



July 1, 2019 – June 30, 2020

Employee Benefits Guide

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

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



DISCLAIMER

This guide is a brief summary of benefits offered to your group and does not constitute a policy.

Your employer may amend the benefits program at any time. Your Summary Plan Description (SPD) will contain the actual detailed provisions of your benefits. The SPD will be available at mymarkiii.com

If there are any discrepancies between the information in this guide and the SPD, the language in the SPD will always prevail.

Important Points for 2019 - 2020

- Annual Open Enrollment Information - Your plan year runs from July 1, 2019 to June 30, 2020. This means your benefit elections will take effect July 1, 2019.
- New Hire Information – Benefits will be effective on the first of the month following 30 days after the date of hire.
- Once the enrollment period is over, you **will not be able to make changes** unless you experience a qualified life event as outlined by the IRS.



Qualifying Life Events

Open Enrollment selections are generally locked for the plan year, but certain exceptions called Qualifying Life Events (QLEs) can grant you a special enrollment period in which to make midyear changes. You are permitted to change benefit elections if you have a “change in status” and you make an election change that is consistent with the “change in status.”

Examples of QLEs

The following events will open a special 30-day enrollment period from the date of the event, allowing you to make changes to your coverage.



marriage



divorce



**childbirth/
adoption**



**death of a
family
member**



**loss of
parental
coverage**



**spouse gains or
loses coverage**



Hi, Randolph County Employee!

I'm here to help guide you through the benefits offered by your employer. If you have any questions regarding your benefits, please feel free to contact me at:

Cindy Hayden
(800) 532-1044 (toll -free)
(704) 365-4280 x217
cindyh@markiii.com

As stated in the disclaimer, this guide is simply a brief summary of benefits offered and does not constitute a policy. Before we review benefits offered, let's look at the difference in pre-tax vs posttax benefits.

Pre-Tax

A "pre-tax basis" means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or until you have a qualifying change in your status (i.e. birth of a child, divorce, separation, reduction in hours, etc.). If your premiums are deducted on a pre-tax basis, any benefits received under the plan could be treated as taxable income.

VS.

Post-Tax

A "post-tax basis" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. Although you do not get any savings from taxes, you have the flexibility of dropping your coverage at any time. If your employer allows, you may also enroll any time during the year but, depending on the plan, you may be subject to waiting periods for pre-existing conditions, or you may have to furnish Evidence of Insurability (EOI).

Pre-Tax Plans Offered:

- CIGNA Consumer Driven Health Plan w/ HSA
- CIGNA Traditional PPO Health Plan
- Health Plan Cost
- FBA Flexible Spending Accounts
- Ameritas Dental
- EyeMed Vision
- Aflac Group Accident
- Allstate Cancer & Specified Disease

Post-Tax Plans Offered:

- Aflac Group Critical Illness
- AUL Short-Term Disability
- AUL Long-Term Disability
- MetLife Term Life
- Texas Life Whole Life

View Your Benefits

Find details about all of your benefits, download forms, submit claims, ask questions, and more at mymarkiii.com.



- ✓ Benefits Guide
- ✓ Product Videos
- ✓ Policy Certificates
- ✓ Plan Forms
- ✓ Contact Info
- ✓ Enrollment Info

Available 24/7* from any internet enabled device for your convenience.

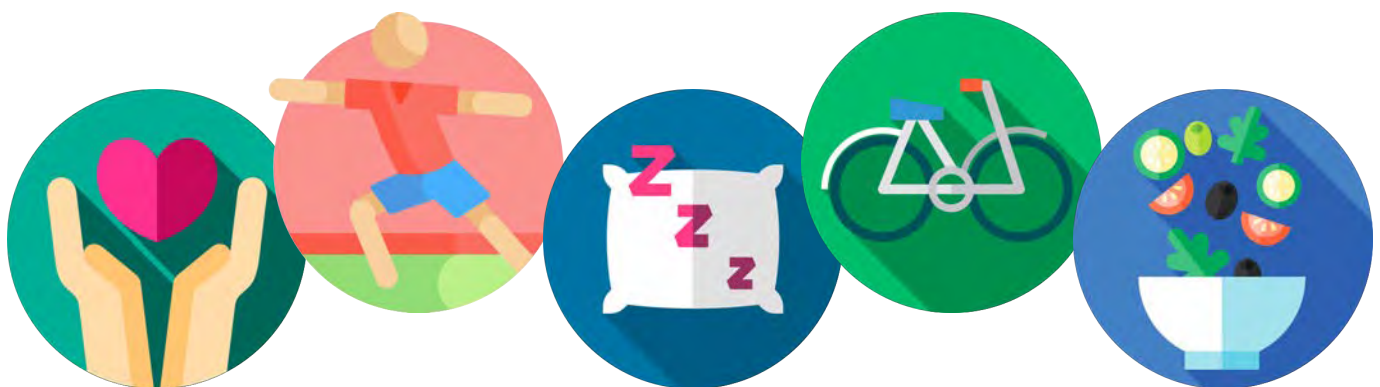
**-As with all technology, due to technical difficulties beyond our control there may be small windows of time the benefits website is down. In the case of outage, plan information can always be requested from your HR office or Mark III Employee Benefits*

Filing a Claim?

