



Plan Year: July 1, 2018 - June 30, 2019
Arranged and Enrolled by Mark III Brokerage, Inc.

Employee Benefits



Table of Contents

Pre-Tax Products

CIGNA Consumer Driven Health Plan with HSA	Page 2
CIGNA Traditional PPO Health Plan	Page 9
Prescription Benefit Overview	Page 16
CIGNA Telehealth Connection.....	Page 18
Health Plan Costs	Page 20
Eligibility	Page 21
Pre-Tax Plans Overview	Page 22
Health Savings Account (HSA)	Page 25
Flexible Benefit Administrators Spending Accounts	Page 26
Ameritas Dental High Plan	Page 29
Ameritas Dental PPO Plan	Page 32
EyeMed Vision Plan	Page 37
Aflac Group Accident Plan	Page 39
Allstate Cancer & Specified Disease Plan	Page 49


After-Tax Products

Aflac Critical Illness Plan	Page 60
American United Life (AUL) Short Term Disability Plan	Page 68
American United Life (AUL) Long Term Disability Plan	Page 72
MetLife Term Life Plan	Page 76
Texas Life Whole Life Plan	Page 81

For Your Reference

Aflac Health Advocate	Page 87
Continuation of Benefits When You Leave Your Employment	Page 89
Important Phone Numbers	Page 91
Information for Benefits Available to Retirees	Page 92



 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.</p>	<p>Important Questions</p>	<p>Answers</p>	<p>Why This Matters:</p>
<p>What is the overall deductible?</p>	<p>For in-network providers: \$1,500/individual or \$3,000/family For out-of-network providers: \$3,000/individual or \$6,000/family Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-network preventive care & immunizations.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers \$3,500/individual or \$5,000/family For out-of-network providers \$7,000/individual or \$10,000/family Combined medical/behavioral and pharmacy out-of-pocket limit</p>	<p>Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers.</p>	<p>Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers.</p>	<p>Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> /visit	40% <u>coinsurance</u>	None
	Specialist visit	20% <u>coinsurance</u> /visit	40% <u>coinsurance</u>	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** ** <u>Deductible</u> does not apply	Not covered/visit 40% <u>coinsurance</u> /screening Not covered/immunizations	None None None None You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Caremark.com	Generic drugs (Tier 1)	20% coinsurance/prescription (retail) ; 20% coinsurance/prescription (home delivery)	Not covered	Coverage is limited up to a 34-day supply (retail) and a 90-day supply (home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. Specialty drugs must be ordered through Caremark Speciality Pharmacy 1-800-237-2767 . Limited to a 30 day supply.
	Preferred brand drugs (Tier 2)	20% coinsurance/prescription (retail) ; 20% coinsurance/prescription (home delivery)	Not covered	
	Non-preferred brand drugs (Tier 3)	20% coinsurance/prescription (retail) ; 20% coinsurance/prescription (home delivery)	Not covered	
	Specialty drugs (Includes oral contraceptives) (Tier 4)	20% coinsurance/prescription (retail) ; 20% coinsurance/prescription (home delivery)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
	Emergency room care	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	50% penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	None
	Inpatient services	20% coinsurance	40% coinsurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	16 hour maximum per day
	Rehabilitation services	20% coinsurance/visit	40% coinsurance/visit	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not covered	Not covered	Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	50% penalty for no precertification.
	Hospice services	20% coinsurance/inpatient ; 20% coinsurance/outpatient services	40% coinsurance/inpatient ; 40% coinsurance/outpatient services	Coverage is limited to 60 days annual max.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	50% penalty for failure to precertify inpatient hospice services .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult)• Dental care (Children)• Eye care (Children)	<ul style="list-style-type: none">• Habilitation services• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (Adult)• Routine foot care• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none">• Bariatric Surgery (in-network only)	<ul style="list-style-type: none">• Chiropractic care (combined with Rehabilitation Services)• Hearing aids (2 devices per 36 months, through age 21)

Prevo Drug - Asheboro, 363 Sunset Avenue, Asheboro NC, 336-625-4311 offers all employees a cost effective alternative option for prescription drugs.

Five Points Medical Center, 300 Mack Road, Asheboro, NC, 336-625-1172, and Five Points Medical Center, 6215 US Hwy 64 E, Ramseur, NC, 336-824-2551 offers all employees a cost effective alternative option for health care.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccijio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$3,510

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$2,800

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.</p>	<p>Why This Matters:</p> <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p> <p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> <p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p> <p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p> <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Important Questions</p>	<p>Answers</p>
<p>What is the overall deductible?</p>	<p>For in-network providers: \$2,000/individual or \$4,000/family For out-of-network providers: \$4,000/individual or \$8,000/family</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-network preventive care & immunizations, office visits, urgent care facility visits, generic prescription drugs, in-network diagnostic colonoscopy and early cancer detection test are covered before you meet your deductible.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes, \$150/individual or \$300/family for brand prescription drugs. There are no other specific deductibles.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers \$4,000/individual or \$10,000/family For out-of-network providers \$8,000/individual or \$20,000/family Combined medical/behavioral and pharmacy out-of-pocket limit</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit Deductible does not apply	40% coinsurance	None
	Specialist visit	\$50 copay/visit Deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge/ visit ** No charge/ screening ** No charge/ immunizations ** ** Deductible does not apply	Not covered/ visit 40% coinsurance / screening Not covered/ immunizations	None None None You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	In-network diagnostic colonoscopy and early cancer detection test - No Charge
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.Caremark.com</p>	Generic drugs (Tier 1)	\$4 <u>copay</u> /prescription (retail); No charge/prescription (home delivery) <u>Deductible</u> does not apply	<u>Copay</u> + charge over in-network amount/prescription (retail); Not covered (home delivery)	<p>Coverage is limited up to a 34-day supply (retail) and a 90-day supply (home delivery).</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p> <p>Specialty drugs (Includes oral contraceptives) (Tier 4) 20% <u>coinsurance</u> / prescription \$50 minimum/\$400 maximum (home delivery) <u>Deductible</u> does apply.</p> <p>Specialty medications must be ordered through Caremark Specialty Pharmacy 1-800-237-2767 . Limited to a 30 day supply.</p>
	Preferred brand drugs (Tier 2)	\$45 <u>copay</u> /prescription (retail); \$90 <u>copay</u> /prescription (home delivery) <u>Deductible</u> does apply	<u>Copay</u> + charge over in-network amount/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	\$60 <u>copay</u> /prescription (retail); \$120 <u>copay</u> /prescription (home delivery) <u>Deductible</u> does apply	<u>Copay</u> + charge over in-network amount/prescription (retail); Not covered (home delivery)	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<p>If you need immediate medical attention</p>	<u>Urgent care</u>	\$50 <u>copay</u> /visit <u>Deductible</u> does not apply	\$50 <u>copay</u> /visit <u>Deductible</u> does not apply	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.
<p>If you have a hospital stay</p>	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.
	Outpatient services	\$25 <u>copay</u> /office visit** 20% <u>coinsurance</u> /all other services ** <u>Deductible</u> does not apply	40% <u>coinsurance</u> /office visit 40% <u>coinsurance</u> /all other services	None
<p>If you need mental health, behavioral health, or substance abuse services</p>	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	16 hour maximum per day
	Rehabilitation services	\$25 copay /PCP visit**	40% coinsurance /PCP visit	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
		\$50 copay /Specialist visit** ** Deductible does not apply	40% coinsurance /Specialist visit	Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	50% penalty for no precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
Hospice services	20% coinsurance /inpatient; 20% coinsurance /outpatient services	40% coinsurance /inpatient; 40% coinsurance /outpatient services	50% penalty for failure to precertify inpatient hospice services .	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric Surgery (in-network only)
- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 36 months, through age 21)

Prevo Drug - Asheboro, 363 Sunset Avenue, Asheboro NC, 336-625-4311 offers all employees a cost effective alternative option for prescription drugs.

