Mark III
Employee Benefits

Plan Year: January 1, 2018 - December 31, 2018
Arranged and Enrolled by Mark III Brokerage, Inc.

Employee Benefits

Table of Contents

Pre-Tax Benefits

After-Tax Benefits

For Your Reference

The Plan Year will run from January 1, 2018 to December 31, 2018

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 (i.e., marriage, divorce, birth of a child, etc.)

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

Plan Arranged By:

Mark III Employee Benefits

Additional information can be found at **www.markiiibrokerage.com/polkcountync**

MedCost Flexible Spending Accounts

Plan Year: January 1, 2018 - December 31, 2018
Medical Flexible Spending Account Maximum: $2,400.00
Medical Spending Account Minimum: $240.00
Dependent Care Account Maximum: $5000.00

What is a flexible spending account?

A flexible spending account (FSA) is a benefit that allows you to set aside money from your paycheck, before it is taxed, to pay for eligible expenses for you and your family. With an FSA, your annual pledged amount is deducted from your paycheck each pay period, in equal installments throughout the year. Every dollar you put into an FSA means more tax-free, spendable income.

There are two types of FSAs:

- **A Medical/Dental/Vision care FSA** provides for reimbursement of eligible out-of-pocket medical, dental, and vision care expenses for you, your spouse, and your dependents that are not paid for by insurance, up to your annual pledged amount.
- **A Dependent Care FSA** provides for reimbursement of work-related child care for dependents under age 13 or dependent disabled adults, up to your annual pledged amount.

How will an FSA help me save money?

You pay less in taxes, which increases your take-home pay. The amount you save in taxes depends on how much you set aside and the amount of your expenses.

Here's an example of the tax savings that are possible for an employee with a gross annual income of $30,000 and with an annual FSA contribution of $2,500. Using a 25% tax bracket, this employee can save $625 by contributing to a health care FSA:

	With FSA	**Without FSA**
Annual Earnings	$30,000	$30,000
FSA Pledged Amount	$2,500	$0
Taxable Income	$27,500	$30,000
Estimated Taxes	$6,875	$7,500
Net Income	$20,625	$22,500
Estimated Out-of-Pocket Health Care Expenses	$2,500	$2,500
Net Income After Out-of-Pocket Health Expenses	$18,125	$20,000
FSA Funds Available for Eligible Expenses	$2,500	$0
Spendable Take Home Pay	$20,625	$20,000

Saving is Simple

- Estimate your FSA-eligible expenses for the year. Then decide how much money you want to set aside, up to $2,400 annually.
- You will enroll in the FSA when you enroll in your benefits.
- After the plan year starts, money will be set aside from each paycheck and put into your FSA. You pay no taxes on that amount.
- As you pay for eligible expenses, you reimburse yourself from your FSA.
- Your FSA also comes with a flex debit card, which makes it easy to pay directly from your FSA for medical related expenses (The card does not work for the Dependent Care FSA).
- You have secure 24-hour access to your account balance and other valuable information through **www. MedCost.com.**

How does the flex debit card work?

Your flex debit card gives you instant access to your FSA funds with a single swipe. You can use your card at tens of thousands of locations, including most major merchants, to pay for qualified medical expenses not covered by your health insurance. Payments are deducted directly from your FSA, reducing the amount of paperwork and turnaround time for reimbursement. Always save your receipts, just in case MedCost needs verification or the IRS audits your tax return. You can always securely access your account balance and other valuable information through **www. MedCost.com.**

You can use the card to pay for

- Prescription* and health plan copayments, deductibles, and coinsurance
- "Amount due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices within the U.S.
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items such as
- First aid dressings and supplies like bandages and rubbing alcohol
- Contact lens solutions/supplies
- Diagnostic products like thermometers, blood pressure monitors, and cholesterol testing
- Insulin and diabetic testing supplies

**Over-the-counter medications now require a prescription to be eligible for FSA reimbursement and cannot be purchased with your flex debit card. You must complete a manual claim form for reimbursement and submit a copy of your prescription with the reimbursement request. Dependent care expenses are not accessible through the flex debit card.*

MEDCOST®
BENEFIT SERVICES

Ameritas Dental Plan

Effective Date: January 1, 2018

Combined Calendar Year Deductible

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

Type 1 - Preventive and Diagnostic

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

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- VSP Eye Exam
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

Type 2 - Basic Procedures

Type 2 benefits are payable at 80% U&C**. $50.00 deductible applies.

