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Pre-Tax Benefits

After-Tax Benefits

For Your Reference

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

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

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- $1,500 Individual/$3,000 Family Total. Out-of-Network- $2,500 Individual/$5,000 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network- $4,800 Individual/$9,600 Family Total. Out-of-Network- $9,600 Individual/$19,200 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	$30/visit	30% coinsurance	None
	Specialist visit	$55/visit	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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/rxinfo	Tier 1 Drugs	$8/prescription	$8/prescription	- * See Prescription Drug section. - For Infertility dosage limits apply - Minimum of $50 in coinsurance but no more than $100 for tier 4 drugs
	Tier 2 Drugs	$40/prescription	$40/prescription	
	Tier 3 Drugs	$55/prescription	$55/prescription	
	Tier 4 Drugs	25% coinsurance	25% coinsurance	

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$500/visit	$500/visit	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$75/visit	$75/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$55/office visit; 10% coinsurance / outpatient	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Inpatient services	10% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
If you are pregnant	Office visits	$30/visit	30% coinsurance	-*See Family planning section. -Cost sharing does not apply for preventive services.

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

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)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	10% 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	10% coinsurance	30% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	10% 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	10% coinsurance	30% coinsurance	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	Hospice services	10% coinsurance	30% coinsurance	-Precertification may be required

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

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

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

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

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

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 copayment	$55
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,700**

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 copayment	$55
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$600
Coinsurance	$90
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	$1,500
Specialist copayment	$55
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

  ➢ BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

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BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

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BCBC Semi-Monthly Rates	
Employee Only	**$15.00**
Employee & Children	**$178.50**
Employee & Spouse	**$260.00**
Employee & Family	**$313.00**

FlexibleBenefit ADMINISTRATORS

Pitt County Government

Get reimbursed for out-of-pocket healthcare and expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars.) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

ELIGIBILITY

Participation in the Plan Begins on July 1, 2017 and ends on June 30, 2018. You will be eligible to join the Plan if you are a part-time or full-time employee working at least 20 hours or more per week in a position eligible for benefits on the first of the month following your date of hire. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period after the enrollment form is received. You must complete an enrollment form to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment form is not completed during open enrollment, your enrollment will be canceled and you will not be able to join until the next anniversary date of the Plan or if you have a qualifying event.

ELECTION CHANGES

Once you have enrolled in an FSA you may NOT make any changes to your election unless you have a change in status such as:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in Dependent Care Providers

REIMBURSEMENT SCHEDULE

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at

www.mywealthcareonline.com/fba to view the following features:

- FSA Login – view balances, check status and view claims history-download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out of pocket health care expenses for yourself, your spouse and all of your dependents for healthcare services that are incurred during your plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." This is a broad definition that lends itself to creativity.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

Fees/Co-Pays/Deductibles For:

- Acupuncture
- Prescription Eyeglasses/ Reading glasses/ Contact lens and supplies/ Eye Exams/ Laser Eye Surgery
- Physician
- Ambulance
- Psychiatrist
- Psychologist
- Anesthetist
- Hospital
- Chiropractor
- Laboratory/ Diagnostic
- Fertility Treatments
- Surgery
- Dental/ Orthodontic Fees
- Obstetrician
- X-Rays
- Eye Exams
- Prescription Drugs
- Artificial limbs & teeth
- Birth control pills, patches
- Orthopedic shoes/ inserts
- Therapeutic care for drug and alcohol addiction
- Vaccinations & Immunizations
- Mileage
- Take-home screening kits
- Diabetic supplies
- Routine Physicals
- Oxygen
- Physical Therapy
- Hearing aids and batteries
- Medical equipment

OVER-THE-COUNTER EXPENSES

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- Antacids
- Pain relievers/aspirin
- Ointments & creams for joint pain
- Allergy & sinus medication
- First aid creams
- Cough & cold medications
- Laxatives
- Anti-diarrhea medicine

THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Full Plan Year is $2,600.

DAY CARE/AGED ADULT CARE REIMBURSEMENT

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives. This can include stepchildren, grandchildren, adopted or foster children; refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
  - Disabled spouse
  - Disabled child
  - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- $5,000 ($2,500 if married filing separately)
- Your wages for the year or your spouse's if less
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Without Flex Benefits	With Flex Benefits
Gross Monthly Income	$ 2,500.00	$ 2,500.00
Eligible Pre-Tax employer medical insurance	$ 0.00	$ 200.00
Eligible Pre-Tax Medical Expenses	$ 0.00	$ 60.00
Eligible Pre-Tax Dependent Child Care Expenses	$ 0.00	$ 300.00
Taxable Income	$ 2500.00	$ 1940.00
Federal Tax (15%)	$ 375.00	$ 291.00
State Tax (5.75%)	$ 125.00	$ 97.00
FICA Tax (7.65%)	$ 191.25	$ 148.41
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax medical expenses	$ 60.00	$ 0.00
After-Tax dependent child care expenses	$ 300.00	$ 0.00
Monthly Spendable Income	$ 1248.75	$ 1403.59

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by $154.84 every month! This means an annual tax savings of $1,858.08. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

- Au Pair
- Nannies
- Before and After Care
- Day Camps
- Babysitters
- Daycare for an Elderly Dependent
- Daycare for a Disabled Dependent
- Nursery School
- Private Pre School
- Sick Child Center
- Licensed Day Care Centers

Ineligible Expenses

- Overnight Camps
- Babysitting for Social Events
- Leave of Absence or Vacation
- Tuition Expenses Including Kindergarten
- Food Expenses (if separate from dependent care expenses)
- Care Provided By Children Under 19 (or by anyone you claim as a dependent)
- Days Your Spouse Doesn't Work (though you may still have to pay the provider)
- Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary.
- Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill.

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you in your Employee Guide or on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to add the $500 roll-over provision to the Medical FSA. Please see the Employee Guide for more info.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible Health Care and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at www.mywealthcareonline.com/fba to help you determine your total expenses for the Plan Year.

Step 2

Complete the Enrollment Form (available from your Benefits Administrator), which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

BENEFITS CARD

You may also use your Benefits Card to pay for eligible medical expenses at approved service providers and merchants. Your benefits card cannot be used to pay for dental or vision expenses. Using your card allows you instant access to your funds with no out of pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. You may also elect to have an additional Benefits Card for your dependent(s) over the age of 18.

Please contact Flexible Benefit Administrators, Inc. to order additional cards

FlexibleBenefit ADMINISTRATORS

P.O. Drawer 8188 • Virginia Beach, VA 23450 • Toll Free (800) 437-3539 • Phone (757) 340-4567 • Fax (757) 431-1155
www.flex-admin.com

***Introducing**… our convenient participant web site! With the online WealthCare Portal you can view your account status, submit claims and report your benefits card lost/stolen right from your computer.*

Follow the simple steps outlined below to establish your secure user account.

- Get started by visiting www.mywealthcareonline.com/fba and click the new user link.
- You will be directed to the registration page.
- Follow the prompts to create your account.
  - Name
  - Email Address
  - Employee ID (Your SSN, no spaces/dashes)
  - Employer ID (**FBAPTGV or benefits card number**)
- Once completed, please proceed to your account.

Contact Us: 800-437-3539

Or email flexdivision@flex-admin.com

We're Going Mobile for You!

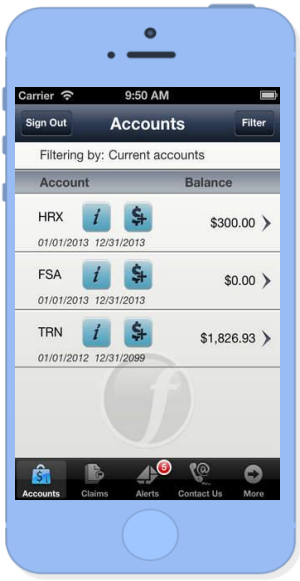
Mobile App for

Flexible Benefit Administrators, Inc.

The mobile app from FBA provides a single access point for you to manage your FSA / HRA/HSA/Transit benefit accounts! Now get up to the minute info when you want it, where you want it... on the go!