Five Points Medical Center, 300 Mack Road, Asheboro, NC, 336-625-1172, and Five Points Medical Center, 6215 US Hwy 64 E, Ramseur, NC, 336-824-2551 offers all employees a cost effective alternative option for health care.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccijio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$2,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$4,010

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$2,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$280
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$980

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$2,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

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



Randolph County

Traditional PPO Health Plan

	<u>1-34 Day Supply*</u> <u>At a retail pharmacy</u>	<u>90 Day Supply</u> <u>Through Mail</u>
Generic Drugs	\$ 4	\$ 0
Preferred Brand	\$45	\$ 90
Non-Preferred Brand	\$60	\$120
Diabetic Supplies	20%	20%
OTC Smoking Cessation	\$ 5	\$ 0

\$150 Deductible per member/\$300 family max applies only to Brand Name Medications

**Not all medications are provided in exactly a 34 or 30 day supply. This can be due to packaging and/or quantity limits. The 1-34 or 30 day supply is indicated to show the range of days' supply allowed.*

Maximum Out of Pocket (MOOP): \$2,000 single / \$6,000 family

The plan year MOOP applies to pharmacy and medical. Each individual family member must meet the single MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. The deductible applies to the MOOP. Generic dispense as written penalties do not apply to the MOOP.

Consumer Driven Health Plan with HSA

Deductible: \$ 1,500 single/ \$3,000 family
Maximum Out of Pocket (MOOP): \$ 3,500 single/ \$5,000 family

The plan year deductible and Maximum Out of Pocket (MOOP) applies to pharmacy and medical. When the deductible is met your covered prescriptions are subject to a 20% coinsurance. Once your MOOP is met, your covered prescriptions are paid at 100%. The deductible applies to the MOOP and one family member or any combination of family members can meet the family deductible/MOOP. Generic dispense as written penalties do not apply to the MOOP.

Specialty Medication Copays are: 1-30 day supply at a 20% coinsurance (\$50 min / \$400 max) and are available as indicated below:

Specialty Medications: Specialty medications must be ordered through Caremark Specialty Pharmacy at 1-800-237-2767. Limited up to a 30 day supply and may require prior authorization or step therapy. Currently, step therapy categories include Autoimmune (Rheumatoid Arthritis) and Multiple Sclerosis.

Generic Policy: If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug.

DRUGS COVERED**

- Legend Drugs (drugs that require a prescription) **Exceptions:** See Exclusion list below.
- Migraine Medications (quantity limits apply)
- Narcolepsy (prior authorization required)
- Topical Acne Agents (prior authorization required over age 35)
- ADD/ADHD (prior authorization required ages 19 and older)
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding \$300 per script will require prior authorization.
- Contraceptives
- Impotency medications (limited to 4 per 30 days or 12 per 90 days)
- Stadol NS (limited to 2 per 25 days or 6 per 75 days)
- Toradol (limited to 20 per 25 days for retail and mail)

For Prescription Drug Card Customer Service Call 1-800-334-8134 NG

DRUGS COVERED (continued)**

- Hormone replacement rings (Estring & Femring) \$150.00 for 90 day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets
- Prescription Vitamins
- Smoking Cessation (Prescription and OTC)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required)
- Growth Hormones (prior authorization required)
- Androgens (prior authorization required)
- Antifungals (prior authorization required)
- Extended Release Controlled Substances-Opioid Analgesics (quantity limits apply)

EXCLUSIONS**

- Biological, blood products, serums, immunization agents and blood derivatives that are not officially classified as drugs
- Anti-obesity/Appetite suppression medications
- Anabolic Steroids
- Compounded prescriptions that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Topical Analgesic Pain Patches
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants and removal products)
- Infertility medications
- OTC (Over the Counter) products unless listed above
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Nutritional Supplements
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

****This is not an inclusive list but is a representation of the most commonly used medications. Contact customer service for specific drug coverage information.**

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Customer Service if you have specific drug questions or register at www.caremark.com to check drug costs and coverage.

THE CARE YOU NEED – WHEN, WHERE AND HOW YOU NEED IT.

Introducing Cigna Telehealth Connection.



Choice is good. More choice is even better.

Now Cigna provides access to **two** telehealth services as part of your medical plan – **AmWell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: AmWell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both AmWell and MDLIVE, you can speak with a doctor for help with:

- › sore throat
- › fever
- › rash
- › headache
- › cold and flu
- › acne
- › stomachache
- › allergies
- › UTIs and more

The cost savings are clear.

Televisits with AmWell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, you telehealth services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.



AmWell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, you have access to the **Cigna Behavioral Health** network of providers.

- › Go to **Cignabehavioral.com** to search for a video telehealth specialist
- › Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

899962 08/16

Choose with confidence.

AmWell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

AmWellforCigna.com*
855-667-9722

MDLIVEforCigna.com*
888-726-3171

Signing up is easy!



Set up and create an account with one or both AmWell and MDLIVE



Complete a medical history using their "virtual clipboard"



Download vendor apps to your smartphone/mobile device**

Cigna Telehealth Connection	PPO Co-pay Plan \$20 Co-pay	Consumer Driven Plan with an HSA \$42. Once deductible is paid, insurance pays 80%
-----------------------------	--------------------------------	--



*Availability may vary by location and plan type and is subject to change. See vendor sites for details.

**The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

AmWell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services, websites and mobile apps are provided exclusively by AmWell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. AmWell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for AmWell/MDLIVE services.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (CHC-TN), and Cigna HealthCare of Texas, Inc. Policy forms: OK - HP-APP-1 et al (CHLIC); TN - HP-POL43/HC-CER1V1 et al (CHLIC), GSA-COVER, et al (CHC-TN). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

MEDICAL – TWO OPTIONS THRU CIGNA

Employees who participate in the biometric screenings and meet the wellness standard program criteria will receive the wellness incentive of \$50.00 to offset the \$50.00 employee monthly premium.

Premiums for Traditional PPO Plan 2018-2019

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee <u>without</u> wellness incentive
Employee Only	\$625	\$0	\$50
Employee/Spouse	\$1,075	\$415	\$465
Employee/Child(ren)	\$955	\$305	\$355
Employee/Family	\$1,205	\$536	\$586
*Monthly Premium includes county contribution for employee plus the cost of dependent coverage.			

Premiums for Consumer Driven Plan with Health Savings Account (HSA) 2018-2019

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee <u>without</u> wellness incentive
Employee Only	\$625	\$0	\$50
Employee/Spouse	\$1,075	\$370	\$420
Employee/Child(ren)	\$955	\$277.50	\$327.50
Employee/Family	\$1,205	\$485	\$535
*Monthly Premium includes county contribution for employee plus the cost of dependent coverage. County HSA contribution of \$750, will be made at the beginning of the plan year, provided that the account has been set up by the employee.			



Eligibility

- **CIGNA Health Plan (Pre-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Flexible Spending Accounts (Pre-tax)**

All full time employees working 30+ hours per week are eligible to participate after 6 months of employment.

- **Dental Coverage (Pre-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Vision Coverage (Pre-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Accident Coverage (Pre-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Cancer Coverage (Pre-tax)**

All full time employees under age 65 working 30+ hours per week are eligible to participate at annual enrollment only and contingent upon underwriting approval unless enrolled when first eligible.

- **Critical Illness Coverage (After-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Short and Long Term Disability (After-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Basic Term Life and AD&D**

Employer Paid \$10,000 basic life: All full time employees working 30+ hours per week are eligible for this benefit on the first day of the month following 30 days of full time employment.

- **Voluntary Term Life and AD&D (After-tax)**

All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- **Whole Life (After-tax)**

All full time employees working 30+ hours per week are eligible to enroll each year during annual enrollment only.

Pre-Tax Plans

Any full-time employee who works 30 or more hours per week will be eligible to participate on the first of the month after 30 days of full-time employment. All new employees who meet the eligibility requirements must turn in the election form before benefits become available.

The Insurance Premium Conversion Options

If you enroll in the coverages offered by your employer, your share of qualified premiums will be pre-taxed. That is, your payment will be made tax-free and be subject to the restrictions listed in the section under the heading IRS Pre-tax Rules and Limitations. You will not be able to change or suspend your participation throughout the year unless you experience a change in family status. Changes in family status are things such as:

- Marriage;
- Gaining a dependent;
- Divorce or legal separation;
- Losing a dependent;
- Termination or commencement of your spouse's employment;
- A change in you or your spouse's eligibility for coverage due to a change in employment.