- Sealants (Under 17)
- Limited Exams-problem focused
- Anesthesia
- Oral Surgery - Complex and Simple Extractions
- Periodontics (Gum Disease)
- Denture Repair
- Endodontics (Root Canal)
- Restorative Amalgam & Resin (excluding inlays & crowns)

Type 3 - Major Procedures

Type 3 Benefits are payable at 50% U&C**. $50.00 deductible applies.

- Restorative - Inlays and Crowns
- Prosthodontics - Removable Dentures, Partials
- Crown Repair
- Prosthodontics - Fixed Pontics or Abutments

Orthodontia

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

Late Entrant Notice: There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees and/or their dependents who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

***Usual and Customary Charge*

Dental Exclusions (deferment Period)

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

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by:

a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or

b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26.

Predetermination of Benefits

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

Coordination of Benefits

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

Certificate of Insurance

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

Section 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

Limitations / Exclusions (This is not a complete List)

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

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

Semi-Monthly Dental Rates

Employee Only	$17.36
Employee/Spouse	$34.82
Employee/Child(ren)	$36.76
Employee/Family	$54.22

For Claims/Customer Service Questions call Ameritas at: (800) 487-5553

This insurance is underwritten by Ameritas Life Insurance Corporation.

AMERITAS
LIFE INSURANCE CORP.

Community Eye Care Vision Plan

Effective Date: January 1, 2018

Vision Plan — Comprehensive Plan & Eyewear Plan

Polk County is pleased to provide you with the following summary of the voluntary vision benefit. The plan enables you and your family members to significantly reduce what you spend for routine eye care. The plan covers eye exams, glasses and contact lenses. And because Community Eye Care has a huge network of optometrists (OD), ophthalmologists (MD) and retail optical chains, you have easy access to every type of eye care provider.

The Community Eye Care vision benefit is simple and easy to use. It includes the following:

Comprehensive Plan

- An eye examination every 12 months ($15 co-pay)
- An eyewear allowance of $130 (per person) every 12 months ($0 co-pay)
- A contact lens fitting, re-fit or evaluation every 12 months ($35 co-pay)

Eyewear Plan

- An eyewear allowance of $130 (per person) every 12 months ($15 co-pay)
- A contact lens fitting, re-fit or evaluation every 12 months ($25 co-pay)

The eyewear allowance is completely flexible. It can be applied to frames, eyeglass 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, your only out-of-pocket expense for the eyewear is the co-pay. If the eyewear you choose is more expensive than $130, you are eligible for attractive discounts on the overage amount from most network providers: 20% for frames and lenses, and 10% for contact lenses.

Members are also eligible for discounts of up to 15% on LASIK refractive surgery performed by participating providers.

Note that maximum coverage for contact lens examinations is $100 for fittings and $80 for annual evaluations. Members are responsible for any charges exceeding these amounts.

How to Use Your 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 provider and select your eyewear.
4) Pay the provider your co-pays, plus any discounted amount that exceeds the $130 eyewear allowance.

To locate a provider in your area, go to www.communityeyecare.net and search by any of the following categories:

- **County**
- **Doctor's last name**
- **Practice name**
- **Zip code**

There are no claims to file when you see an in-network provider. Network providers file claims on your behalf.

Members who obtain exams and eyewear from a non-network provider still receive their full benefit. The member simply submits a claim form to Community Eye Care and is reimbursed for the full cost of their exam (minus the co-pay) and for the cost of their eyewear, up to the amount of the allowance, (minus any co-pays). Note that a claim form can be printed from the member benefit page of the Community Eye Care website. Alternatively, members can contact Community Eye Care to obtain a form.