Filing a claim with Aflac just got easier! Introducing Online Claim Submission for all of your Aflac Plans!

Simply log on to <https://www.aflacgroupinsurance.com/customer-service/default.aspx> to file a Wellness/Health Screening Benefit claim or a claim for your Aflac Accident or Critical Illness plan.

Plan Name	Wellness Benefit Amount	Am I Enrolled?	Date Claim Filed
Aflac Accident	\$60		
Aflac Critical Illness (Employee/Spouse Only)	\$100		





CORE BENEFITS

Medical, Dental, &
Vision options to
keep you and your
family healthy.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Randolph County: Open Access Plus

Coverage Period: 07/01/2018 - 06/30/2019
Coverage for: Individual/Individual + Family | **Plan Type:** OAP



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.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For <u>in-network providers</u>: \$1,500/individual or \$3,000/family For <u>out-of-network providers</u>: \$3,000/individual or \$6,000/family Combined medical/behavioral and pharmacy <u>deductible</u> Deductible per individual applies when the employee is the only individual covered under the <u>plan</u>.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. <u>In-network preventive care & immunizations</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For <u>in-network providers</u> \$3,500/individual or \$5,000/family For <u>out-of-network providers</u> \$7,000/individual or \$10,000/family Combined medical/behavioral and pharmacy <u>out-of-pocket limit</u></p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, the overall family <u>out-of-pocket limit</u> must be met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for failure to obtain <u>pre-authorization</u> for services, <u>premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</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 <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance/visit</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance/visit</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge/ <u>visit</u> ** No charge/ <u>screening</u> ** No charge/ <u>immunizations</u> ** ** <u>Deductible</u> does not apply	Not covered/ <u>visit</u> 40% <u>coinsurance/screening</u> Not covered/ <u>immunizations</u>	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
	<u>Imaging</u> (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)	
<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)	20% coinsurance/prescription (retail) ; 20% coinsurance/prescription (home delivery)	Not covered	<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 must be ordered through Caremark Specialty Pharmacy 1-800-237-2767 . Limited to a 30 day supply.</p>
	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	
<p>If you have outpatient surgery</p>	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
<p>If you need immediate medical attention</p>	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	50% penalty for no precertification.
<p>If you have a hospital stay</p>	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% penalty for no precertification.
	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	None
<p>If you need mental health, behavioral health, or substance abuse services</p>	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% <u>coinsurance</u>	40% <u>coinsurance</u>	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	16 hour maximum per day
	Rehabilitation services	20% <u>coinsurance</u> /visit	40% <u>coinsurance</u> /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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.
	Hospice services	20% <u>coinsurance</u> /inpatient; 20% <u>coinsurance</u> /outpatient services	40% <u>coinsurance</u> /inpatient; 40% <u>coinsurance</u> /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 <u>hospice services</u> .

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)

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.cciio.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): Dine'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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Randolph County: Open Access Plus

Coverage Period: 07/01/2018 - 06/30/2019
Coverage for: Individual/Individual + Family | **Plan Type:** OAP