If you have a change in family status and need to alter your participation, you should contact Human Resources within 30 days of the change. The change must be consistent with your change in family status. For example, you could not change to a lesser plan of coverage because you gained a dependent. You can always change your participation at the beginning of any plan year.

To review how the Premium Conversion Option impacts your paycheck, see Examples A & B on the following page.

Cigna Health Plan

The County offers employees group health insurance as administered through CIGNA to provide employee, employee/child(ren), employee/spouse, and employee/family coverage.

Examples of Premium Conversion

EXAMPLE A

You are single with no dependents/\$2,000 gross monthly salary.

Without Cafeteria Benefits		With Cafeteria Benefits	
\$2,000.00	Gross Salary	\$2,000.00	Gross Salary
608.53	Federal, State, FICA	-58.63	Insurance Premiums
		-80.00	Medical Reimbursement Account
1,391.47			
-58.63	Insurance Premiums	1,861.37	New Taxable Income
-80.00	Out of Pocket Medical Expense	547.68	Federal, State, FICA
1,252.84	Spendable Income	1,313.69	New Spendable Income

You receive an increase in take-home pay of \$60.85

EXAMPLE B

You are married with two dependents/\$2,500 gross monthly salary.

Without Cafeteria Benefits		With Cafeteria Benefits	
\$2,500.00	Gross Salary	\$2,500.00	Gross Salary
-594.50	Federal, State, FICA	-356.32	Insurance Premiums
		-120.00	Medical Reimbursement Account
1,905.50		2,023.68	
-356.32	Insurance Premiums	2,023.68	New Taxable Income
-120.00	Out of Pocket Medical Expense	440.34	Federal, State, FICA
1,429.18	Spendable Income	1,583.34	New Spendable Income

You receive an increase in take-home pay of \$154.16

* * * * * ***NOTICE*** * * * * *

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for eligible Randolph County Government employees.

The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The plan year is July 1, 2018 through June 30, 2019

All products described in this booklet are pre-taxed **EXCEPT:**

- **Aflac Critical Illness Plan**
- **AUL Long and Short Term Disability**
- **MetLife Term Life Insurance**
- **Texas Life Whole Life Insurance**

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.

Health Savings Account (HSA)

What is a Health Savings Account?

- An HSA is your personal account to manage that you set up through the local Credit Union.

- Contribute money **tax-free**
- Use money to pay for deductibles and unreimbursed medical expenses tax-free
- Offers Tax-Advantages savings
- Interest Earning Account

You must elect the Consumer Driven Plan to open an HSA Account

Randolph County will contribute \$750 on July 1st to your HSA account set up with the Credit Union.

The money is your with no use it or lose it rules. Any money in the account is yours to use for qualified expenses even if you:

- Get married or divorced
- Move to another state
- Change employment
- Change medical coverage
- Become unemployed

You are eligible to open and contribute to an HSA if:

- You are covered by an eligible Consumer Driven Health Plan
- You are not covered by any other health plan
- You are not enrolled in Medicare, TRICARE, or TRICARE for Life
- You have not received VA benefits within the past 3 months
- You are not claimed as a dependent on someone else's tax return
- You are not covered by a health care FSA

Annual Contribution set by the IRS for 2018 - **\$3,450** for Individuals and **\$6,900** for families.

Those 55 years of age or higher but not entitled to Medicare benefits can fund an additional \$1,000 per year "catch-up" contribution.

Get reimbursed for out-of-pocket healthcare and child/aged adult day care expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

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

ELIGIBILITY

Participation in the Plan Begins on July 1, 2018 and ends on June 31, 2019. You will be eligible to join the Plan six(6) months following the date of full-time employment. Full-time are employees who works at least 30 hours or more per week. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

ELECTION CHANGES

Election changes are only allowed if you experience one of the following qualifying events:

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

REIMBURSEMENT SCHEDULE

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

ONLINE ACCESS

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

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

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

THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

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

Contribution Limits: The Minimum you may place in your Flexible spending account is \$240. The maximum you may place in this account for the Plan Year is \$2,650.

HEALTHCARE REIMBURSEMENT

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

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

Fees/Co-Pays/Deductibles For:

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

OVER-THE-COUNTER EXPENSES

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

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

DAY CARE/AGED ADULT CARE REIMBURSEMENT

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

- Under age 13
- Physically or mentally unable to care for themselves such as:
 - Disabled spouse
 - Children who became disabled prior to age 19.
 - Elderly parents that live with you

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

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

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

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

Ineligible Expenses

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

HOW TO RECEIVE REIMBURSEMENT

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

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

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

HOW THE FLEXIBLE BENEFIT PLAN WORKS

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

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

FORFEITING FUNDS

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

HOW TO ENROLL IN OUR FSA PLAN

Step 1

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

Step 2

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

BENEFITS CARD

The Benefit Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Please contact Flexible Benefit Administrators, Inc. to order additional cards.





Get **CONNECTED** with your account... Wherever, whenever.

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

Once your account is established, you can use
the same user name and password to access your
account via our Mobile App!



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

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

**Getting Started
is Easy!**

If you are having difficulty creating your user account or you have forgotten your password to an existing account, please contact us at 800-437-3539 or flexdivision@flex-admin.com.

Ameritas Dental High Plan

Effective Date: July 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)
- 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
- Denture Repair
- Oral Surgery - Complex and Simple Extractions
- Anesthesia
- Restorative Amalgam & Resin (excluding inlays & crowns)

Type 3 - Major Procedures

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

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

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: There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees 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

Annual Maximum Benefit

- Type 1, Type 2, and Type 3 Procedures - \$1,000* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover doesn't apply)

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

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than \$500.

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

Dental Exclusions (deferral Period)

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

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26.

Predetermination of Benefits

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

Coordination of Benefits

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

Certificate of Insurance

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

Section 125

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

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

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

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

Limitations / Exclusions (This is not a complete List)

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

This insurance is underwritten by Ameritas Life Insurance Corporation.

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

Ameritas High Plan Dental Rates

Employee Only	\$32.32
Employee/Spouse	\$66.38
Employee/Child(ren)	\$73.80
Employee/Family	\$107.86



Ameritas Dental PPO Plan

Effective Date: July 1, 2018

To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan as your Out-of-Network benefits will be significantly reduced.

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% MAC*. No deductible applies.

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

Type 2 - Basic Procedures

Type 2 benefits are payable at 80% MAC*. \$50.00 deductible applies.

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

Type 3 - Major Procedures Type 3 Benefits are payable at 50% MAC*. \$50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Prosthodontics - Removable Dentures, Partial
- Restorative - Crowns
- 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.

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

*Percentage Paid based on Maximum Allowable Charge

** Percentage Paid based on Usual and Customary Charges

Annual Maximum Benefit

- Type 1, Type 2, and Type 3 Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover doesn't apply)

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

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than \$500.

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

Dental Exclusions (deferment Period)

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

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26.

Predetermination of Benefits

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

Coordination of Benefits

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

Certificate of Insurance

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

Section 125

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

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

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

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

Limitations / Exclusions (This is not a complete List)

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

Commonly Asked PPO Questions

Do I have to use an Ameritas PPO provider?