FEATURES

- Check your account details
- View recent transactions
- Confirm reimbursements
- Upload receipts by taking a photo
- View account notices and alerts
- Contact FBA through the app



Download for your Apple Product

Download for your Android Product

Ameritas Dental

Plan 1: Dental Plan

Coinsurance	
Type 1	100%
Type 2	50%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 $150/family
Maximum (per person)	$1,000 per calendar year
Allowance	90th U & C
Waiting Period	None

Orthodontia Summary - Adult and Child Coverage

Allowance	U&C
Coinsurance	50%
Lifetime Maximum (per person)	$1,500
Waiting Period	None

Sample Procedure Listing (Current Dental Terminology © American Dental Association)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months) • Bitewing X-Rays (1 in 12 months) • Full Mouth/Panoramic X-Rays (1 in 5 years) • Periapical X-Rays • Cleaning (1 in 6 months) • Fluoride for Children 15 and under (1 in 12 months) • Sealants (age 15 and under) • Space Maintainers	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)

Rates Per Pay Period

Employee Only (EE)	$14.62
EE + Spouse	$30.12
EE + Children	$42.04
EE + Spouse & Children	$57.54

Ameritas Information

We're Here to Help

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

Dental Rewards ®

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

Benefit Threshold	$500	Dental Benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Dental Rewards amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the member sees a PPO provider
Maximum Carryover	$1,000	Maximum possible accumulation for Dental Rewards and PPO Bonus combined

PPO Information

To find a provider, visit ameritasgroup.com and select FIND A PROVIDER, then DENTAL. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose PPO Dental Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. The enrollment period will be held each year and those who elect to participate in the policy at that time will have their insurance become effective on July 1.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Community Eye Care Vision

Pitt County Government is pleased to provide this summary of the voluntary vision plan available to our employees. There are two plan options from which you can choose. Offered through Community Eye Care, the two plan options are as follows:

COMPREHENSIVE PLAN

- **An eye exam once a year** ($15 co-pay)
- **A $200 allowance for eyewear annually** ($15 co-pay)
- **A contact lens fitting, re-fit, or evaluation once a year** ($15 co-pay)

EYEWEAR PLAN

A $200 allowance for eyewear annually ($15 co-pay)

The allowance can be applied to frames, spectacle lenses, contact lenses, special lens options, or any combination. As long as you select eyewear having a retail price that's less than or equal to your allowance, the only out-of-pocket expense you incur for the eyewear is the $15 co-pay.

HOW TO USE THE BENEFIT

1. Select a provider from the Community Eye Care provider network.
2. Call the provider to make an appointment, and let them know that you have Community Eye Care coverage.
3. See the doctor and select your eyewear.
4. Your only payments to the provider are your co-pays, plus any discounted amount that exceeds the eyewear allowance.

PROVIDER SEARCH

To locate a provider in your area, go to **communityeyecare.net** and search by:

- county
- doctor's last name
- practice name
- zip code

CLAIMS

There are no claims to file when you see an in-network provider. Network providers file claims on your behalf. Additionally, most CEC network providers offer discounts on the overage if you exceed your allowance — 20% on glasses and 10% on contact lenses.

Maximum coverage for contact lens exams is $100 for fittings and $80 for annual evaluations.

If you see a non-network provider, simply submit a claim form and a receipt to Community Eye Care.

CUSTOMER SUPPORT

Contact CEC's helpful Customer Support Team at **1.888.254.4290** with any questions about benefits or providers.

SEMI-MONTHLY RATES		
	Comprehensive Plan	Eyewear Plan
Employee Only	$6.15	$5.10
Employee + One	$11.69	$10.00
Employee + Family	$17.84	$15.26

COMMUNITY Eye Care

Group Cancer and Specified Disease Insurance

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

Plan Features

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

Benefit	Benefit Amounts
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	Up to $100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	1. $0 2. $2,500 3. $0 4. $5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Actual Charges
Non-Local Transportation. Payable for transportation to a Hospital, clinic, treatment center, or from one medical facility to another which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. Ambulance benefits shall include transportation from one medical facility to another. No Lifetime Maximum	Actual Charges
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following expenses incurred by the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual Charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	(a) $200 (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to $50 per day

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

Benefit	Benefit Amounts
Bone Marrow and Stem Cell Transplant. We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Actual charges to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum	Up to 25% of surgical benefit paid.
For anesthesia in connection with the treatment of skin Cancer. No Lifetime Maximum	$100 maximum per Covered Person
Ambulatory Surgical Center. We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum	$250 Per Day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	1. Actual charges up to $2,500 per month 2. Actual charges up to $2,500 per month 3. Actual charges up to $5,000 per month 4. Actual charges up to $5,000 per month
Miscellaneous Therapy Charges. Covers charges for physical exams, lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Item 15 or within 30 days following a covered treatment.	Actual charges up to a lifetime maximum of $10,000
Self-Administered Drugs. We will pay the actual expenses incurred for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Actual charges up to $4,000 per month
Colony Stimulating Factors. We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Actual charges up to $500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Actual charges up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the expense incurred if an Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging expenses incurred. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation Benefits of the policy.	Expenses incurred limited to a lifetime maximum up to $750 for evaluation. Expenses incurred limited to a lifetime maximum up to $350 for transportation and lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Actual Charges
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	$1,500 lifetime maximum per amputation.
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	Up to $35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay a Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	$300 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	Up to $50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	Up to $100 per day
New or Experimental Treatment. We will pay the expenses incurred by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the expenses incurred for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	Up to $50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day

Benefit	Benefit Amounts
Hairpiece. We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual charge up to a lifetime maximum of $150
Rental or Purchase of Durable Goods. We will pay the actual expenses incurred for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Actual charges up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 per day

Other Specified Diseases Covered:

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

Payment of Benefits

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

Pre-Existing Condition Limitation

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

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

Exceptions and Other Limitations

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

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

Termination of Coverage

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

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

Portability

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

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

Covered Persons

Covered Person means any of the following:

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

Child (Children)

means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

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

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

Benefits

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

Hospital Intensive Care Confinement Benefit

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

Double Benefits

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

Emergency Hospitalization and Subsequent Transfer to an ICU

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

Step Down Unit

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

Exceptions and Other Limitations

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

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

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

Pitt County Government

Semi-Monthly Rates

Coverage Tier	Option 1	Option 2	Option 3	Option 4
Individual	$8.83	$11.69	$9.82	$15.45
Individual + Spouse	$17.79	$23.80	$19.72	$31.44
Individual + Child(ren)	$12.60	$16.60	$13.82	$21.68
Family	$21.55	$28.72	$23.73	$37.67

Variable Benefit Elections

Benefit	Option 1	Option 2	Option 3	Option 4
Hospital Confinement	$100	$100	$100	$100
Surgical	$3,000	$3,000	$3,000	$3,000
Radiation/Chemotherapy	$2,500 per month	$2,500 per month	$5,000 per month	$5,000 per month
First Diagnosis	$0	$2,500	$0	$5,000
Colony Stimulating Factors	$500 per month	$500 per month	$500 per month	$500 per month
Wellness	$100	$100	$100	$100
Intensive Care Rider	$0	$325	$0	$625

Underwritten by:
Humana Insurance Company

Administered by:

BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"™

P.O. Box 16190 - Austin, Texas 78716 - (800) 845-7519

Aflac Group Accident Insurance

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.
- Coverage is effective on the first of the month following the enrollment form approval date, provided payroll deductions begin during that month.
- 24-Hour Coverage.

Eligibility

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

Guaranteed-Issue

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

Portability

When coverage would otherwise terminate because an employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.
The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.
The employee may continue the coverage until the earlier of:

- the date he fails to pay the required premium; or
- the date the class of coverage is terminated.

Coverage may not be continued:

- if the employee fails to pay any required premium; or
- if the Company receives notice of Class I plan termination.