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.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For <u>in-network providers</u>: \$2,000/individual or \$4,000/family For <u>out-of-network providers</u>: \$4,000/individual or \$8,000/family</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own <u>individual deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall <u>family deductible</u>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. <u>In-network preventive care</u> & immunizations, office visits, <u>urgent care</u> facility visits, generic <u>prescription drugs</u>, <u>In-network diagnostic colonoscopy</u> and early cancer detection test are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes, \$150/individual or \$300/family for brand <u>prescription drugs</u>. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For <u>in-network providers</u> \$4,000/individual or \$10,000/family For <u>out-of-network providers</u> \$8,000/individual or \$20,000/family Combined <u>medical/behavioral</u> and <u>pharmacy out-of-pocket limit</u></p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall <u>family out-of-pocket limit</u> has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for failure to obtain <u>pre-authorization</u> for services, <u>premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</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 <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit Deductible does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit Deductible does not apply	40% <u>coinsurance</u>	None
	Preventive care/ <u>screening</u> / immunization	No charge/visit** No charge/ <u>screening</u> ** No charge/ <u>immunizations</u> ** ** <u>Deductible</u> does not apply	Not covered/visit 40% <u>coinsurance</u> / <u>screening</u> Not covered/ <u>immunizations</u>	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>	In-network diagnostic colonoscopy and early cancer detection test - No Charge
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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)	\$4 <u>copay/prescription</u> (retail); No charge/ <u>prescription</u> (home delivery) <u>Deductible</u> does not apply	<u>Copay</u> + charge over in-network allowed amount/ <u>prescription</u> (retail); Not covered (home delivery)	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 (Includes oral contraceptives) (Tier 4) 20% <u>coinsurance</u> / <u>prescription</u> \$50 minimum/ \$400 maximum (home delivery) <u>Deductible</u> does apply. Specialty medications must be ordered through Caremark Specialty Pharmacy 1-800-237-2767 . Limited to a 30 day supply.
	Preferred brand drugs (Tier 2)	\$45 <u>copay/prescription</u> (retail); \$90 <u>copay/prescription</u> (home delivery) <u>Deductible</u> does apply	<u>Copay</u> + charge over in-network allowed amount/ <u>prescription</u> (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	\$60 <u>copay/prescription</u> (retail); \$120 <u>copay/prescription</u> (home delivery) <u>Deductible</u> does apply	<u>Copay</u> + charge over in-network allowed amount/ <u>prescription</u> (retail); Not covered (home delivery)	
If you have outpatient surgery	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
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> <u>Deductible</u> does not apply	\$50 <u>copay/visit</u> <u>Deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay/office visit</u> ** 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
	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** \$50 copay /Specialist visit** ** Deductible does not apply	40% coinsurance /PCP visit 40% coinsurance /Specialist 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. Coverage is limited to 60 days annual max.
If your child needs dental or eye care	Hospice services	20% coinsurance /inpatient; 20% coinsurance /outpatient services	40% coinsurance /inpatient; 40% coinsurance /outpatient services	None
	Children's eye exam	Not covered	Not covered	50% penalty for failure to precertify inpatient hospice services .
	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.)	
<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)

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.cciio.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): Dine'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
Effective July 1, 2019

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.

**The MOOP includes a medical only deductible of \$2,000 single / \$4,000 family. Your pharmacy coverage does not apply to the medical only deductible. The separate pharmacy deductible and copays apply to the coinsurance maximums of \$2,000 single / \$6,000 family.*

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.

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

DRUGS COVERED*(continued)

- 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)
- Hormone replacement rings (Estring & Femring) \$150.00 for 90-day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes and lancets
(Diabetic medications (generic and brand) and supplies are covered at a \$0 copay if the member is enrolled in the Disease Management Program)
- 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
- Formulary Exclusion List including low clinical value drugs, new to market drugs, and non-essential drugs
- 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.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.

***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.

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

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.

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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 Driver Plan with an HSA AmWell \$49/MDLIVE \$45 Once deductible is paid, insurance pays 80%
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*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.

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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 2019-2020

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee <u>without wellness incentive</u>
Employee Only	\$680	\$0	\$50
Employee/Spouse	\$1,105	\$425	\$475
Employee/Child(ren)	\$993	\$313	\$363
Employee/Family	\$1,229	\$549	\$599

Premiums for Consumer Driven Plan with Health Savings Account (HSA) 2019-2020

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee without wellness incentive
Employee Only	\$680	\$0	\$50
Employee/Spouse	\$1,059	\$379	\$429
Employee/Child(ren)	\$964	\$284	\$334
Employee/Family	\$1,177	\$497	\$547

*Monthly Premium includes county contribution for employees plus the cost of dependent coverage, County HSA contribution on \$750, will be made at the beginning of the plan year, provided that the account has been set up by the employee.



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, 2019 and ends on June 30, 2020. 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. De-ductions begin on the first pay period following your plan start date. You must complete an enrollment to participate in the Flexible Spend-ing 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 \$2,700.

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.



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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 <https://fba.wealthcareportal.com> 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.



Dental Plan

Proper dental care is important and taking care of your oral health is an investment in your overall wellbeing. Your coverage is provided by Ameritas and it covers preventative, basic, and major dental procedures.