Semi-monthly Rates (24 deductions)

	Comprehensive Plan	*Eyewear Plan*
Employee Only	$4.35	$3.15
Employee + One	$8.70	$6.25
Employee + Family	$13.48	$9.48

Customer Service and Claims Administration

1-888-254-4290
Fax: 704-426-6044

www.communityeyecare.net

2359 Perimeter Pointe Parkway
Suite 150
Charlotte, NC 28208

COMMUNITY Eye Care
Vision Benefits Made Simple

Aflac Group Accident Plan

Effective Date: January 1, 2018

Plan Features

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

Eligibility

Issue Ages

Employee at least age 18

Spouse at least age 18

Children under age 26

The employee may purchase Accident Plus coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

Guaranteed-Issue

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

Portability

Coverage may be continued with certain stipulations. See certificate for dealils.

Accident Benefits

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

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

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

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

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

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

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

Complete Dislocations	Closed Reduction Benefits	
	Employee	**Spouse/Child**
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% of the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

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

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

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

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

Lacerations	
Up to 2" long	$50
2" - 6" long	$200
Over 6" long	$400
Lacerations not requiring stitches	$25

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

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

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	$250
Removal of foreign body (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 (within 60 days) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400

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

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

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

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

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

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

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

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

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

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

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

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

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

Accident Follow-Up Treatment	$25

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

Physical Therapy	$25

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

Air Ambulance	$500
Ambulance	$100

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

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

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

Blood/Plasma	$100

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

Prosthesis	$500

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

Appliance	$100

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

Family Lodging Benefit (per night)	$100

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

Wellness	$60

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

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

Hospital Admission	$1,000

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

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

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

Hospital Confinement (per day)	$200

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

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

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

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

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

Hospital Intensive Care (per day)	$400

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

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

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

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

Dismemberment means:

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

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

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

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

Common carrier means:

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

Limitations And Exclusions

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

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

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.

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

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

Continental American Insurance Company
Columbia, South Carolina

Customer Service 800.433.3036

AGCM378NC-10-BK R2 IV (5/17)

Humana Group Cancer and Specified Disease Insurance

Effective Date: January 1, 2018

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:	**Up to $100 per calendar year**

For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum

Positive Diagnosis Test: **Up to $300 per calendar year**

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.

First Diagnosis Benefit	**Option 1: No Benefit**
	Option 2: $2,500
	Option 3: No Benefit
	Option 4: $5,000

First Diagnosis means the first time a covered person is diagnosed as having internal cancer or malignant melanoma (this excludes all other skin cancer); provided the diagnosis is [after the Waiting Period and] while this policy is in force with respect to the covered person. While this policy is in force, if a covered person receives a First Diagnosis of Cancer or malignant melanoma (this excludes all other skin cancer), We will pay the insured the benefit amount, provided the First Diagnosis is after the Waiting Period. No benefit is payable for diagnosis of skin cancer other than malignant melanoma. Each covered person is limited to one First Diagnosis benefit under the terms of this policy.

Benefit	*Benefit Amounts*
Second and Third Surgical Opinions	**Actual Charges**

Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum.

Non-Local Transportation	**Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used**

Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum.

Adult Companion Lodging and Transportation	**Up to $75 per day for lodging, 50 cents per mile if a personal vehicle is used.**

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

Ambulance	**Actual Charges**

For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum.

Surgery	**Up to $3,000**

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

Donor Benefit Bone Marrow and Stem Cell Transplant	**(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**

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.

Benefit	*Benefit Amounts*
Bone Marrow and Stem Cell Transplant	**Actual charges to a combined lifetime maximum of $15,000**

We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant.

Anesthesia **Up to 25% of surgical benefit paid**

For services of an anesthesiologist during a Covered Person's surgery.

For anesthesia in connection with the treatment of the treatment of skin Cancer.

No Lifetime Maximum **$100 maximum per Covered Person**

Ambulatory Surgical Center **$250 Per Day**

We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum.

Drugs and Medicines **Up to $25 per day, $600 per calendar year**

Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum.

Outpatient Anti-Nausea Drugs **Up to $250 per calendar year**

Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum.

Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy.

Option 1- Actual charges up to $2,500 per month
Option 2- Actual charges up to $2,500 per month
Option 3- Actual charges up to $5,000 per month
Option 4- Actual charges up to $5,000 per month

Miscellaneous Therapy Charges **Actual charges up to a lifetime maximum of $10,000**

Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.