Accident Benefits – High Option

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

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

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

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

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

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

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

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

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

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

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

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

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

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

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

- The insured is injured,

- The injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.
If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Accident Follow-Up Treatment	$25

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

Physical Therapy	$25

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

Air Ambulance	$500
Ambulance	$100

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

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

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

Blood/Plasma	$100

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

Prosthesis $500

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

Appliance $100

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

Family Lodging Benefit (per night) $100

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

Wellness $60

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

- Annual physical exams
- 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 or Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

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

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

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

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

traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

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

LIMITATIONS AND EXCLUSIONS

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

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

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

TERMINATION OF AN EMPLOYEE'S INSURANCE

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

1. the date the Plan is terminated, for Class I insureds;
2. the 31st day after the premium due date if the required premium has not been paid;
3. the date he ceases to meet the definition of an employee as defined in the Plan,

for Class I insureds; or
4. the date he is no longer a member of the Class eligible for coverage.

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

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

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

DEFINITIONS

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

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

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

Dependent children are your or your Spouse's natural children, step-children, legally adopted children, foster children or children placed for adoption who are younger than age 26.

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

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

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

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

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

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

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

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

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

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

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

and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

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

Notices

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

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

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

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

AGCM378NC-25-BK IV (2/17)

GROUP ACCIDENT+ INSURANCE
Policy Series CA7800

ACG

Pitt County Government

HIGH OPTION - 24 HOUR PLAN	Semimonthly (24pp/yr)
Employee	$8.10
Employee and Spouse	$11.58
Employee and Dependent Children	$15.45
Family	$18.93

Wellness Benefit included in Rates

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

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Aflac Group Hospital Indemnity Insurance

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

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

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

Spouse and Dependent Children Coverage Available
The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate. If the employee is eligible then the employee's spouse and dependent children are eligible to participate.

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

Portability
When coverage would otherwise terminate because an employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- the date he fails to pay the required premium; or
- the date the class of coverage is terminated.

Coverage may not be continued:

- if the employee fails to pay any required premium; or
- if the Company receives notice of Class I plan termination.

Benefits

Hospital Confinement (per day)	
Plan I	$100
Plan II	$150

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

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

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

Hospital Admission (per confinement)	
Plan I	$500
Plan II	$1,500

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

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

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

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

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

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

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

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

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

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

Wellness (per calendar year)	
Plan I & II	$50

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

Limitations and Exclusions

Pre-Existing Condition Limitation
A ***pre-existing condition*** means, within the 12-month period prior to the insured's effective date, conditions for which medical advice or treatment was received or recommended.
We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured's effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition—whichever is less.

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

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

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

Exclusions
We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above).

We will not pay benefits for loss contributed to by, caused by, or resulting from:
1. War – Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.

2. Suicide – Committing or attempting to commit suicide, while sane or insane.

3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.

4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.

5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.

6. Aviation – Operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft, including those, which are not motor–driven.

7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.

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

9. Sports – Participating in any organized sport: professional or semi–professional.

10. Routine physical exams and rest cures.

11. Custodial care. This is care meant simply to help people who cannot take care of themselves.

12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.

13. Services performed by a relative.

14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.

15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.

16. Elective abortion.

17. Treatment, services, or supplies received outside the United States and its possessions or Canada.

18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.

19. Dental services or treatment.

20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

21. Mental or emotional disorders without demonstrable organic disease.

22. Alcoholism, drug addiction, or chemical dependency.

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

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

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

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

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

Definitions

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

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

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

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

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

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

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

A **hospital** is not:

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

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

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

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

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

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

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

i. Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
ii. Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
iv. Will not impose pre-ex limitations or waiting periods.
If Dependent Children are covered under the plan, Dependent Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

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

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

Notices

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

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

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

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

GROUP HOSPITAL INDEMNITY

HI G

	Pitt County Government Semi-Monthly Rates	
Plan I	Employee	$ 7.85
	Employee & Spouse	$ 15.52
	Employee & Dependent Children	$ 10.76
	Family	$ 18.43

Benefit Summary	
Hospital Confinement (Per Day)	$ 100
Hospital Admission (Per Confinement)	$ 500
Surgical Benefit (up to amount)	$ 750
Wellness	$ 50

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

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GROUP HOSPITAL INDEMNITY

HI G

	Pitt County Government Semi-Monthly Rates	
Plan II	Employee	$ 15.48
	Employee & Spouse	$ 30.59
	Employee & Dependent Children	$ 21.46
	Family	$ 36.57

Benefit Summary	
Hospital Confinement (Per Day)	$ 150
Hospital Admission (Per Confinement)	$ 1,500
Surgical Benefit (up to amount)	$ 1,500
Wellness	$ 50

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

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

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Exclusions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the Pre-Existing Condition Limitation provision above).

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

1. War – Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.
2. Suicide – Committing or attempting to commit suicide, while sane or insane.
3. Self–Inflicted Injuries – Injuring or attempting to injure yourself intentionally.
4. Traveling – Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing – Riding in or driving any motor–driven vehicle in a race, stunt show or speed test.
6. Aviation – Operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft, including those, which are not motor–driven.
7. Intoxication – Being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts – Participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports – Participating in any organized sport: professional or semi–professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

Terminations

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

Terminations (continued)

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

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

Definitions

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

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

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

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

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

Calendar Year – The period beginning on the policy effective date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Doctor or Physician – A person, other than the insured, or a member of the insured's immediate family, who:
- Is licensed by the state to practice a healing art;
- Performs services which are allowed by his or her license; and
- Performs services for which benefits are provided by the Plan.

Definitions (Continued)

Immediate Family/Family Member – means an insured's spouse, son, daughter, mother, father, sister, or brother.

Hospital – A place that:

- Is legally licensed and operated as a hospital;
- Provides overnight care of injured and sick people;
- Is supervised by a doctor;
- Has full-time nurses supervised by a registered nurse;
- Has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities(this requirement is not applicable to state tax-supported institutions); and
- Maintains permanent medical history records.

A hospital is not:

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

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

Dependent Children – means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

1. Coverage on Dependent Children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, and not more frequently than annually from then forward.
2. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.
3. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.
4. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer.
    - Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
    - Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

Definitions (Continued)

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

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

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

Your Occupation – The job in which the insured is regularly engaged at the time the employee becomes insured.

Actively at Work – to be considered actively at work, the insured must perform for a full normal workday the regular duties of employment. These duties may be performed at the your employer's regular place of business or at a location to which the insured may be required to travel to perform the regular duties of your employment. Treatment – Consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

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) is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

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

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

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

Aflac Group Critical Illness Plan

Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $30,000 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.
- There are no pre-existing condition limitations.
- The plan doesn't have a waiting period for benefits.
- Benefits do not reduce as insureds get older.
- Coverage is portable, with certain stipulations.
- Annual health screening benefit is included.

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-issue coverage is offered during the first three annual open enrollments and for new hires thereafter:

Up to **$30,000** for employees and up to **$15,000** for spouses with no participation requirement.

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

Individual Eligibility

Issue Ages:

- Employee 18+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **20 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers <u>are not</u> 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

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of $5,000. To apply for spouse coverage, ***the employee must also apply***. To be eligible, the spouse must not be disabled or unable to work at the time of application.

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 be limited to face amounts between $5,000 and $30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. ***Children-only coverage is not available.***

Waiver of Premium Benefit

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

Successor Insured Benefit

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

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 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

Termination of an Employee's Insurance

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

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

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

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

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Heart Attack	100%
Major Organ Transplant	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Transient Ischemic Attack (TIA)	$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Additional Diagnosis

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	$100 per calendar year

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

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, the following:

- Stress test on a bicycle or treadmill
- 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
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- DNA stool analysis
- Spiral CT screening for lung cancer
- Fasting blood glucose test, blood test for triglycerides, or serum cholesterol test to determine level of HDL and LDL

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1 - Specified Surgeries of the Heart	
Coronary Artery Bypass Surgery	75%*
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal Aortic Aneurysm	100%
Category 2 Invasive Procedures and Techniques of the Heart	
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%

**The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.*

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

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

Exclusions

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

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.

- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
    - War (declared or undeclared) or military conflicts. This does not include terrorism.
    - Insurrection or riot.
    - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following**:
    - Abuse of legally-obtained prescription medication.
    - Illegal use of non-prescription drugs.

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, may be payable only while coverage is in force.