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

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

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

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

Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

***If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553***

***Or, visit the Ameritas website at:
www.AmeritasGroup.com***

Ameritas PPO Plan Dental Rates

Employee Only	\$25.98
Employee/Spouse	\$52.80
Employee/Child(ren)	\$57.78
Employee/Family	\$84.60



EyeMed Vision Plan

Effective Date: July 1, 2018

	EyeMed Access Network	Out-of-Network
Deductibles:	\$10.00 Exam \$10.00 Eye Glass Lenses	No Deductible
Annual Eye Exam	Covered in Full	Up to \$35.00
Lenses (Per Pair):		
Single Vision	Covered in Full	Up to \$25.00
Bifocal	Covered in Full	Up to \$40.00
Trifocal	Covered in Full	Up to \$55.00
Lenticular	20% Discount	No Benefit
Progressive	See lens options	N/A
Contacts		
Fit and Follow Up Exams		
Standard	Standard: Member cost up to \$55	No Benefit
Premium (Allowance)	Premium: 10% off of retail	No Benefit
Elective	Up to \$150	Up to \$120
Medically Necessary	Covered in Full	Up to \$200.00
Frames	\$150	Up to \$75
Frequencies		
Exams	Every 12 months	Every 12 months
Lens	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months
	Based on Date of Service	Based on Date of Service
Lens Options (member cost)		
Progressive Lenses		
Standard	Standard: \$65 + lens deductible	No Benefit
Premium	Premium: lens cost - 20% discount - \$120 allowance + Standard Progressive cost	
Std. Polycarbonate	\$40	No Benefit
Tint (solid and gradient)	\$15	No Benefit
Scratch Resistant Coating	\$15	No Benefit
Anti-Reflective Coating	\$45	No Benefit
Ultraviolet Coating	\$15	No Benefit
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers	No Benefit

EyeMed In-Network Discounts

15% discount off the remaining balance in excess of the conventional contact lens allowance.

20% discount off the remaining balance in excess of the frame allowance.

20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.

EyeMed In-Network Secondary Purchase Plan

Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted.

Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.

Contact Lens Replacement by Mail Program

After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit EyeMedvisioncare.com for details.

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed Access network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com

View plan benefit information at: eyemedvisioncare.com

Monthly Rates

Employee Only	\$8.80
Employee + One	\$17.72
Employee + Family	\$25.60



Aflac Group Accident Plan

Effective Date: July 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 details.

Accident Benefits – High Option

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

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

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

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

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

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

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

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

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

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

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

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

The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount.

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

Paralysis	
Quadriplegia	\$10,000
Paraplegia	\$5,000

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

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

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

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

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

The laceration must be repaired with stitches by a doctor within 14 days after the accident.

The amount paid will be based on the length of the laceration.

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

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	\$250
Removal of foreign body from eye (requiring no surgery)	\$50
Tendons/Ligaments (treatment within 60 days, surgical repair within 90 days) <i>Single</i> <i>Multiple</i>	\$400 \$600
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.	
Ruptured Disc (treatment within 60 days, surgical repair within one year) <i>Injury occurs during first certificate year</i> <i>Injury occurs after first certificate year</i>	\$100 \$400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year) <i>Injury occurs during first certificate year</i> <i>Injury occurs after first certificate year</i>	\$100 \$400

Burns (treatment within 14 days), first degree burns not covered

Second Degree	
<i>Less than 10% of body surface covered</i>	\$100
<i>At least 10%, but not more than 25% of body surface covered</i>	\$200
<i>At least 25%, but not more than 35% of body surface covered</i>	\$500
<i>More than 35% of body surface covered</i>	\$1,000
Third Degree	
<i>Less than 10% of body surface covered</i>	\$1,000
<i>At least 10%, but not more than 25% of body surface covered</i>	\$5,000
<i>At least 25%, but not more than 35% of body surface covered</i>	\$10,000
<i>More than 35% of body surface covered</i>	\$20,000
Other Injuries	
Concussion (A concussion or <i>Mild Traumatic Brain Injury (MTB)</i> is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: <i>Concussion and MTB</i> 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)	
<i>Repaired with crown</i>	\$150
<i>Resulting in extraction</i>	\$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

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

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

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.

Monthly Premium Rates

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

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

Continental American Insurance Company

Columbia, South Carolina

Customer Service: 1-800-433-3036

www.aflacgroupinsurance.com



We've got you under our wing.®

Allstate Benefits Group Cancer Plan

Effective Date: July 1, 2018

In 2017, there were an estimated 1,688,780 new cancer cases diagnosed and 600,920 cancer deaths in the US.¹

Group Voluntary Cancer

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

Meeting Your Needs:

Cancer coverage provided by Allstate Benefits can help offer you and your family member financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

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

You and each covered family member can be sure they will receive:

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

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

**Employee only*

***List of covered diseases on the next page*

¹<https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-factsfigures-2017.html>

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.¹

Your Benefit Coverage

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

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

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

Government or Charity Hospital

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

Surgery

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

Second Opinion

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

Physical or Speech Therapy

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

¹<https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-factsfigures-2017.html>

Anesthesia

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

Ambulatory Surgical Center

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

Radiation/Chemotherapy for Cancer

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

Anti-Nausea Benefit

Up to a \$200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine

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

Hematological Drugs

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

Medical Imaging

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

Private Duty Nursing Services

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

New or Experimental Treatment

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

Blood, Plasma, and Platelets

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

Physician's Attendance

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

At Home Nursing

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

Prosthesis

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

Hair Prosthesis

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

Nonsurgical External Breast Prosthesis

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

Ambulance

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

Hospice Care

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

Extended Care Facility

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

Outpatient Lodging

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

Non-Local Transportation

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

Family Member Lodging and Transportation

Up to a \$50 benefit per day will be paid for lodging and \$0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment. 1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement. 2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

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

Bone Marrow or Stem Cell Transplant*

A (1) \$1,000*, (2) \$2,500*, (3) \$5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person. (1) A transplant which is other than non-autologous. (2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia. (3) A transplant which is non-autologous for the treatment of Leukemia. ***This benefit is payable only once per covered person per calendar year.**

Additional Benefit

Wellness

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

Optional Benefits

Cancer Initial Diagnosis (First Occurrence)

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

*Intensive Care***

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

- A. Hospital Intensive Care Unit Confinement \$600* - This benefit is for hospital intensive care unit confinement for any illness or accident.
- B. Step-Down Hospital Intensive Care Unit Confinement \$300*- This benefit is for step down hospital intensive care unit confinement for any illness or accident.
- C. Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

***This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.**

****This benefit is not disease-specific and pays a benefit for a covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**

Eligibility

Family members eligible for coverage include: you; your legal spouse or domestic partner; and your children.

Portability Privilege

Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage

As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which you made any required premium payments; or the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid.

Pre-Existing Condition, Exclusions and Limitations

Allstate Benefits does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn, adopted or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date.

Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. Allstate Benefits does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations

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

Coverage Subject to the Policy

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

The policy is Limited Benefit Cancer and Specified Disease Insurance.

This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

The coverage is provided by a limited benefit supplemental insurance policy.

This coverage does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than April 1, 2021. Group Cancer and Specified Disease benefits provided by policy GVCP3, or state variations thereof. The policy and rider are underwritten by American Heritage Life Insurance Company. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

This brochure is for use in enrollments which are situated in North Carolina.



Allstate[®]
Benefits

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

1776 American Heritage Life Drive, Jacksonville, Florida 32224

***Customer Care Center: 800-521-3535
www.allstate.com or AllstateBenefits.com***

Monthly Rates

Issue Ages: 18 and older while actively at work.

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

Option without Cancer Initial Diagnosis and Intensive Care

<i>Insureds</i>	<i>Monthly</i>
<i>Employee</i>	\$20.07
<i>Employee + Child(ren)</i>	\$27.71
<i>Employee + Spouse</i>	\$30.96
<i>Family</i>	\$38.57

Option with Cancer Initial Diagnosis and Intensive Care

<i>Insureds</i>	<i>Monthly</i>
<i>Employee</i>	\$26.06
<i>Employee + Child(ren)</i>	\$36.81
<i>Employee + Spouse</i>	\$41.50
<i>Family</i>	\$52.23

Aflac Group Critical Illness Plan

Lump Sum Single Payment Policy/First Occurrence

Effective Date: July 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 to \$50,000 for employees and up to \$30,000 for spouse
- An annual health screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- Includes an Additional Benefits Rider with benefits for the following:
 - Coma
 - Paralysis
 - Severe Burn
 - Loss of Sight
 - Loss of Hearing
 - Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines - Guaranteed-Issue

Guaranteed-issue coverage if offered for All Employees:

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

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

Individual Eligibility

Issue Ages

Employees - 18-69

Spouses - 18-69

Children under age 26

Benefit-eligible employees working at least 19 hours or more weekly with at least 0 days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his or her spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

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 \$30,000 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 \$30,000.