Self-Administered Drugs **Actual charges up to $4,000 per month**

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.

Colony Stimulating Factors **Actual charges up to $500 per month**

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.

Benefit	*Benefit Amounts*

Blood, Plasma and Platelets — **Actual charges up to $200 per day**

For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum.

Physician's Attendance — **Up to $35 per day**

For one visit per day while Hospital confined. No Lifetime Maximum.

Private Duty Nursing Service — **Up to $100 per day**

For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation — **Benefit 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.**

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.

Breast Prosthesis — **Actual Charges**

Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum.

Artificial Limb or Prosthesis — **$1,500 lifetime maximum per amputation**

Covers implantation of an artificial limb or prosthesis when an amputation is performed.

Physical or Speech Therapy — **Up to $35 per session**

Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum.

Extended Benefits — **$300 per day**

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.

Extended Care Facility — **Up to $50 per day**

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.

At Home Nursing — **Up to $100 per day**

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.

Benefit	*Benefit Amounts*

New or Experimental Treatment — **Up to $7,500 per calendar year**

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.

Hospice Care — **Up to $50 per day**

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.

Government or Charity Hospital — **$200 per day**

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.

Hairpiece — **Actual charge up to a lifetime maximum of $150**

We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.

Rental or Purchase of Durable Goods — **Actual charges up to $1,500 per calendar year**

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.

Waiver of Premium — **After 60 days**

After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.

Hospital Confinement — **$100 per day**

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.

Other Specified Diseases Covered:

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

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 cover age has become effective;

(c) any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or

(d) a newborn child (as described in the Eligibility Section).

Child (Children)

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

(a) not yet age 25; or

(b) not yet age 26 if a full time student at an accredited school.

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

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

Benefits

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

Hospital Intensive Care Confinement Benefit

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

Double Benefits

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

Emergency Hospitalization and Subsequent Transfer to an ICU

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

Step Down Unit

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

Exceptions and Other Limitations

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

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

Bay Bridge Administrators

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

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 per month	$2,500	$2,500	$5,000	$5,000
First Diagnosis	$0	$2,500	$0	$5,000
Colony Stimulating Factors per month	$500	$500	$500	$500
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 161690 - Austin, Texas 78716 - (800) 845-7519

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

Effective Date: January 1, 2018

Plan Features

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

Underwriting Guidelines - Guaranteed-Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available: Up to $10,000 for employees and up to $5,000 for spouses with no participation requirement.

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

Individual Eligibility

Issue Ages

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

Benefit-eligible employees working at least 20 hours or more weekly with at least 0 days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his or her spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **100%** of the employee amount, not to exceed the $25,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts up to $25,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured.

Children-only coverage is not available. Please see the Definitions section for a complete definition of *dependent children*.

Portability

Coverage may be continued with certain stipulations. See certificate for details.

Group Critical Illness Benefits

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

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

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

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

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

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

Health Screening Benefit - $100

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

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

Additional Benefits Rider

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

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

Heart Event Rider

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

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

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

Exceptions And Reductions

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

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

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

Benefits will not be paid for loss due to:

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

No benefits will be paid for loss which occurred prior to the Effective Date.

No benefits will be paid for diagnosis made or treatment received outside of the United States.

Pre-Existing Condition Limitation and Exceptions

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

Additional Benefit Rider Exceptions

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

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

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

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

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

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

Heart Event Rider Exceptions

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

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

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

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

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

Pre-Existing Conditions Exception

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition.

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

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

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

Exceptions

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

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

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

Notices

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

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

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

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

Continental American Insurance Company, Columbia, South Carolina.

