides us with proof of total disability as required; and
5. The Employee is still totally disabled when he/she submits the proof of disability.

The amount of insurance continued will be the amount in force on the date the insured employee becomes totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance in effect on the date of total disability. This amount will not be increased while the insured employee remains totally disabled.

The insured employee will no longer be eligible for the Extended Insurance Benefit and his life insurance will terminate on the earliest of the following dates:

1. The date the insured employee ceases to be totally disabled;
2. The last day of the 60 day period following our request for proof of total disability, if he does not give us proof or he refuses to take a medical exam; or
3. The date the insured employee attains age 70. He will be entitled to the Conversion Privilege as of that date.

Dependent's Group Life Insurance

Death Benefits

The amount of Dependent's Group Life Insurance, as determined by the Schedule of Benefits, is payable to the employee in the event of death of an eligible dependent. The life insurance will be paid in a lump sum.

Right of Conversion

An insured dependent spouse or child may convert all or part of his life insurance to an individual life insurance policy, other than Term, if his dependent life insurance is terminated because:

1. The employee stopped working full-time for the employer; or
2. The employee ceased to be a member of a class eligible for insurance; or
3 The dependent ceased to be an eligible family member; or
4. The employee's death.

Group Accidental Death & Dismemberment

Benefits

An amount, as determined by the Schedule of Benefits, is payable in the event of loss of life or dismemberment through accidental means, Accidental Death and Dismemberment Insurance provides protection for losses occurring on or off the job. Payment will be made if the loss is suffered within 365 days of the date of the accident. However, we will pay no more than the full amount shown on the Schedule of Benefits for losses resulting from any one injury. The amounts payable are as follows:

Full Amount Of Insurance For Accidental Loss Of:

- Life (in addition to any amount of Group Life Insurance).
- Both Hands or Both Feet.
- Sight of Both Eyes.
- One Hand and One Foot.
- One Hand and Sight of One Eye.
- One Foot and Sight of One Eye.

One Half Amount Of Insurance For Accidental Loss Of:

- One Hand.
- One Foot.
- Sight of One Eye.

Group Accidental Death & Dismemberment Limitations

We will not pay a benefit for loss caused directly or indirectly by:

- disease, bodily or mental infirmity of infection (except bacterial infection of a visible injury);
- suicide or intentionally self-inflicted injury, whether sane or insane;
- participation in a riot or insurrection, or commission of an assault or felony;
- war or any act of war, declared or undeclared;
- the employee's use of any drug, hallucinogen, controlled substance or narcotic unless prescribed by a physician.*
- travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on (a) a scheduled route; or (b) a charter flight;
- participation in parachute or hang gliding sports, or any organized race or speed contest; or
- the insured employee being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Accelerated Benefits Rider

This rider is made part of the policy or certificate issued by USAble Life to which it is attached. It takes effect and expires at the same time as the policy or certificate.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits described in this Rider may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor. The receipt of accelerated benefit payments may adversely affect the insured's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Insured Person" means an insured employee or an insured dependent. Each will be insured for the benefits of this rider only if he becomes and remains insured for life insurance benefits under the group policy.

"Terminal Illness" means a medical condition:

1. which is expected to result in the insured person's death within 12 months; and
2. from which the insured person is not expected to recover.

Eligible Classes

1. All employees under age 70 who are insured for a minimum of $15,000 of life insurance under the group policy.
2. All dependents of the person described in 1 above, if they are insured for a minimum of $15,000 of life insurance under the group policy and are under age 70.

Date Persons Are Eligible For Insurance Under This Rider

A person will be eligible for such insurance on the later of:

1. the date he is eligible for life insurance under the group policy, or
2. the effective date of the group policy rider.

Non-Confinement Requirement

An employee or his dependent might be confined for medical treatment in an institution or at home on the date the insurance is to take effect under this rider. If so, the insurance will take effect on the day following his final medical discharge from such confinement.

The Accelerated Benefit

The accelerated benefit is an advance payment to the person who:

1. is terminally ill, and
2. elects to receive part of his insurance amount under the group policy, subject to the maximum and minimum benefit requirements stated below.

We will pay an accelerated benefit to the insured employee when we receive the following:

1. a written request for payment of the accelerated benefit, and
2. due proof that the insured person is terminally ill.

The accelerated benefit will be paid once and in one lump sum to the insured employee.

Amount of Accelerated Benefit

The maximum accelerated benefit will be equal to 50% of the insured person's life insurance amount as shown in the Schedule of Benefits of his certificate.

An insured employee's life insurance amount may be scheduled for a reduction within 12 months after the date he requests the payment of the accelerated benefit. In this case, the maximum accelerated benefit will be limited to 50% of the life insurance amount which will be in effect after the scheduled reduction. The minimum accelerated benefit for the insured employee or the insured dependent will be $7,500.

Exclusions

We will not pay an accelerated benefit if:

1. the insured person has made an absolute assignment of his life insurance under the group policy;
2. all or part of the insured person's life insurance under the group is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. we do not receive written consent by any irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide.