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.

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%

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 six months.

Re-Occurrence Benefit

We will pay benefits for the re-occurrence of any Critical Illness once every twelve months. Therefore, once benefits have been paid for a 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%

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%

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

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

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

Benefits will not be paid for loss due to:

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

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

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

Pre-Existing Condition Limitation and Exceptions

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

Additional Benefit Rider Exceptions

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

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

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

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

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

Heart Event Rider Exceptions

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

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

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

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

Pre-Existing Conditions Exception

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

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

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

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

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

Exceptions

No benefits will be paid if the specified critical illness is a result of:

- (a) Intentionally self-inflicted injury or action;
- (b) Suicide or attempted suicide while sane or insane;
- (c) Illegal activities or participation in an illegal occupation;
- (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or
- (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician.

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

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

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

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: 1-800-433-3036
www.aflacgroupinsurance.com



AGCM328-NC-525-BK R2 IV (3/18)

Monthly Rates for Employee and Spouse

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	\$5.52	\$7.54	\$9.56	\$11.57	\$13.59	\$15.61	\$17.63	\$19.65	\$21.67	\$23.69
30-39	\$6.89	\$10.27	\$13.66	\$17.04	\$20.43	\$23.82	\$27.20	\$30.59	\$33.97	\$37.36
40-49	\$10.44	\$17.38	\$24.32	\$31.26	\$38.20	\$45.14	\$52.08	\$59.02	\$65.96	\$72.90
50-59	\$15.20	\$26.89	\$38.59	\$50.28	\$61.98	\$73.67	\$83.37	\$97.06	\$108.76	\$120.45
60-69	\$25.34	\$47.18	\$69.02	\$90.86	\$112.71	\$134.55	\$156.39	\$178.23	\$200.07	\$221.91

NON-TOBACCO - Spouse

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000	\$30,000
18-29	\$5.52	\$6.53	\$7.54	\$8.55	\$9.56	\$10.57	\$11.57	\$12.58	\$13.59	\$15.61
30-39	\$6.89	\$8.58	\$10.27	\$11.96	\$13.66	\$15.35	\$17.04	\$18.74	\$20.43	\$23.82
40-49	\$10.44	\$13.91	\$17.38	\$20.85	\$24.32	\$27.79	\$31.26	\$34.73	\$38.20	\$45.14
50-59	\$15.20	\$21.04	\$26.89	\$32.74	\$38.59	\$44.43	\$50.28	\$56.13	\$61.98	\$73.67
60-69	\$25.34	\$36.26	\$47.18	\$58.10	\$69.02	\$79.94	\$90.86	\$101.79	\$112.71	\$134.55

TOBACCO - Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$6.61	\$9.72	\$12.83	\$15.94	\$19.04	\$22.15	\$25.26	\$28.37	\$31.48	\$34.59
30-39	\$8.85	\$14.20	\$19.55	\$24.90	\$30.24	\$35.59	\$40.94	\$46.29	\$51.64	\$56.99
40-49	\$17.21	\$30.92	\$44.63	\$58.34	\$75.05	\$85.76	\$99.47	\$113.18	\$126.88	\$140.59
50-59	\$26.68	\$49.86	\$73.04	\$96.22	\$119.41	\$142.59	\$165.77	\$188.95	\$212.13	\$235.31
60-69	\$45.28	\$87.06	\$128.85	\$170.63	\$212.41	\$254.19	\$295.98	\$337.76	\$379.54	\$421.32

TOBACCO - Spouse

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000	\$30,000
18-29	\$6.61	\$8.16	\$9.72	\$11.27	\$12.83	\$14.38	\$15.94	\$17.49	\$19.04	\$22.15
30-39	\$8.85	\$11.52	\$14.20	\$16.87	\$19.55	\$22.22	\$24.90	\$27.57	\$30.24	\$35.59
40-49	\$17.21	\$24.06	\$30.92	\$37.77	\$44.63	\$51.48	\$58.34	\$65.19	\$75.05	\$85.76
50-59	\$26.68	\$38.27	\$49.86	\$61.45	\$73.04	\$84.63	\$96.22	\$107.82	\$119.41	\$142.59
60-69	\$45.28	\$66.17	\$87.06	\$107.96	\$128.85	\$149.74	\$170.63	\$191.52	\$212.41	\$254.19

AUL/OneAmerica Short Term Disability

Effective Date: July 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 issued and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company

©2016 One America Financial Partners, Inc. All rights reserved

ONEAMERICA® IS THE MARKETING NAME FOR THE COMPANIES OF ONEAMERICA / ONEAMERICA.COM

Class Description

All Full-Time Eligible Employees working a minimum of 30 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.

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

Recurrent Disability

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

Exclusions and Limitations

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

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions, 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 apply for portability by calling 800-553-5318.

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

Please refer to the Mark III web-site for a copy of your certificate or claim form.

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

Customer Service: 800-553-5318

**Disability Claims: American United Life Insurance Company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 844-287-9499**

OneAmerica.claims@customdisability.com

855-517-6365



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

***AUL Life Short-Term Disability
Monthly Rates***

***Benefit Duration:
13 weeks***

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

AUL Voluntary Long-Term Disability

Effective Date: July 1, 2018

Class Description

All Full-Time Eligible Employees working a minimum of 30 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 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

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

Please refer to the Mark III web-site for a copy of your certificate or claim 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
Monthly Rates***

Monthly Benefit	Monthly Deduction
\$500	\$8.15
\$1,000	\$16.30
\$1,500	\$24.45
\$2,000	\$32.60

Customer Service: 800-553-5318

**Disability Claims: American United Life Insurance Company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 844-287-9499**

**OneAmerica.claims@customdisability.com
855-517-6365**

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.



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

Metlife 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
- Child(ren) from 15 days of age to age 19 (to age 25 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit.

It is the responsibility of the employee to notify payroll in writing when a dependent becomes ineligible for coverage. Examples of an ineligible dependent status are divorce, or a child graduates from college.

Accidental Death and Dismemberment

Benefits under this coverage are payable for accidental death or injury as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage.

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.

Increases in coverage, a re-entry in the plan and participants who enroll beyond 31 days of employment will be required to provide evidence of insurability satisfactory to MetLife.

Low Cost

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

Eligibility

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

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. If a Statement of Health was completed, you will be notified as to when coverage starts.

Beneficiary

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

When Your Insurance Starts

Your Basic Employee Life Insurance becomes effective on the date of your eligibility (the first day of the month after you complete 30 days of continuous employment) if you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional and/or Dependent Life Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you or a covered dependent are confined in a hospital, not actively at work, or not performing normal daily activities, your insurance will not be effective. You and/or your dependents will become covered when you return to active full-time work, are no longer confined in a hospital, and can perform normal daily activities. Normal daily activities means not confined at home under the care of a doctor for sickness or injury and not entitled to receive any disability income from any source.

If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to Metropolitan Life.

Termination of Coverage

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

Extended Death Benefit

This benefit provides that an employee who becomes disabled on or after the effective date of coverage may continue without payment of premium until the earliest of: 12 months from the date of disability; or, beginning with the date of disability, the length of time the employee was covered under the plan plus 31 days, or attainment of age 70.

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 Metropolitan Life in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Dependent Life Insurance as well.

Portability

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance, not dependents.

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is \$20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

The accelerated benefit option (ABO)

Metropolitan 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.

Suicide Exclusion

No Optional Employee Life or Dependent Life Benefits are payable if you or your dependent(s) commit suicide within two years from the effective date of the coverage.

Claims Procedure

Procedures for Presenting Claims for Benefits - Claim forms needed to file for benefits under the group insurance program can be obtained from your employer. 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.

Routine Questions

If there is any question about a claim payment, an explanation can be requested from MetLife.

Schedule of Benefits

Basic Employee Life Insurance and AD&D (No cost to you)

All eligible full-time employees: \$10,000

Optional Employee Life Insurance and AD&D

Your choice of the following amounts:

Coverage of \$10,000 to \$200,000 in \$10,000 increments.