Customer Service 800.433.3036

AGCM328-NC-S25-BK R1 IV (5/17)

Aflac Group Critical Illness Semi-Monthly Rates

NON-TOBACCO - Employee

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.76	$3.77	$4.78	$5.79	$6.80	$7.81	$8.82	$9.82	$10.83	$11.84
30-39	$3.44	$5.14	$6.83	$8.52	$10.21	$11.91	$13.60	$15.29	$16.99	$18.68
40-49	$5.22	$8.69	$12.16	$15.63	$19.10	$22.57	$26.04	$29.51	$32.98	$36.45
50-59	$7.60	$13.45	$19.29	$25.14	$30.99	$36.84	$42.68	$48.53	$54.38	$60.23
60-69	$12.67	$23.59	$34.51	$45.43	$56.35.	$67.27	$78.19	$89.11	$100.04	$110.96

NON-TOBACCO - Spouse

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.76	$3.26	$3.77	$4.27	$4.78	$5.28	$5.79	$6.29	$6.80
30-39	$3.44	$4.29	$5.14	$5.98	$6.83	$7.68	$8.52	$9.37	$10.21
40-49	$5.22	$6.96	$8.69	$10.43	$12.16	$13.90	$15.63	$17.37	$19.10
50-59	$7.60	$10.52	$13.45	$16.37	$19.29	$22.22	$25.14	$28.06	$30.99
60-69	$12.67	$18.13	$23.59	$29.05	$34.51	$39.97	$45.43	$50.89	$56.35.

TOBACCO - Employee

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.30	$4.86	$6.41	$7.97	$9.52	$11.08	$12.63	$14.19	$15.74	$17.29
30-39	$4.42	$7.10	$9.77	$12.45	$15.12	$17.80	$20.47	$23.15	$25.82	$28.49
40-49	$8.60	$15.46	$22.31	$29.17	$36.02	$42.88	$49.73	$56.59	$63.44	$70.30
50-59	$13.34	$24.93	$36.52	$48.11	$59.70	$71.29	$82.88	$94.47	$106.07	$117.66
60-69	$22.64	$43.53	$64.42	$85.31	$106.21	$127.10	$147.99	$168.88	$189.77	$210.66

TOBACCO - Spouse

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.30	$4.08	$4.86	$5.64	$6.41	$7.19	$7.97	$8.74	$9.52
30-39	$4.42	$5.76	$7.10	$8.44	$9.77	$11.11	$12.45	$13.78	$15.12
40-49	$8.60	$12.03	$15.46	$18.89	$22.31	$25.74	$29.17	$32.60	$36.02
50-59	$13.34	$19.14	$24.93	$30.73	$36.52	$42.32	$48.11	$53.91	$59.70
60-69	$22.74	$33.09	$43.53	$53.98	$64.42	$74.87	$85.31	$95.76	$106.21

AUL Short Term Disability

Effective Date: January 1, 2018

THE NEED FOR DISABILITY INSURANCE

Protect your paycheck

You insure your home, car and other valuable possessions, so why not also protect what pays for all those things? Your income. Without it, think about how your mortgage/rent, groceries or credit card bills would get paid. That's where disability insurance can help.

A disability can happen to anyone at any time and it can last for a short or long period of time. Purchasing disability insurance through your workplace is a way to replace a portion of your pre-disability earnings if you get sick or hurt and are unable to work. Being prepared can help ease the financial burden for you.

Things to think about

A severe injury or illness can leave you unable to work for years. Workers' compensation only covers injuries that happen on the job and, to qualify for coverage, you must meet certain eligibility requirements. Additionally, medical insurance will only help cover your medical costs.

You might be able to dip into savings or borrow money from loved ones, but if you don't have these options,can you really afford not to have disability insurance?

Protect yourself and your income with disability insurance.

Disability insurance can provide you with the income protection you need. Consider purchasing it today

Let's figure it out. Everyone's circumstances are different. This calculator can help you figure out how much you need to protect your lifestyle and the lifestyles of those you love if you become disabled.

Estimate your essential monthly expenses

Living Expenses	**Amount**
Monthly housing (e.g., mortgage, rent, insurance, taxes)	
Utilities (e.g., telephone, electricity, gas, oil, cable, TV, internet)	
Food	
Transportation (e.g., car payments, gasoline, insurance)	
Subtotal =	
Debt expenses	
Education (e.g.,tuition, books,supplies)	
Health care (e.g., out-of-pocket costs, insurance premiums)	
Debt payments (e.g., credit cards, other debt)	
Subtotal =	
Other expenses	
Dependent care	
Life insurance premiums	
Subtotal =	
Minimum monthly amount to cover with disability insurance.	**$**

Note: Products issues and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company

G-27786 03/17/16

Class Description

All Full-Time Eligible Employees working a minimum of 37.5 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability

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

Monthly Benefit

You can choose to insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000.