Terms You Need to Know

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a bone marrow transplant (stem cell transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.
Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant)**: The date the surgery occurs.
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a doctor recommends that an insured begin renal dialysis.
- **Major Organ Transplant:** The date the surgery occurs.
- **Stroke:** The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).

- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the **Sudden Cardiac Arrest** definition).
- **Transient Ischemic Attack (TIA)**: The date the transient ischemic attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).
- **Coma:** The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Loss of Sight, Speech, or Hearing:** The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- **Paralysis:** The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- **Severe Burn:** The date the burn takes place.

Dependent means the primary insured's spouse or dependent child. **Spouse** is the primary insured's legal wife or husband who is listed on his application. **Dependent Children** are the primary insured's or his spouse's natural children, foster children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must provide us with proof of this incapacity and dependency within 31 days following the dependent child's 26th birthday, but not more frequently than annually.

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

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

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

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

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this plan for the particular critical illness being diagnosed. Diagnosis must be made and treatment must be received in the United States or its territories.

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A doctor does not include the primary insured or any of his family members. For the purposes of this definition, family member includes the primary insured's spouse as well as the following members of his immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother
- Step-Family Members and Family-Members-in-law

Employee is a person who meets eligibility requirements under Section I – Eligibility, Effective Date, and Termination, and who is covered under this plan. The employee is the primary insured under this plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary artery disease or acute coronary syndrome. Heart attack (myocardial infarction) does not include the following:

- Any other disease or injury involving the cardiovascular system
- Cardiac arrest not caused by a heart attack (myocardial infarction)

Diagnosis of a heart attack (myocardial infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function. Kidney failure (end-stage renal failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital heart disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary artery disease.
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

A major organ transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include the following:

- Transient ischemic attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden cardiac arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
    - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
    - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant hypertension
- Brain aneurysm
- Arteriovenous malformation

The TIA must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- Encephalitis, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- Epilepsy, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- Hyperglycemia, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- Hypoglycemia, which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- Meningitis, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease, which is a disease that affects the retina of the eye;
- Optic nerve disease, which is a disease that affects the optic nerve of the eye; or
- Hypoxia, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease, which is a progressive mental deterioration due to generalized degeneration of the brain; or
- Arteriovenous malformation, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be

considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;
- Autoimmune inner ear disease, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- Chicken pox, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;
- Goldenhar syndrome, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- Meniere's disease, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- Meningitis, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or
- Mumps, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- Cerebral palsy, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- Parkinson's disease, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or
- Poliomyelitis, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The diagnosis of paralysis must be supported by neurological evidence.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

- Be a full-thickness or third-degree burn, as determined by a doctor. A full-thickness burn or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Heart Event Rider

Covered Heart Procedure is one of the Category I or Category II procedures defined below:

Category I – Specified Surgeries of the Heart

Specified surgeries of the heart (open heart surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart

surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **Coronary Artery Bypass Surgery (also Coronary Artery Bypass Graft Surgery or Bypass Surgery)** is a surgical procedure performed to relieve angina and 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. A blood vessel 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 this rider.
- **Mitral Valve Replacement or Repair** is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement or Repair** is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **AngioJet Clot Busting** clears 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)** opens 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** uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil 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.
- **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person'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.
- **Valvular Heart Disease** is a disease characterized by damage to or a defect in one of the four heart valves.

Optional Benefits Rider

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan, ADLs include the following:

- Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;

- Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and
- Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Date of Diagnosis is defined as follows:
- **Advanced Alzheimer's Disease**: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease**: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.
- **Benign Brain Tumor**: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Advanced Alzheimer's Disease means Alzheimer's disease that causes the Insured to be incapacitated. Alzheimer's disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease. To be incapacitated due to Alzheimer's disease, the Insured must:
- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's disease that causes the Insured to be incapacitated. Parkinson's disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease. To be incapacitated due to Parkinson's disease, the insured must:
Exhibit at least two of the following clinical manifestations:
- Muscle rigidity
- Tremor
- Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a cancer. Benign brain tumor must be caused by multiple endocrine neoplasia, neurofibromatosis, or Von Hippel-Lindau syndrome.

> **Multiple Endocrine Neoplasia** is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
>
> **Neurofibromatosis** is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.
>
> **Von Hippel-Lindau Syndrome** is a genetic disease that predisposes a person to have benign or malignant tumors.

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.

AGCM321-NC-BK IV (1/17)

Group Critical Illness Advantage

Pitt County Government
Semi-Monthly Rates

NONTOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 2.12	$ 2.71	$ 3.30	$ 3.88	$ 4.47	$ 5.06	$ 5.65	$ 6.24	$ 6.83	$ 7.41
30-39	$ 2.44	$ 3.35	$ 4.27	$ 5.18	$ 6.09	$ 7.00	$ 7.92	$ 8.83	$ 9.74	$ 10.65
40-49	$ 3.63	$ 5.72	$ 7.82	$ 9.92	$ 12.01	$ 14.11	$ 16.21	$ 18.31	$ 20.40	$ 22.50
50-59	$ 4.97	$ 8.42	$ 11.86	$ 15.31	$ 18.75	$ 22.19	$ 25.64	$ 29.08	$ 32.53	$ 35.97
60+	$ 7.16	$ 12.80	$ 18.43	$ 24.07	$ 29.70	$ 35.34	$ 40.97	$ 46.61	$ 52.24	$ 57.88

NONTOBACCO - Spouse

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 2.12	$ 2.71	$ 3.30	$ 3.88	$ 4.47	$ 5.06
30-39	$ 2.44	$ 3.35	$ 4.27	$ 5.18	$ 6.09	$ 7.00
40-49	$ 3.63	$ 5.72	$ 7.82	$ 9.92	$ 12.01	$ 14.11
50-59	$ 4.97	$ 8.42	$ 11.86	$ 15.31	$ 18.75	$ 22.19
60+	$ 7.16	$ 12.80	$ 18.43	$ 24.07	$ 29.70	$ 35.34

TOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 2.64	$ 3.75	$ 4.86	$ 5.97	$ 7.08	$ 8.19	$ 9.30	$ 10.42	$ 11.53	$ 12.64
30-39	$ 3.69	$ 5.85	$ 8.01	$ 10.17	$ 12.33	$ 14.49	$ 16.65	$ 18.81	$ 20.97	$ 23.13
40-49	$ 6.09	$ 10.66	$ 15.22	$ 19.79	$ 24.35	$ 28.92	$ 33.48	$ 38.05	$ 42.61	$ 47.18
50-59	$ 8.70	$ 15.87	$ 23.03	$ 30.20	$ 37.37	$ 44.54	$ 51.70	$ 58.87	$ 66.04	$ 73.21
60+	$ 13.70	$ 25.87	$ 38.03	$ 50.20	$ 62.37	$ 74.54	$ 86.71	$ 98.88	$ 111.04	$ 123.21

TOBACCO - Spouse

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 2.64	$ 3.75	$ 4.86	$ 5.97	$ 7.08	$ 8.19
30-39	$ 3.69	$ 5.85	$ 8.01	$ 10.17	$ 12.33	$ 14.49
40-49	$ 6.09	$ 10.66	$ 15.22	$ 19.79	$ 24.35	$ 28.92
50-59	$ 8.70	$ 15.87	$ 23.03	$ 30.20	$ 37.37	$ 44.54
60+	$ 13.70	$ 25.87	$ 38.03	$ 50.20	$ 62.37	$ 74.54

Base Plan:
-Without Cancer Benefit
-$100 Health Screening Benefit
-Without Skin Cancer Benefit
-With Additional Benefits
(Loss of Sight, Speech, Hearing)
(Coma, Burns, Paralysis)

Riders:
-Optional Benefits Rider (BTAP)
-Heart Rider
-$250 TIA (mini-stroke) Rider

Provisions:
-No Pre-Existing Condition Limitation
-Add'l Separation Waiting Period: 6 Months
-Re-Separation Waiting Period: 6 Months
-Class I/II Portability
-Rate Guarantee: 3 Years

Group Attributes:
-Situs State: NC
-Eligible Lives: 1200

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

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Need help with healthcare?