Amounts over \$100,000 will require medical evidence of insurability*.

Optional Dependent Life Insurance Coverage

****Optional Spouse Life Insurance and AD&D***

Spouse - Increments of \$10,000 up to a maximum of \$100,000.

Spouse coverage cannot exceed employee coverage.

Amounts over \$10,000 require Evidence of Insurability*.

****Optional Child Life Insurance***

Child - Increments of \$2,000 to \$10,000 per child (No Evidence of Insurability Required)

**Evidence of Insurability is also required for late entrants and anyone increasing their coverage in any amount.*

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance. If both husband and wife are employees of the employer only one can cover the dependent children.

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

If you have any questions regarding your Statement of Health or Life Insurance claim, please call MetLife at: (800) 638-6420



MetLife Optional Term Life Rates

Rates are based on employee's age at the beginning of each benefit year effective July 1st

Optional Employee & Spouse Term Life and AD&D Monthly Rates											
Amount of Coverage	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$0.95	\$0.95	\$1.15	\$1.55	\$1.75	\$2.35	\$3.65	\$5.95	\$9.95	\$18.45	\$29.65
\$20,000	\$1.90	\$1.90	\$2.30	\$3.10	\$3.50	\$4.70	\$7.30	\$11.90	\$19.90	\$36.90	\$59.30
\$30,000	\$2.85	\$2.85	\$3.45	\$4.65	\$5.25	\$7.05	\$10.95	\$17.85	\$29.85	\$55.35	\$88.95
\$40,000	\$3.80	\$3.80	\$4.60	\$6.20	\$7.00	\$9.40	\$14.60	\$23.80	\$39.80	\$73.80	\$118.60
\$50,000	\$4.75	\$4.75	\$5.75	\$7.75	\$8.75	\$11.75	\$18.25	\$29.75	\$49.75	\$92.25	\$148.25
\$60,000	\$5.70	\$5.70	\$6.90	\$9.30	\$10.50	\$14.10	\$21.90	\$35.70	\$59.70	\$110.70	\$177.90
\$70,000	\$6.65	\$6.65	\$8.05	\$10.85	\$12.25	\$16.45	\$25.55	\$41.65	\$69.65	\$129.15	\$207.55
\$80,000	\$7.60	\$7.60	\$9.20	\$12.40	\$14.00	\$18.80	\$29.20	\$47.60	\$79.60	\$147.60	\$237.20
\$90,000	\$8.55	\$8.55	\$10.35	\$13.95	\$15.75	\$21.15	\$32.85	\$53.55	\$89.55	\$166.05	\$266.85
\$100,000	\$9.50	\$9.50	\$11.50	\$15.50	\$17.50	\$23.50	\$36.50	\$59.50	\$99.50	\$184.50	\$296.50
\$110,000	\$10.45	\$10.45	\$12.65	\$17.05	\$19.25	\$25.85	\$40.15	\$65.45	\$109.45	\$202.95	\$326.15
\$120,000	\$11.40	\$11.40	\$13.80	\$18.60	\$21.00	\$28.20	\$43.80	\$71.40	\$119.40	\$221.40	\$355.80
\$130,000	\$12.35	\$12.35	\$14.95	\$20.15	\$22.75	\$30.55	\$47.45	\$77.35	\$129.35	\$239.85	\$385.45
\$140,000	\$13.30	\$13.30	\$16.10	\$21.70	\$24.50	\$32.90	\$51.10	\$83.30	\$139.30	\$258.30	\$415.10
\$150,000	\$14.25	\$14.25	\$17.25	\$23.25	\$26.25	\$35.25	\$54.75	\$89.25	\$149.25	\$276.75	\$444.75
\$160,000	\$15.20	\$15.20	\$18.40	\$24.80	\$28.00	\$37.60	\$58.40	\$95.20	\$159.20	\$295.20	\$474.40
\$170,000	\$16.15	\$16.15	\$19.55	\$26.35	\$29.75	\$39.95	\$62.05	\$101.15	\$169.15	\$313.65	\$504.05
\$180,000	\$17.10	\$17.10	\$20.70	\$27.90	\$31.50	\$42.30	\$65.70	\$107.10	\$179.10	\$332.10	\$533.70
\$190,000	\$18.05	\$18.05	\$21.85	\$29.45	\$33.25	\$44.65	\$69.35	\$113.05	\$189.05	\$350.55	\$563.35
\$200,000	\$19.00	\$19.00	\$23.00	\$31.00	\$35.00	\$47.00	\$73.00	\$119.00	\$199.00	\$369.00	\$593.00

Spouse Rates are based on Employee Age.

*Evidence of Insurability is required on Employee Optional Term Life coverage over \$100,000.

*Evidence of Insurability is required on Spouse Term Life coverage amounts over \$10,000.

MetLife Optional Child Coverage Monthly Rates					
Amount of Coverage	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
Monthly rate	\$0.24	\$0.48	\$0.72	\$0.96	\$1.20



Texas Life Whole Life Insurance - Solutions 121

Common Issue Date: August 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.²

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

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

Individual Protection

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

Coverage for Your Family

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

Paid Up Insurance

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

Convenience of payroll deduction

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

Portable, Permanent

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

Accelerated Death Benefit due to Terminal Illness

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

Accelerated Death Benefit for Chronic Illness

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

Waiver of Premium Rider

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

Coverage begins immediately

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

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire, as long as you pay premiums due
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit ¹
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness on all policies
- Waiver of Premium included for ages 17-59
- If desired, you may apply for higher amounts of coverage by answering additional underwriting questions
- Coverage available for spouse, children and grandchildren²

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

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

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

³ LIMRA; Life Insurance Ownership Focus – 2016

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

TEXASLIFE INSURANCE
COMPANY

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

SOLUTIONS Series 121 — Tier 1 / Tier 2 / Tier 3

Issue Age (ALB)	Includes Added Cost for Waiver of Premium Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)								POLICY IS PAID UP for the Face Amount At Attained Age
	\$ 5,000		\$ 7,500		\$ 10,000		\$ 12,500		
	NT	T	NT	T	NT	T	NT	T	
17					9.67	11.21	11.27	13.19	65
18					10.03	11.56	11.71	13.63	65
19					10.03	11.68	11.71	13.78	65
20					10.26	12.03	12.01	14.22	65
21					10.38	12.27	12.15	14.51	65
22					10.62	12.50	12.45	14.81	65
23					10.97	12.86	12.89	15.25	65
24					11.09	13.21	13.04	15.69	65
25					11.32	13.57	13.33	16.14	65
26					11.80	13.92	13.92	16.58	65
27					12.15	14.39	14.37	17.17	65
28					12.62	14.86	14.96	17.76	65
29					13.09	15.45	15.55	18.50	65
30					13.33	16.04	15.84	19.23	65
31					14.04	16.75	16.73	20.12	65
32					14.75	17.46	17.61	21.00	65
33					15.34	18.29	18.35	22.04	65
34					15.69	18.99	18.79	22.92	65
35					16.28	19.94	19.53	24.10	65
36					17.11	20.88	20.56	25.28	65
37					18.05	21.94	21.74	26.61	65
38					18.88	23.12	22.77	28.08	65
39					20.29	24.54	24.54	29.85	65
40					21.00	25.72	25.43	31.33	65
41					22.18	27.25	26.90	33.25	65
42					23.24	28.91	28.23	35.31	65
43					24.42	30.68	29.71	37.52	65
44					26.07	32.80	31.77	40.18	65
45					27.73	35.04	33.84	42.98	65
46					28.79	36.58	35.16	44.90	66
47					29.97	38.11	36.64	46.82	67
48					31.27	39.76	38.26	48.88	68
49					32.68	41.41	40.03	50.95	69
50	18.52	22.72	26.14	32.42	33.74	42.12	41.36	51.83	70
51	19.18	23.66	27.11	33.84	35.04	44.01	42.98	54.19	71
52	19.88	24.54	28.18	35.16	36.46	45.78	44.75	56.40	72
53	20.65	25.55	29.32	36.67	37.99	47.79	46.67	58.91	73
54	21.47	26.66	30.56	38.35	39.64	50.03	48.73	61.71	74
55	21.83	27.32	31.09	39.32	40.35	51.33	49.62	63.34	75
56	22.53	28.32	32.16	40.82	41.77	53.33	51.39	65.84	76
57	23.66	29.38	33.84	42.42	44.01	55.46	54.19	68.50	77
58	24.66	30.68	35.34	44.36	46.02	58.05	56.70	71.74	78
59	25.48	32.09	36.58	46.49	47.67	60.88	58.76	75.28	79
60	24.60	30.92	35.40	44.88	46.20	58.84	57.00	72.80	80
61	25.84	32.43	37.27	47.15	48.68	61.86	60.11	76.58	81
62	27.03	34.21	39.05	49.82	51.06	65.42	63.08	81.03	82
63	28.16	36.10	40.75	52.66	53.33	69.20	65.91	85.76	83
64	29.73	37.99	43.10	55.49	56.46	72.98	69.83	90.48	84
65	31.13	40.04	45.21	58.57	59.27	77.09	73.34	95.61	85
66	33.02	42.47	48.04	62.22	63.05	81.95	78.06	101.69	86
67	34.91	44.90	50.88	65.86	66.83	86.81	82.79	107.76	87
68	37.13	47.55	54.19	69.83	71.26	92.10	88.32	114.38	88
69	39.50	50.74	57.76	74.60	76.01	98.47	94.26	122.34	89
70	42.10	54.14	61.64	79.71	81.19	105.28	100.74	130.85	90