Elimination Period

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

Benefit Duration

This is the period of time that benefits will be payable for disability. The maximum STD benefit duration, if continually disabled, is 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.

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.

Annual Enrollment

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

Portability

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

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

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

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.

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.

Customer Service:
800-553-5318

Disability Claims:
866-258-8744
Fax: 207-766-3448

Disability Claims E-mail: claims@disabilityrms.com

www.employeebenefits.aul.com

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

AUL Life Short-Term Disability
Semi-Monthly Rates

Benefit Duration:
13 weeks

Monthly Benefit	*Semi-Monthly Premium*
$500	$5.18
$600	$6.22
$700	$7.25
$800	$8.29
$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	$15.54
$1,600	$16.57
$1,700	$17.61
$1,800	$18.64
$1,900	$19.68
$2,000	$20.71

AUL Voluntary Long-Term Disability

Effective Date: January 1, 2018

Class Description

All Full-Time Eligible Employees working a minimum of 37.5 hours per week, electing to participate in the Voluntary Long Term Disability.

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.

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.

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

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.

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.

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.

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

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

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period;
   And
2. The Person changes from one AUL short term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period.

The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short term disability plan's Pre-Existing Condition Limitation.

Portability

Once an employee is on the AUL disability plan for 3 months, you may be eligible to port your coverage for one year without evidence of insurability. You have 31 days from your date of termination apply. Please refer to the Mark III website for a copy of your certificate, a claim form, or an application to port form.

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly 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 certain events or conditions such as but not limited to 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. Additional exclusions and limitations may apply.

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

Customer Service
800-553-5318

Disability Claims
866-258-8744

Fax: 207-766-3448

Disability Claims Email: claims@disabilityrms.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.

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Dearborn National Term Life Plan

Basic Employee Life Insurance

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

Optional Employee Life Insurance

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

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

Optional Dependent Life Insurance

Provides coverage on:

- Your Spouse
- Unmarried Child(ren) from 15 days of age to age 19 (to age 23 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. Children can only be covered by one parent if both work for the County.

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

Flexibility

Simply choose the amount of coverage that suits your needs from the selection provided, as outlined on the back of this folder.

Features

The plan features easy eligibility and simple enrollment procedures.

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

Low Cost

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

Eligibility

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

Enrollment

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

Beneficiary

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

When Your Insurance Starts

If you enroll on or before the day you become eligible, your employer provided insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

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

Termination Of Coverage

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

Reductions at Age 65 & Over

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

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

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

Family Status Change

This provision allows you to increase your coverage by one times your basic annual salary without evidence of insurability within 31 days of the following:

- Marriage or divorce
- Death of a spouse or dependent child
- Birth or adoption of a dependent child
- Change in employment status for you or your spouse

Waiver Of Premium

Your Basic and Voluntary Life coverages include a wavier of premium provision. If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of 6 months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first. Your Voluntary Dependent Life Insurance may be continued provided you remit the applicable premium to your employer.

Conversion

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Dearborn National Life Insurance Company in any amount up to the amount of your life coverage in effect on your date of termination.

You must apply for this policy within 31 days after the date your coverage terminates. This privilege applies to Supplemental Life Insurance and Supplemental Dependent Life Insurance as well as to Basic Life Insurance.

Portability

Voluntary Life benefits are portable upon retirement or termination for the employee and/or his insured spouse. If an insured employee or spouse elects portability, he may also elect to continue Dependent Child(ren)'s coverage. Ported coverage terminates at age 70.

Accelerated Benefits Option

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

Group Policy and Certificate

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

Plan Sponsor

Polk County Government
40 Courthouse Street
Columbus, NC 28722
(828) 894-3302

Claims Procedure

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

This is only a brief summary of the life insurance benefits available. Some restrictions may apply. For more specific information about the coverage details, including limitations, exclusions and other requirements, please refer to your certificate booklet or contact Human Resources.