We've got your lifeline.

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

We've enhanced your plan without adding cost.

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

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

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

SERVICES AVAILABLE AS SOON AS YOUR COVERAGE STARTS

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

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

DID YOU KNOW?

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

HealthAdvocate™ MeMD™ Aflac®

Get more without spending more.

More than just peace of mind.

Health Advocacy from Health Advocate

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

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

More than just cash benefits.

Medical Bill Saver™ from Health Advocate

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

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

More than just care.

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

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

Questions? Call 855-423-8585

Aflac

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

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

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

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

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

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AGC1500186 R5

IV (3/17)

AUL Short-Term Disability Plan

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

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

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

Advantages of shopping at work include:

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

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

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2011.asp)

90% of disability are caused by illness.

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

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

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

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

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

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

Class Description
All Full-Time Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

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

Monthly Benefit
You can choose to ***insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum benefit is $500.***

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

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

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

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

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

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

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

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

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

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

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

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

www.markiiibrokerage.com/pittcountync

Customer Service
800-553-5318

Disability Claims
Phone: 855-517-6365
Fax: 844-827-9499

Disability Claims Email: OneAmerica.claims@customdisability.com

www.employeebenefits.aul.com

AUL Short-Term Disability
Semi-Monthly Rates

Benefit Duration*:*

13 Weeks

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

AUL Long-Term Disability Plan

LTD Class Description
All Full-Time Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Long Term Disability Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voluntary Long Term Disability	
Monthly Benefit	**Semi-Monthly Rate**
$500	**$3.20**
$1,000	**$6.40**
$1,500	**$9.60**
$2,000	**$12.80**

Customer Service
800-553-5318

Disability Claims
Phone: 855-517-6365
Fax: 844-827-9499

Disability Claims Email: OneAmerica.claims@customdisability.com

www.employeebenefits.aul.com

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

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

www.markiiibrokerage.com/pittcountync

Aetna Basic and Supplemental Life

Schedule of Benefits
(GR-29N 01-01 01 NC)

Employer:	Pitt County Government
Group Policy Number:	GP-885267
Issue Date:	January 12, 2011
Effective Date:	January 1, 2011
Schedule:	1A
Cert Base:	1

For: Life Insurance, Dependent Life Insurance and Accidental Death and Personal Loss - Full-time and Part-time Employees

Schedule of Life Insurance Benefits
(GR-9N S-02-01 01)

Employees
(GR-9N S-02-01 01)
Basic Schedule

Classification (GR-9N S-02-01 01)	Amount
All Employees	100% of your basic annual earnings, as determined by your employer, rounded to the next higher $1,000, if not an integral multiple of $1,000. Maximum: $150,000 Minimum: $ 10,000

(GR-9N S-02-01 01)
Employees

Supplemental Schedule

Classification	Amount
All Employees Electing	$10,000 or increments of $10,000, not to exceed 500% of Employee Basic Annual Earnings, to a maximum of $400,000

Note: Your overall combined maximum for Basic and Supplemental Life Insurance is $550,000.

You may elect coverage under any one of the available options shown above for Supplemental Life Insurance. Once you have made a selection, if you wish to make a change, your employer can provide you with information on how and when changes can be made.

Evidence Requirements for Supplemental Life Insurance

To become insured for Supplemental Life Insurance coverage, certain requirements will need to be met. You can become insured for Supplemental Life Insurance in excess of the lesser of 1 times your basic annual earnings or $150,000 as long as you submit evidence of good health, and Aetna approves. If Aetna does not approve your evidence of good health, the amount of Supplemental Life Insurance will be limited to the Guaranteed Standard Issue amount.

In addition, the following apply while you are insured:

- If you first become eligible for an amount of Supplemental Life Insurance in excess of the lesser of 1 times your basic annual earnings or $150,000, you can become insured for this higher amount only if you submit evidence of good health, and Aetna approves. This does not apply if the sole reason you become eligible for the higher amount is because of an earnings increase.
- You first become eligible for an amount of Supplemental Life Insurance in excess of the lesser of 1 times your basic annual earnings or $150,000, except due to an earnings increase, or you elect to increase your Supplemental Life Insurance by more than one level or multiple of your basic annual earnings then you can only become insured for the higher amount if you submit evidence of good health, and Aetna approves. This applies even if Aetna has approved evidence of your good health in the past.
- You elect to increase your Supplemental Life Insurance by any amount after you have applied for an Accelerated Death Benefit, you can become insured for this higher amount only if you submit evidence of good health, and Aetna approves.

If you do not or did not elect Supplemental Life Insurance within 31 days of the date you were first eligible to elect Supplemental Life Insurance, whether under this Plan or any other group plan sponsored by the Policyholder, coverage under this Plan will not take effect until you submit evidence of good health to Aetna. If evidence of good health is not acceptable to Aetna, you will not be eligible for coverage under this Plan.

Dependents Schedule (GR-9N S-02-02 01)

Classification	Amount
Wife or husband	$5,000
Unmarried child, age 14 days to age 19 or age 25 if student	$5,000

Accelerated Death Benefit

Employees

ADB months	24 months
ADB percentage	up to 75%
ADB minimum	$5,000
ADB maximum	up to $500,000

Accidental Death and Personal Loss Coverage
(GR-29N 03-01 01)

Schedule of Accidental Death and Personal Loss Benefits

Employees
Basic Schedule

Classification	Principal Sum
All Employees	100% of your basic annual earnings, as determined by your em ployer, rounded to the next higher $1,000, if not an integral multiple of $1,000. Maximum: $150,000 Minimum: $ 10,000

Employees
Supplemental Schedule

Classification	Principal Sum
All Employees Electing	$10,000 or increments of $10,000, not to exceed 500% of Employee Basic Annual Earnings, to a maximum of $400,000

You may elect any one of the available options shown above for Supplemental Accidental Death and Personal Loss Coverage. Once you have made a selection, if you wish to make a change in your coverage, your employer will provide you with information on how and when changes can be made.

Additional Accidental Death and Personal Loss Benefit Maximums
(GR-9N S-03-02 01)

Employees

Passenger Restraint Benefit Maximum for you	$10,000*
Airbag Benefit Maximum	One half of a person's Passenger Restraint Benefit
Education Benefit Maximum for each dependent child	Your actual expenses not to exceed 5% of your or your spouse's principal sum or $5,000 per year for up to 4 years, whichever is less for your spouse Your actual expenses not to exceed 5% of your principal sum or $5,000 per year for up to 4 years, whichever is less
Child Care Benefit Maximum for each child	Your actual expenses not to exceed 3% of your principal sum or $2,000 per year per child for up to 4 years, whichever is less

Repatriation of Remains Benefit Maximum Your actual expenses up to $5,000*

*This benefit maximum is payable only once, even if the person is covered for both Basic and Supplemental Accidental Death and Personal Loss Coverage at the time of the loss.

General (GR-9N S-28-01 01)

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company Basic Term Life

Semi-Monthly Rates per $1,000	
Employee Supplemental Term Life & Supplemental AD&D	$0.114
Semi-Monthly Rates per $5,000	
Dependent Term Life	$0.99

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]

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

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

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

Accelerated Death Benefit due to Terminal Illness For no additional premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92.6% (92% in CA, CT, DC, DE, FL, ND & SD) of the death benefit, minus a $150 ($100 in Florida) administrative fee in lieu of the insurance proceeds otherwise payable at death. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. (Conditions apply)
(Policy Form ICC-ULABR-11 or Form Series ULABR-11)

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

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

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

Texas Life Whole Life Insurance – SOLUTIONS 121

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 Benefit due to Chronic Illness rider.

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

SOLUTIONS Review

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

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

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

[3] LIMRA; Life Insurance Ownership Focus – 2016

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

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

TEXASLIFE INSURANCE COMPANY

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

16M419-C 1119 (exp1118)

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

LegalShield® Worry Less. Live More. | IDShield

Prepared for:
Pitt County

HAVE YOU EVER?