General Provisions

Master Policy and Individual Certificates

This proposal provides coverage highlights only. The complete terms of the insurance are contained in a Master Policy issued to the Policyholder. Each employee receives a Certificate, which outlines his benefits under the plan.

Eligible Employees

All permanent, active, full-time employees who have completed the waiting period established by the Policyholder are eligible unless limited by conditions pertaining to their employment. The term “employees” includes all persons who work for the Policyholder at least the minimum number of hours per week shown on the group application.

Eligible Dependents

An employee’s spouse and unmarried children under 19 years of age (or age 26 if the dependent is a full-time student).

Effective Date of Coverage

Employees - All eligible employees actively at work on the effective date of the plan may be insured immediately. New employees will become insured following completion of the waiting period specified on the group application. If an Employee is not actively working on the date his insurance or any increase in insurance is scheduled to take effect, it will take effect on the day he returns to active work. If the Employee’s insurance is scheduled to take effect on a non-working day, his active work status will be based on the last working day before the scheduled effective date of his insurance.

Dependents - Insurance on dependents will not become effective until the employee’s insurance is effective. Coverage for any dependant who is hospital confined on the date dependent insurance is scheduled to take effect will not become effective until the dependent is no longer hospital confined.

If the employee does not apply for insurance within 31 days after becoming eligible, satisfactory evidence of insurability is required.

Termination of Insurance

Insurance will terminate automatically on the earliest of the following dates:

(a) the last day of the period for which a premium payment is made, if the next payment is not made;

(b) the date the policy or a specific benefit terminates;

(c) the date the insured ceases to be a member of an eligible class; or

(d) the date the insured ceases to be actively at work.

Rates

	Employee	*Family*
Full-Time Employee Premium	*$6.52*	*$8.37*
Full-Time Employee Over 70	*$3.26*	*$5.11*

USAble Life
USAble Corporate Center
P.O. Box 1650
Little Rock, Arkansas 72203

Toll Free: (800) 648-0271
Or: (501) 375-7200
Fax: (501) 235-8404

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

The SOLUTIONS Advantage

Individual Protection

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

Coverage for Your Family

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

16M419-C1119 (exp1118)

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

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

Accelerated Death Benefit for Chronic Illness

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

Waiver of Premium Rider

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

Coverage begins immediately

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

Sample Rates

The chart below displays examples of SOLUTIONS 121 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.

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

SOLUTIONS Review

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

If you have any questions regarding your Texas Life policy, please call 800-283-9233, prompt #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] *LIMRA; Life Insurance Ownership Focus – 2016*

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

TEXASLIFE INSURANCE COMPANY

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

16M419-C 1119 (exp1118)

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

Continuing Your Benefits If You Leave Employment with Onslow County Government

Blue Cross Blue Shield Of NC PPO Plan

Under the PPO medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA according to the following "qualifying events".
If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue medical 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. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. Please contact your Human Resources office at **910-347-7600** for additional information.

Blue Cross Blue Shield Of NC HSA Plan

Under the HSA medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA according to the following "qualifying events".
If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue medical 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. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. Please contact your Human Resources office at **910-347-7600** for additional information.

Flexible Spending Account: Medical

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Flexible Spending Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. For information about continuing your Flexible Spending Account, please contact your Human Resources office at **910-347-7600.**

Flexible Spending Account: Dependent Care

If you have a positive balance (payroll deductions are greater than the amount you have in reimbursement) in your Flexible Spending Account at the time of your termination, you may continue to submit claims within the plan year until the available balance is exhausted. For information about your Flexible Spending Account, please contact your Human Resources office at **910-347-7600.**

Ameritas Dental Plan

Under the dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events".
If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child turns 26 years old. Please contact your Human Resources office at **910-347-7600** for additional information.

Superior Vision Plans

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child turns 26 years old. Please contact your Human Resources office at **910-347-7600** for additional information.

Aflac Policies

You may continue your Aflac insurance policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed directly to your home. **Contact Aflac at 800-992-3522** for more information.

Aflac/ CAIC Critical Illness Plan

When you leave employment, coverage may be continued. You will continue the coverage that is in force on the date employment ends, including dependent coverage then in effect. You must contact CAIC within 30 days of the date employment ends to take advantage of the portability option. **Call CAIC at: 800-433-3036**

USAble Voluntary Term Life Insurance Plan

If you leave employment, you have 31 days from the date of termination to convert your group life insurance without evidence of insurability, to an individual life insurance policy. For more information and a quote, **contact USAble at 800-648-0271.**

Texas Life Whole Life

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. **You may do that by contacting Texas Life at: 800-283-9233 prompt #3.**

Benefits available to Retirees of North Carolina State and Local Governments

MetLife Dental and Superior Vision Insurance Plans for Retirees of State or Local Government Offered Through North Carolina Retired Governmental Employees' Association, Inc.

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

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

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