SOLUTIONS Series 121 — Tier 1 / Tier 2 / Tier 3

Issue Age (ALB)	Includes Added Cost for Waiver of Premium Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)								POLICY IS PAID UP for the Face Amount At Attained Age
	\$ 15,000		\$ 20,000		\$ 25,000		\$ 30,000		
	NT	T	NT	T	NT	T	NT	T	
17	12.86	15.16	16.04	19.11	19.23	23.07	22.42	27.02	65
18	13.39	15.69	16.75	19.82	20.12	23.95	23.48	28.08	65
19	13.39	15.87	16.75	20.06	20.12	24.25	23.48	28.43	65
20	13.75	16.40	17.22	20.76	20.71	25.13	24.19	29.50	65
21	13.92	16.75	17.46	21.24	21.00	25.72	24.54	30.20	65
22	14.27	17.11	17.93	21.71	21.59	26.31	25.25	30.91	65
23	14.81	17.64	18.64	22.42	22.48	27.20	26.31	31.97	65
24	14.98	18.17	18.88	23.12	22.77	28.08	26.66	33.04	65
25	15.34	18.70	19.35	23.83	23.36	28.97	27.37	34.10	65
26	16.04	19.23	20.29	24.54	24.54	29.85	28.79	35.16	65
27	16.58	19.94	21.00	25.48	25.43	31.03	29.85	36.58	65
28	17.29	20.65	21.94	26.43	26.61	32.21	31.27	37.99	65
29	18.00	21.54	22.89	27.61	27.79	33.69	32.68	39.76	65
30	18.35	22.42	23.36	28.79	28.38	35.16	33.39	41.53	65
31	19.41	23.48	24.78	30.20	30.15	36.93	35.51	43.66	65
32	20.47	24.54	26.19	31.62	31.92	38.70	37.64	45.78	65
33	21.35	25.78	27.37	33.27	33.39	40.77	39.41	48.26	65
34	21.89	26.85	28.08	34.69	34.28	42.54	40.47	50.38	65
35	22.77	28.26	29.26	36.58	35.75	44.90	42.24	53.21	65
36	24.01	29.68	30.91	38.46	37.82	47.26	44.72	56.05	65
37	25.43	31.27	32.80	40.59	40.18	49.91	47.55	59.23	65
38	26.66	33.04	34.45	42.95	42.24	52.86	50.03	62.77	65
39	28.79	35.16	37.28	45.78	45.78	56.40	54.28	67.02	65
40	29.85	36.93	38.70	48.14	47.55	59.35	56.40	70.56	65
41	31.62	39.24	41.06	51.21	50.50	63.19	59.94	75.16	65
42	33.22	41.71	43.18	54.51	53.16	67.32	63.13	80.12	65
43	34.99	44.36	45.54	58.05	56.11	71.74	66.67	85.43	65
44	37.47	47.55	48.85	62.30	60.24	77.05	71.62	91.80	65
45	39.94	50.92	52.15	66.78	64.37	82.66	76.58	98.53	65
46	41.53	53.21	54.28	69.85	67.02	86.49	79.76	103.13	66
47	43.30	55.52	56.64	72.92	69.97	90.33	83.30	107.73	67
48	45.25	58.00	59.23	76.22	73.22	94.46	87.20	112.69	68
49	47.38	60.48	62.06	79.53	76.76	98.59	91.45	117.64	69
50	48.97	61.54	64.19	80.94	79.41	100.36	94.63	119.77	70
51	50.92	64.37	66.78	84.72	82.66	105.08	98.53	125.43	71
52	53.04	67.02	69.62	88.26	86.20	109.50	102.77	130.74	72
53	55.34	70.03	72.68	92.27	90.03	114.52	107.38	136.76	73
54	57.82	73.39	75.99	96.76	94.16	120.12	112.33	143.48	74
55	58.88	75.34	77.40	99.35	95.93	123.37	114.46	147.38	75
56	61.00	78.35	80.24	103.36	99.47	128.38	118.70	153.40	76
57	64.37	81.53	84.72	107.61	105.08	133.69	125.43	159.77	77
58	67.37	85.43	88.73	112.80	110.09	140.18	131.45	167.56	78
59	69.85	89.68	92.04	118.47	114.22	147.26	136.40	176.05	79
60	67.80	86.75	89.40	114.67	111.00	142.59	132.60	170.51	80
61	71.53	91.29	94.37	120.72	117.21	150.15	140.05	179.58	81
62	75.09	96.64	99.12	127.85	123.15	159.06	147.18	190.27	82
63	78.49	102.31	103.66	135.41	128.82	168.51	153.98	201.61	83
64	83.19	107.98	109.92	142.97	136.65	177.96	163.38	212.95	84
65	87.40	114.13	115.54	151.18	143.67	188.22	171.80	225.26	85
66	93.07	121.42	123.10	160.90	153.12	200.37	183.14	239.84	86
67	98.74	128.71	130.66	170.62	162.57	212.52	194.48	254.42	87
68	105.38	136.65	139.51	181.20	173.64	225.75	207.77	270.30	88
69	112.51	146.21	149.02	193.94	185.52	241.68	222.02	289.42	89
70	120.29	156.41	159.38	207.55	198.48	258.69	237.58	309.83	90