- ☐ Needed your Will prepared or updated
- ☐ Been overcharged for a repair or paid an unfair bill
- ☐ Had trouble with a warranty or defective product
- ☐ Signed a contract
- ☐ Received a moving traffic violation
- ☐ Had concerns regarding child support
- ☐ Worried about being a victim of Identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information on-line
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

WHAT IS LEGALSHIELD?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

THE LEGALSHIELD® MEMBERSHIP INCLUDES:

- ✓ Personal Legal advice on unlimited issues
- ✓ Letters/ calls made on your behalf
- ✓ Contracts & documents reviewed (up to 15 pages)
- ✓ Residential Loan Document Assistance
- ✓ Lawyers prepare your Will, your Living Will and your Health Care Power of Attorney
- ✓ Moving Traffic Violations (available 15 days after enrollment)
- ✓ IRS Audit Assistance
- ✓ Trial Defense (if named defendant/ respondent in a covered civil action suit)
- ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- ✓ 25% Preferred Member Discount (Bankruptcy, Criminal Charges, DUI, Other Matters, etc.)
- ✓ 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

THE IDSHIELD℠ MEMBERSHIP INCLUDES:

Privacy Monitoring
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

Security Monitoring
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

Full Service Restoration
Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18

Payroll Deduction Semi-Monthly	Family
LegalShield	$9.48
IDShield	$9.48
Combined	$16.95

For more information, please call your independent associate:
Ann Palmer
704-904-1774
apalmer@legalshieldassociate.com

Dear Employees:

This booklet has been created to provide you with general information on the employee benefits provided by Pitt County Government and the voluntary benefits that you may purchase via payroll deduction. You are a valued member of Pitt County Government, and it is important that you understand the benefits offered to you. Your benefits add value to your overall compensation program by offering you medical, dental, life, accident, disability and other benefits that work together to provide overall wellness and financial security for you and your family.

This booklet is not intended to be comprehensive or to address all the possible applications of, or exceptions to, the benefits described. For that reason, if you have any questions concerning eligibility for a particular benefit, or the applicability of a policy or practice to you, you may obtain additional information from the Human Resources Department. The benefits described are offered to all probationary and permanent employees working at least 20 hours per week in a permanently established position.

The County reserves the right to modify or discontinue these benefit programs at any time. This booklet is not intended as a promise of future benefits. You will be notified of any benefit changes. This booklet does not create a contract or a guarantee of employment between Pitt County Government and any individual.

If you have any questions regarding your benefits, please contact the Pitt County Human Resources Department at 252-902-3050.

Additional Benefits for Pitt County Employees

HEALTH INSURANCE

The health insurance plan is administered by Blue Cross and Blue Shield of North Carolina. All part-time or full-time County employees who are eligible for benefits may participate in the County's group health insurance plan. The Board of Commissioners determines the level of coverage and any fees charged to employees for coverage. Employees may pay the cost of dependent coverage by purchasing a Parent/Child, Employee/Spouse, or Family plan. Family coverage is available for the employee's spouse and child or children. Parent/Child coverage is available if the employee has only one child. If an employee has more than one child under 19 years of age and chooses to cover one child, then all children under 19 must be covered on the group health insurance plan, unless a Court Order states otherwise. However, if there are one or more dependent children over 19, in addition to one or more under 19, then the employee is not required to cover the dependents over 19, but can if he/she chooses to do so. Children may be covered until they reach age 26, and do not have to be in school, nor do they have to be a dependent under IRS standards. Because the cost to cover two employees is equivalent to the cost of Family coverage, married couples where both spouses are employed and actively working for Pitt County Government in positions eligible for benefits prior to July 1, 2013, do not have to pay for dependent coverage, but are required to pay any Board mandated participation fees. Administration of the health insurance plan including types of coverage offered and any fees or premiums charged for the coverage shall be determined by the Board of Commissioners during the annual budget process each fiscal year or at any other time as they deem necessary.

DENTAL/VISION REIMBURSEMENT

Dental/Vision Reimbursement is not an insurance plan but a reimbursement program provided at no cost to the employee and to family members covered under the BCBS health insurance plan. Dependents who are late enrollees to the health insurance plan (not enrolled in Parent/Child, Employee/Spouse, or Family coverage when the employee was first eligible for coverage) will have a six-month waiting period for all dental/vision reimbursement and a two-year waiting period for all orthodontic reimbursement. The waiting period is waived for dependents added within 30 days of a marriage or birth.

The plan operates on a fiscal year basis (July 1 - June 30). To have a dental or vision expense considered for reimbursement, the service must have been performed and the bill must have been paid in full within 12 months of the date of service. Copayments for dental or vision services are not eligible for reimbursement. A reimbursement claim form and an original itemized receipt must be submitted to Human Resources for approval and payment. Claims will be paid biweekly. All claims received by the 2nd Friday of each pay period will be paid the following Friday.

RETIREMENT

All employees appointed to a permanently established position and required to work at least 1,000 hours a year are required to participate in the Local Governmental Employees' Retirement System. As a member, you will contribute 6% of your annual salary (before taxes) into the plan. The County contributes an actuarially determined amount to your Retirement account. Once vested (five years of creditable service), you will be eligible for a monthly benefit based upon your age and years of service in the plan. Upon vesting, you will also be eligible for a monthly benefit if you become permanently disabled and are approved by the NC Retirement System.

If you leave the Retirement System for any reason other than retirement or death, you may: (1) receive a refund of your contributions (plus interest, if you have at least five years of service as a contributing member), (2) leave your contributions in the System and keep all the earned creditable service, or (3) if you accept employment with the State, transfer your contributions and creditable service to the Teachers' and State Employees' Retirement System, as long as you are an eligible member of the System to which you are transferring and did not receive a refund of your contributions.

Federal and North Carolina income tax laws require the withholding of Federal, and in most cases, North Carolina income tax from the taxable portion of the refund of accumulated contributions, unless the refund is directly rolled over to a traditional IRA or another employer plan that accepts your direct rollover. If you receive payment of your accumulated contributions before age 59½, you may have to pay an additional 10% early withdrawal penalty. Your refund will not be paid by the Retirement System earlier than 60 days from the date of your termination of employment.

In the event of your death, your designated beneficiaries will receive your contributions in the Retirement System. The County has elected to pay a Retirement System death benefit to your beneficiary, if you die while in active service with Pitt County, after one year as a contributing member of the Local Governmental Employees' Retirement System. Your beneficiary will receive a lump sum payment which equals the highest 12 months' salary in a row during the 24 months preceding the month before death. The death benefit payment will be no less than $25,000 and no more than $50,000. Beneficiary designation may be changed at any time by completing the necessary forms from the Human Resources Department.

GROUP TERM LIFE INSURANCE

Permanent employees who are eligible for benefits are provided basic life insurance at no cost to the employee equal to his/her base annual salary rounded to the next higher $1,000 up to a maximum of $150,000. The basic insurance includes Accidental Death & Dismemberment coverage. This coverage is guaranteed at employment with no evidence of insurability required.

Employees may purchase supplemental life insurance in increments of $10,000 up to 5 times his/her base salary up to a maximum of $400,000. However, if this coverage is not purchased at the time of employment, evidence of insurability is required and the insurance carrier has the option to deny coverage. The supplemental insurance also includes Accidental Death & Dismemberment coverage.

Once a year, the basic life insurance is adjusted for any changes in the employee's base salary. There will be one Annual Benefit Election Period, and employees will be allowed to increase the supplemental life insurance coverage by $10,000 as long as their total supplemental coverage amount does not exceed $150,000, with no evidence of insurability, provided the employee is already purchasing supplemental coverage.

Life insurance in the amount of $5,000 may be purchased on a spouse and dependents.

NC 401(k) PLAN

The Supplemental Retirement Income Plan of North Carolina was created by the North Carolina General Assembly to offer employees additional ways to save for retirement. The plan is allowed and governed under Section 401(k) of the Internal Revenue Code. Employees who are eligible for benefits may make traditional before-tax 401(k) contributions and/or Roth 401(k) after-tax contributions.