This coverage is underwritten by Dearborn National Life Insurance Company.

Schedule Of Benefits

Basic Life and AD&D Insurance

In the amount of $15,000 at no cost to you; paid by the County

Voluntary Group Life Insurance

You choose the following amounts on yourself and your spouse*:
$10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000, $150,000, $200,000, $250,000, $300,000, $400,000, or $500,000

Your Semi-Monthly Cost For Employee And Spouse Voluntary Group Life Insurance

(Spouse coverage based on spouse's age)

Age	Rate Per $1,000
Less than 35	.04
35-39	.06
40-44	.10
45-49	.14
50-54	.24
55-59	.41
60-64	.65
65-69	1.02
70-74	1.62
75+	2.86

Voluntary Dependent Life Insurance

$10,000 on each of your eligible children - $1.00/semi-monthly
$ 5,000 on each of your eligible children - $0.50/semi-monthly

- Employees under age 60 must furnish evidence of insurability for amounts over $100,000.
- Employees age 60-69 must furnish evidence of insurability for amounts over $20,000.
- Employees age 70 and over must furnish evidence of insurability for all amounts of coverages.
- To be eligible for $20,000 or more your spouse must furnish medical evidence of insurability.

***Spouse voluntary coverage cannot exceed the amount of the employee's voluntary coverage.**

Texas Life Whole Life Insurance - Solutions 121

Common Issue Date: February 1, 2018

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.

As an employee, you are eligible to apply once you have satisfied your employer's eligibility period. [2]

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

Individual Protection

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

Coverage for Your Family

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

Paid Up Insurance

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

Convenience of payroll deduction

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

Portable, Permanent

You may continue the peace of mind SOLUTIONS 121 provides, even when you change jobs or retire. Once your policy is issued, the coverage is yours to keep. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to Texas Life by automatic bank draft or monthly bill (for monthly bill we may add a billing fee not to exceed $2.00). Premiums are guaranteed to remain level to your age 65, or for 20 years if you purchase the policy after age 46, when the policy is fully paid-up and your death benefit reduces to a percentage of the initial face amount.

Accelerated Death Benefit due to Terminal Illness

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

Accelerated Death Benefit for Chronic Illness

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

Waiver of Premium Rider

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

Coverage begins immediately

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

Sample Rates

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

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

SOLUTIONS Review

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

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

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

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

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

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

15M002-C 1001 CI (exp0117)

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

Continuation of Benefits Options If You Leave Polk County Government

MedCost Medical Reimbursement Account

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call **MedCost at: (800) 795-1023.**

Ameritas Dental Plan

Under the group dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the same qualifying events listed above. Should you have any questions you may contact **Ameritas at (800) 487-5553**.

Community Eye Care Vision Plan

Under the group vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the same qualifying events listed above. Should you have any questions you may contact **Community Eye Care at (888) 254-4290**.

Aflac Accident and Critical Illness Plans

You may continue your Aflac Accident and/or Critical Illness policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, contact: **Aflac at 1-800-433-3036**

Humana Cancer Plan

You may continue your Humana Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information please contact: **Humana at 1-800-845-7519.**

AUL Short and Long Term Disability Plans

Once an employee is on the AUL disability plans for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to port your coverage by calling **1-800-553-5318.**

Dearborn National Term Life Insurance

When you leave employment, you may elect to continue your group term life in one of two ways:

1. You may "port" the existing group term coverage you have through your employer to a term policy. It is guaranteed issue, which means you do not have to answer any medical questions. You must apply for coverage within 31 days after the date your coverage terminates. For more information and a quote, please call **Dearborn National Life at (800) 348-4512.**

2. You may "convert" the existing group term coverage you have through your employer to an individual whole life policy. You must apply for coverage within 31 days after the date your coverage terminates. It is also guaranteed issue. For more information and a quote, please call **Dearborn National at (800) 348-4512.**

If you do not convert or port your group term life insurance, your life insurance coverage will terminate.

Texas Life Whole Life Insurance

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

Benefits available to Retirees of North Carolina State and Local Governments

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

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

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

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

View Benefit Information & Download Forms at:

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