SOLUTIONS Series 121 — Tier 1 / Tier 2 / Tier 3

Issue Age (ALB)	Includes Added Cost for Waiver of Premium Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)								POLICY IS PAID UP for the Face Amount At Attained Age
	\$ 35,000		\$ 40,000		\$ 45,000		\$ 50,000		
	NT	T	NT	T	NT	T	NT	T	
17	25.60	30.98	28.79	34.92	31.97	38.88	35.16	42.83	65
18	26.85	32.21	30.20	36.34	33.57	40.47	36.93	44.60	65
19	26.85	32.63	30.20	36.81	33.57	41.01	36.93	45.19	65
20	27.67	33.86	31.15	38.23	34.63	42.59	38.11	46.96	65
21	28.08	34.69	31.62	39.17	35.16	43.66	38.70	48.14	65
22	28.91	35.51	32.56	40.12	36.22	44.72	39.88	49.32	65
23	30.15	36.76	33.98	41.53	37.82	46.32	41.65	51.09	65
24	30.56	37.99	34.45	42.95	38.35	47.90	42.24	52.86	65
25	31.38	39.24	35.40	44.36	39.41	49.50	43.42	54.63	65
26	33.04	40.47	37.28	45.78	41.53	51.09	45.78	56.40	65
27	34.28	42.12	38.70	47.67	43.13	53.21	47.55	58.76	65
28	35.93	43.77	40.59	49.56	45.25	55.34	49.91	61.12	65
29	37.58	45.84	42.48	51.92	47.38	58.00	52.27	64.07	65
30	38.41	47.90	43.42	54.28	48.44	60.65	53.45	67.02	65
31	40.89	50.38	46.25	57.11	51.63	63.83	56.99	70.56	65
32	43.37	52.86	49.08	59.94	54.81	67.02	60.53	74.10	65
33	45.43	55.76	51.44	63.24	57.46	70.74	63.48	78.23	65
34	46.67	58.23	52.86	66.08	59.06	73.93	65.25	81.77	65
35	48.73	61.54	55.22	69.85	61.71	78.18	68.20	86.49	65
36	51.63	64.84	58.52	73.63	65.43	82.42	72.33	91.21	65
37	54.93	68.55	62.30	77.88	69.68	87.20	77.05	96.52	65
38	57.82	72.68	65.60	82.60	73.39	92.51	81.18	102.42	65
39	62.77	77.64	71.27	88.26	79.76	98.88	88.26	109.50	65
40	65.25	81.77	74.10	92.98	82.95	104.19	91.80	115.40	65
41	69.38	87.14	78.82	99.12	88.26	111.10	97.70	123.07	65
42	73.10	92.93	83.07	105.72	93.04	118.53	103.01	131.33	65
43	77.23	99.12	87.79	112.80	98.35	126.49	108.91	140.18	65
44	83.01	106.55	94.40	121.30	105.79	136.05	117.17	150.80	65
45	88.80	114.40	101.00	130.27	113.22	146.14	125.43	162.01	65
46	92.51	119.77	105.25	136.40	118.00	153.04	130.74	169.68	66
47	96.64	125.14	109.97	142.54	123.31	159.95	136.64	177.35	67
48	101.19	130.92	115.16	149.15	129.15	167.38	143.13	185.61	68
49	106.14	136.70	120.83	155.76	135.52	174.82	150.21	193.87	69
50	109.85	139.18	125.08	158.59	140.30	178.00	155.52	197.41	70
51	114.40	145.79	130.27	166.14	146.14	186.50	162.01	206.85	71
52	119.36	151.98	135.93	173.22	152.52	194.46	169.09	215.70	72
53	124.72	159.01	142.07	181.24	159.41	203.49	176.76	225.73	73
54	130.50	166.85	148.68	190.21	166.85	213.58	185.02	236.94	74
55	132.98	171.40	151.51	195.40	170.03	219.42	188.56	243.43	75
56	137.94	178.41	157.17	203.43	176.41	228.44	195.64	253.46	76
57	145.79	185.85	166.14	211.92	186.50	238.00	206.85	264.08	77
58	152.81	194.93	174.16	222.31	195.52	249.68	216.88	277.06	78
59	158.59	204.84	180.77	233.64	202.96	262.43	225.14	291.22	79
60	154.20	198.43	175.80	226.34	197.40	254.26	219.00	282.18	80
61	162.89	209.01	185.74	238.44	208.58	267.87	231.42	297.30	81
62	171.21	221.48	195.24	252.70	219.27	283.91	243.30	315.12	82
63	179.15	234.71	204.31	267.82	229.48	300.92	254.64	334.02	83
64	190.11	247.94	216.84	282.94	243.57	317.93	270.30	352.92	84
65	199.94	262.31	228.07	299.35	256.21	336.40	284.34	373.44	85
66	213.17	279.32	243.19	318.79	273.22	358.27	303.24	397.74	86
67	226.40	296.33	258.31	338.23	290.23	380.14	322.14	422.04	87
68	241.90	314.85	276.02	359.40	310.15	403.95	344.28	448.50	88
69	258.53	337.15	295.03	384.89	331.54	432.62	368.04	480.36	89
70	276.67	360.97	315.77	412.10	354.86	463.24	393.96	514.38	90

Need help with healthcare?

We've got your lifeline.

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



We've enhanced your plan without adding cost.

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

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

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

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

Questions? Call 855-423-8585



DID YOU KNOW?

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

Get more without spending more.



More than just peace of mind. Health Advocacy from Health Advocate

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

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



More than just cash benefits. Medical Bill Saver™ from Health Advocate

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

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



More than just care. Telemedicine from MeMD

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

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

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service Providers, and does not own or administer any of the products or services provided by the Value Added Service providers. Each Value-Added Service Provider offers its products and services subject to its own terms, limitations and exclusions. Value Added Services are not available in Idaho or Minnesota. Value Added Services are also not available with group plans underwritten by American Family Life Assurance Company of New York. State availability may vary.

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

Telemedicine by MeMD

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

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

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. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

Continuation of Benefits Options If You Leave Your Employment with Randolph County Government

CIGNA Medical Plans

Under the group medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA if you experience certain “qualifying events”.

If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue medical coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. For more information, call **FBA at (800) 437-3539**.

Medical Reimbursement Account:

Under the Flexible Benefit Administrators Medical Spending Account plan, you are eligible to continue coverage through COBRA.

If you are enrolled in the Medical Reimbursement Account, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. You will receive notification from Flexible Benefit Administrators (FBA) with your account balance and continuation options shortly following your termination of employment. You may call **FBA at 1-800-437-3539**.

Ameritas Dental:

Under the dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child ages out of the plan. You will receive notification from Flexible Benefit Administrators (FBA) with premium and continuation options shortly following your termination of employment or you may call them at **1-800-437-3539**.

EyeMed Vision

Under the EyeMed Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA.

Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child ages out of the plan. For more information, call **Flexible Benefit Administrators at 1-800-437-3539.**

Aflac Accident and Critical Illness Plans

You may continue your policy(ies) by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, contact **Aflac/CAIC at 1-800-433-3036**

AUL Short and Long Term Disability Plans

Once an employee is on the AUL disability plan(s) for 3 months, you can port the coverages 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.**

Allstate Cancer Plan

Allstate Benefits will provide portability coverage providing you send a written request and payment of the first premiums for the portability coverage not later than 63 days after termination. For details call **Allstate at: 1-800-521-3535**

Texas Whole Life

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Texas Life at: 1-800-283-9233 prompt #3.**

Metlife Term Life

Conversion: If your employment terminates while you and/or your dependents are covered under the plan or when your Extended Death Benefit period is over, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within **30** days after the date your or your dependents' coverage terminates. **It is the responsibility of the employee to contact Metlife if you wish to pursue the conversion option. You may do so by calling 1-877-275-6387.**

Portability: If you terminate employment, the portability provision allows you to take your **Optional life** coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your employment terminates.
- You must be **ACTIVELY** at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

It is the responsibility of the employee to contact MetLife if you wish to port your current coverage. You may do so by calling 1-877-275-6387.

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

Important Phone Numbers

Flexible Benefit Administrators - 1-800-437-FLEX (3539)

Ameritas Life (Dental) - 1-800-487-5553

EyeMed (Vision) - 1-866-289-0614

Aflac (CAIC) - (Accident or Critical Illness) - 1-800-433-3036

Allstate Life (Cancer) - Customer Service: 1-800-521-3535

Assurity Life (Old Cancer Policy) - Customer Service: 1-866-289-7337

To Call in a Wellness Claim: 1-888-358-8808, ext. 23

To Fax in a Wellness Claim: 1-800-869-0368

American United Life (Disability)

Customer Service: 1-800-553-5318

Claims: 1-855-517-6365

MetLife (Term Life)

Customer Service - 1-800-638-6420

Conversion/ Portability - 1-877-275-6387

Texas Life (Whole Life) - 1-800-283-9233

MetLife Whole Life (Old Whole Life Coverage) 1-800-634-5007

Mark III Employee Benefits: 1-800-532-1044, Ext. 212

**To Download Claim Forms go to the
Randolph County Government/ Mark III Website:**

www.markiiibrokerage.com/randolphcountync

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:**
www.markiiibrokerage.com/randolphcountync

OR

scan this QR with your smartphone!*



***-3rd party iOS or Android app required**

Arranged and Enrolled by Mark III Brokerage, Inc.



Mark III
Employee Benefits

211 Greenwich Road
Charlotte, NC 28211

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

learn more at: www.markiiieb.com