The traditional contribution helps you plan for retirement in three ways: 1) The amount of money you contribute to the Plan in a year is excluded from your taxable income for that year. 2) Earnings on money you contribute accumulate tax-deferred. 3) The money in the tax-deferred plan is taxed only when it is withdrawn. The Roth 401(k) contributions are made with after-tax dollars. Roth contributions grow tax free and can provide tax-free income at retirement. To be eligible for the tax free status on a distribution, you must wait at least five (5) years after making your first Roth 401(k) contribution, and the distribution must occur when you are 59 ½ years of age or older.

The County contributes to the 401(k) account on behalf of all part-time and full-time employees who are eligible for benefits. All employer contributions are made on a pre-tax basis. The County's rate of contribution is determined at the beginning of each fiscal year. Employees may voluntarily contribute through payroll deduction. These voluntary contributions are subject to annual limits set by the Internal Revenue Service. Employees are allowed to start and stop their contributions at any time, and this does not affect the County's rate of contribution.

Refer to your 401(k) handbook for rules and regulations on withdrawals, payout options, or rollovers to other plans.

PERSONAL LEAVE

Each county employee eligible for benefits shall accrue personal leave based on length of County service as follows:

	Month	Year
Less than 2 years	7.75 hours	93.00 hours
2 but less than 5	9.00 hours	108.00 hours
5 but less than 10	11.00 hours	132.00 hours
10 but less than 15	13.00 hours	156.00 hours
15 but less than 20	15.00 hours	180.00 hours
20 years or more	17.00 hours	204.00 hours

Personal leave accrues semi-monthly on the 1st and the 16th of each month for all employees eligible for benefits. Leave for part-time employees eligible for benefits shall accrue on a pro rata basis determined by the number of hours worked. Personal leave must be approved by the department head or his/her designee at such times as will least interfere with the efficient operation of the department.

Personal leave may be accumulated throughout the calendar year without a maximum number of hours, except the last pay period of the year when it must not exceed 240 hours. Personal leave accrued in excess of 240 hours as of the end of the last pay period of the year will be transferred from personal leave to sick leave just prior to the first full pay period of the new calendar year.

SICK LEAVE

Sick leave shall accrue at a rate of 4 hours semi-monthly on the 1st and the 16th of the month for all employees eligible for benefits. Sick leave for part-time employees eligible for benefits shall accrue on a pro rata basis determined by the number of hours worked. There is no maximum accumulation of sick leave.

DIRECT DEPOSIT

Direct deposit of your bi-weekly paycheck is required and can be made to the bank of your choice. You may change your direct deposit account by completing a change form in Human Resources.

CAFETERIA PLAN (125)

The Cafeteria Plan offers employees the opportunity to purchase various insurance policies including County sponsored health insurance and certain supplemental insurance plans with pre-tax dollars through payroll deduction. The result is less taxes taken out of your paycheck and more take home pay.

The County offers Health Care and Dependent Care Flexible Spending Accounts to allow employees to pay for out-of-pocket medical and/or dependent care expenses on a pre-tax basis. These out-of-pocket expenses may be for you or your eligible dependents and include expenses not reimbursed by an insurance or reimbursement plan.

The Internal Revenue Service prohibits you from changing your election on any pre-taxed benefits during the plan year, unless there is a qualified change in status (for example: marriage, divorce, death of spouse or child, birth or adoption of a child, change in employment status that affects eligibility for benefits for employee, spouse, or dependent). An election change must be requested within 30 days of the qualifying change in status.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a professional, confidential counseling service to help employees and their family members resolve personal issues and problems before they affect health, family relationships, or job performance. Vidant Employee Assistance Program is the program administrator. Persons eligible for EAP services are Pitt County Government employees and dependents of an employee that are eligible for coverage under the County's group health insurance plan. Employees and eligible dependents must reside within the employee's service area or reside with the employee in order to be eligible for EAP services. Persons eligible for EAP services are provided three (3) free visits each fiscal year to the Vidant Employee Assistance Program. Self-referrals may be made by calling the Employee Assistance Program at 847-4357 to make an appointment. Employees may be referred to the program by their supervisor in cases of declining job performance. With a self-referral or supervisor referral, the employee is entitled to three (3) free visits per fiscal year. If additional visits are needed, the employee and/or eligible dependents will be referred to a provider in the County's health insurance plan network.

(457) DEFERRED COMPENSATION

Deferred Compensation is a tax-deferred supplemental retirement program that allows employees to voluntarily contribute a portion of their salary on a pre-tax basis to a retirement account. These contributions are subject to annual limits set by the Internal Revenue Service. The plan is administered by Nationwide Retirement Solutions. Contact Human Resources for enrollment information.

NORTH CAROLINA'S NATIONAL COLLEGE SAVINGS PLAN (529 PLAN)

Pitt County employees may contribute to North Carolina's National College Savings Plan by payroll deduction or lump sum payment. This plan is authorized by the General Assembly of the State of North Carolina and is administered by College Foundation Inc. This 529 plan offers options to help employees save toward a college education for your child, yourself, or someone else. A beneficiary can be any age from newborn to adult. You decide what you can afford to invest and when. You may choose the investment option that meets your objectives and risk tolerance. Account earnings are free from federal and North Carolina income taxes when the money is used to pay for qualified higher education expenses such as tuition, fees, room and board, and books. Contact Human Resources for enrollment information.

CREDIT UNION

Employees of the County may become members of the Credit Union by simply visiting a local State Employees' Credit Union and opening a Share Account with a minimum deposit required. Deductions may be taken from your paycheck and forwarded to your Credit Union account. The Credit Union is a cooperative, member-owned financial institution that is operated by and for the benefit of State and Local Governmental Employees and their families.

WELLNESS PROGRAM

All employees eligible for County benefits may participate in the Employee Wellness Program which is administered through the Health Education Division of the Public Health Department. Participation is strictly voluntary; however, the Governing Board strongly encourages all employees to participate. To facilitate full participation, employees are not required to use personal leave as long as all departments maintain normal office hours and adequate staffing. If the employee is unable to complete job assignments as a result of participation in wellness activities, the use of flextime is encouraged.

All activities are conducted during normal working hours. Wellness Program staff try to coordinate programs to maximize convenience for employees and to minimize disruption of work activities. When possible, programs are limited to one hour or less and are offered at various sites. An exception is the Employee Health Fair. The program staff will also customize programs to suit a department's specific needs.

EMPLOYEE CLINIC

All employees eligible for County Benefits may utilize the Pitt County Employee Clinic called Greenville Express Care, which is located at 613 South Memorial Drive. The Clinic offers routine checkups and annual physicals, treatment of minor health issues, and provides assistance with the management of some chronic health conditions such as diabetes or high blood pressure. You may contact the Clinic for an appointment at 413-0720. Employees must pay a $10 copay at the time of the office visit, and Pitt County Government will pay the balance of the copay. You must present your Blue Cross Blue Shield of NC insurance card (or clinic eligibility card) and your County ID badge. Employees are not required to use accrued leave for time spent receiving health care services at the Employee Health Clinic.

PITT COUNTY TRAINING PROGRAM

The County encourages employees to improve their skills and enhance their professional growth through continuing educational opportunities. The Pitt Program (Performance Improvement Through Training) offers many excellent in-house training opportunities from short 90-minute to all-day formats, and live instructors to self-study, to serve the needs of employees in every department. Managers are encouraged to request special programs to fit the needs of their departments or workgroups. The training department posts news, schedules, and enrollment information at http://pickle/depts/hr/training.

PITT COUNTY GOVERNMENT ALSO OFFERS:

- Paid Holidays
- Family and Medical Leave
- Military Leave
- Civil Leave
- Educational Leave
- Voluntary Shared Leave
- Sick Leave Payback – for employees with hire dates prior to 1/1/11
- Workers' Compensation
- Longevity Pay – for employees with hire dates prior to 1/1/11

FREQUENTLY ASKED QUESTIONS

- Do I need to contact anyone if I have a change of address?
  Always report the change to your department head or the agency's personnel contact. Contact Human Resources for the necessary forms that must be completed to insure that 401(k) statements and information from Blue Cross and Blue Shield and the Retirement System are mailed to you. Upon completion of these forms your address will be changed in the payroll system.

- If I get married, what do I need to do?
  Forms need to be completed if there is a name, address, beneficiary, and/or tax status change. At this time you will be offered the availability of health and life insurance for your spouse.

- I am recently divorced. Do I need to contact Human Resources?
  You may wish to change your beneficiaries or your tax status. If your name changed, you must present a new Social Security card to Human Resources and complete additional forms. There may be a possibility that you are paying for health or life insurance coverage that you no longer need or are eligible to purchase.

- I recently completed my income taxes, and my CPA recommended that I change my tax status. Am I allowed to make the change at any time?
  An employee's tax status may be changed at any time during the year by completing a W-4 and/or NC-4 tax form. These forms may be obtained from the Human Resources Department.

- I have direct deposit but I plan to change banks in the near future. What do I need to do?
  Never close your account the week your check is scheduled to be directly deposited. The payroll process has already taken place and your monies will be sent to your old account. Make changes the week you are not scheduled to be paid. When you complete a new direct deposit form, on the next pay date you will receive a hard copy check. Your pay, thereafter, will be directly deposited into your new account.

- My spouse and I want to seek professional counseling through theEmployee Assistance Program. Will this information be shared with my supervisor or coworkers?
  Information from EAP visits is confidential and cannot be released to anyone without your consent.

- In three months I am expecting a baby and plan to add the child to my health insurance plan. When should I add the child?
  The child should be added within 30 days after the birth date. Adding the child as soon as possible after the birth date reduces the possibility of the insurance company initially denying medical claims. If claims are denied, you will have to contact Blue Cross and Blue Shield and ask for them to be reprocessed.

- My child will graduate from high school in a few months. Does he have to be removed from my insurance coverage at that time?
  No, dependent children may be covered on the plan until they reach age 26.

- If my child gets married prior to age 19, can he continue to be covered under the health insurance plan?
  Yes, children may be covered until age 26.

- My child turned 26 and now has to be dropped from my health insurance plan. Is there any way to continue coverage on my child?
  When your child is dropped from your plan, he/she will be offered the option to purchase an individual policy under COBRA (Consolidated Omnibus Budget Reconciliation Act) for up to 36 months. The premium would be the entire cost of an individual policy plus an administrative fee.

- How do I file a dental claim with both the dental/vision reimbursement and my health care flexible spending account?
  First, file your claim with the Pitt County Dental/Vision Reimbursement Program. (Remember the bill for services must be paid in full.) After you receive reimbursement, submit a copy of the itemized receipt along with a copy of the reimbursement check paid to you by the County, and request only the difference between the reimbursement and the total amount of the receipt. This claim should be sent to the flexible spending account administrator.

- I recently paid $325 for a new pair of glasses. How much will I be reimbursed under the Dental/Vision Reimbursement Plan?
  The plan will reimburse 50% of your expenditures up to $200 per fiscal year for vision expenses.

- I plan to buy a new pair of prescription sunglasses. Will I be reimbursed?
  No. Sunglasses, whether prescription or not, are not covered by the Dental/Vision Reimbursement Plan.

- Since I am purchasing dental insurance, how do I file a claim with the Dental/Vision Reimbursement Plan?
  Insurance must pay first. Before you can file a claim for reimbursement, you must pay any remaining balance after insurance. Complete a reimbursement claim form attaching the explanation of benefits from the insurance company along with an itemized receipt from the dental office showing all procedures performed and payments received.

- If I have my teeth bleached, could I file for reimbursement?
  No. Bleaching is considered a cosmetic procedure. The reimbursement plan does not cover any procedure that is done only for cosmetic purposes.

- I plan to retire within the next six months, when do I complete my application?
  The effective date of your retirement is always the first day of a month. Your application should be completed 60 to 90 days before your planned retirement date; however, your application may not be executed more than 120 days prior to your retirement.

- Can I borrow money from my Local Government Retirement account?
  No. You cannot make loans against your NC Retirement account. The only time you have access to the balance is at retirement or termination of employment.

- If I terminate employment and decide to withdraw my retirement contributions, how long does it take to receive my refund?
  State law does not permit the Retirement System to make a refund earlier than 60 days after your separation from covered employment. Upon receipt of your refund of contributions, you waive any rights to the employer's contributions for any other benefit from the Retirement System.

- I will be resigning soon to accept employment with a state agency. Will my retirement contributions transfer to the state?
  You can transfer your contributions and creditable service between the Local Governmental Employees' Retirement System and the Teachers' and State Employees' Retirement System, as long as you are an eligible member of the System to which you are transferring; do not receive a refund of your contributions from the System from which you are transferring; and complete the necessary form to transfer your contributions and creditable service.

- What happens to my contributions to the Retirement System if I die while in service?
  Your beneficiary(ies) would receive a refund of your contributions (with interest, if applicable).

- In addition to my beneficiary(ies) receiving my contribution to the Retirement System, are they entitled to other benefits from the Retirement System?
  If you die while in active service after one year as a contributing member of the Local Governmental Employees' Retirement System, your beneficiary will receive a single lump sum payment. The payment equals the highest 12 months' salary in a row during the 24 months preceding the month before death. The death benefit payment will be no less than $25,000 and no more than $50,000.

- The County has been contributing to my 401(k) since I began work. If I terminate employment with the County, do I keep those contributions?
  This money was placed in your personal investment account and is your money.
  •
- I would like to make a change in my investment options with the 401(k) program. What do I need to do?
  To make investment changes in future contributions, obtain a change form from the Human Resources Department. However, if you wish to transfer existing balances to different investments, you must contact the 401(k) program and authorize the transfer.

- I would like to start contributing to my 401(k) account. What do I do to start this payroll deduction?
  Contact the Human Resources Department to get the necessary form. Your voluntary contributions are subject to annual limits set by the Internal Revenue Service. Check with Human Resources to obtain the current annual maximums.

- I purchased the $5,000 dependent life insurance when I started work, but I would like to increase that amount. May I purchase additional life on my dependents?
  No. $5,000 is the maximum amount employees may purchase with Pitt County's group term life insurance plan. Employees may wish to explore additional insurance coverage options through voluntary benefit plans. Contact the Human Resources Department to obtain contact information.

- I may qualify for Family and Medical Leave, because I am going to be out of work due to a serious health condition. What should I do?
  Contact your supervisor and complete a "Request for Family and Medical Leave" form at least 30 days in advance of the start of the leave, if it is foreseeable. Leave for unexpected or emergency reasons must be requested on this form as soon as possible.

ASK PITT COUNTY HUMAN RESOURCES
(252)902-3050

Continuing Your Benefits

Ameritas Dental Plans

Under the Ameritas Dental Plans, you and your covered dependents are eligible to continue coverage through COBRA according to the “qualifying events”.

If you and your dependents are enrolled in the dental or vision plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental and 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 graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment.

AUL Short-Term and/or Long-Term Disability

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 31 days from your date of termination to apply for portability. For more information, contact AUL at **1-800-553-5318.**

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 drafted from your bank account. You may do that by contacting Texas Life at **1.800. 283.9233 prompt #2.**

To Continue Other Policies

You may continue your **Aflac Group Accident**, **Aflac Group Critical Illness**, **Aflac Group Hospital Indemnity**, and **Humana Cancer** plans by having the premiums that are currently being deducted from your paycheck drafted from your bank account or billed to your home.

For more information, contact:

Aflac Group at 1-800-433-3036

Humana Cancer Plan at 1-800-845-7519

Contact Information for Questions and Claims

Aflac Group
Customer Service
1-800-433-3036

Ameritas Dental
Customer Service
1-800-487-5553
www.ameritasgroup.com

Community Eye Care
Customer Service
1-888-254-4290
Fax: 704-426-6044
www.communityeyecare.net
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208

Humana Cancer Plan
1-800-845-7519

American United Life (AUL)
Claims Email
OneAmerica.claims@customdisability.com
Customer Service
1-844-287-9499

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
www.aetna.com

Texas Life Insurance Company
PO Box 830
Waco, TX 76703-0830
1-800-283-9233

Legal Shield
704-904-1774
apalmer@legalshieldassociate.com

Pitt County Government
1-252-902-3050

Mark III Brokerage
211 Greenwich Rd
Charlotte, NC 28211
1-800-532-1044 x217