Procedures (Low and High Plan)

Type 1 – Preventative 100%	Type 2 – Basic 80%	Type 3 – Major 50%
Evaluations (2 per benefit period)	Sealants (under 17)	Endodontics (nonsurgical and surgical)
Cleanings (2 per benefit period)	Limited Exams	Periodontics (nonsurgical and surgical)
Fluoride for Children (under age 19)	Restorative Amalgam & Resin (excluding inlays & crowns)	Crowns (1 in 5 years per tooth)
Space Maintainers	Oral Surgery – Complex & Simple Extractions	Prostodontics (Bridges, Dentures) (1 in 5 years)
Radiographs (X-rays)	Denture Repair	
Bitewings (2 per benefit period)	Anesthesia	

Deductible – Type 1 Services	Deductible – Type 2 Services	Deductible – Type 3 Services
\$0	\$50 per person, per calendar year	\$50 per person, per calendar year

	Low Plan	High Plan
Claims Allowance	80 th U&C	Maximum Allowable Benefit

Orthodontia Summary – Adult Ortho Included	
Plan Benefit	50%
Lifetime Maximum	\$1,000
Lifetime Deductible	\$0

Benefit Year Maximum for Type 1 and 2 Services – Per Person, Per Calendar Year: \$1000 (Low and High Plan)
When 3 family members satisfy their deductible amounts for the benefit period, no additional deductibles will apply to any family members for the rest of this benefit period.





Dental Plan

Dental Rewards

Your dental plan includes Dental Rewards as a way to grow your annual maximum benefit. Simply by visiting a dental provider each year and submitting a claim, you can increase your annual maximum benefit over time. After your initial benefit is used, accumulated rewards are there to help pay for more expensive procedures, such as root canals or crowns.

Here's how it works. For each year, you submit at least one dental claim and your total dental benefits paid for the year are at or under \$500 you qualify to carry over \$250 in rewards to the following year. You may accumulate rewards up to the maximum amount of \$1000. Please note, if you do not submit a dental claim during the year, no rewards are earned and accumulated rewards are reset to zero. However, you can start qualifying for rewards again the very next year.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Dental Network Information

To find a provider, visit www.ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by locations or for a specific dentist or practice.

Monthly Rates (12 deductions)

Covered	High Plan	PPO Plan
Employee Only	\$32.32	\$25.98
Employee + Spouse	\$66.38	\$52.80
Employee + Dependent Child(ren)	\$73.80	\$57.78
Employee, Spouse, + Dependent Child(ren)	\$107.86	\$84.60





Vision Plan

We need to take care of our eyes like we take care of our bodies and teeth; care should be preventative, not reactive. Many simple vision problems go undiagnosed. A comprehensive eye exam is not only important to your vision, but can help your eye care provider identify other systematic issues such as diabetes, hypertension, and high cholesterol.

EyeMed has re-envisioned the world of vision benefits. In our world, members are at the heart of everything we do, so whether you have an existing vision correction need or you rely on annual eye exams to keep your vision healthy and sharp, you can feel confident knowing you get more to love with EyeMed.

	Frequency	EyeMed Access Network	Non-Network
Copay		\$10 Exam \$10 Eye Glass Lenses	No Deductible
Annual Eye Exam	12 Months	Covered in Full	Up to \$35.00
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular Progressive	12 Months	Covered in Full Covered in Full Covered in Full 20% Discount See lens options	Up to \$25.00 Up to \$40.00 Up to \$55.00 No Benefit N/A
Contact Lenses (per pair) Medically Necessary Cosmetic (Elective)	12 Months	Covered in Full Up to \$150.00	Up to \$200.00 Up to \$120.00
Contacts Fit & Follow Up Exams	12 Months	Member cost up to \$55	No Benefit
Frames (Standard)	24 Months	\$150	Up to \$75.00

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





STAY WELL

Voluntary Benefit
Options that
enhance your and
your family's well
being.



Cancer Plan

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 cancer insurance can provide security when you need it most.

Plan Features

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability is required at initial enrollment
- 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 (see next page)
- Portable coverage

Benefits *(See full terms and conditions for each benefit in the SPD as each vary.)*

Benefit	Benefit Amounts
Continuous Hospital Confinement	\$100 benefit per each day
Government or Charity Hospital	\$100 benefit per each day
Surgery	Up to \$3000 benefit
Second Opinion	\$400 benefit
Physical or Speech Therapy	\$50 benefit per each day
Anesthesia	25% of the surgery benefit
Ambulatory Surgical Center	\$500 benefit
Radiation/Chemotherapy for Cancer	Up to \$10,000 per 12 month period
Anti- Nausea	Up to \$200 per calendar year
Inpatient Drugs and Medicine	\$25 benefit per day (does not pay for drugs covered under radiation or anti-nausea)





Cancer Plan

Benefits (See full terms and conditions for each benefit in the SPD as each vary.)

Benefit	Benefit Amounts
Hematological Drugs	Up to \$200 benefit
Medical Imaging	Actual cost up to \$500 benefit
Private Duty Nursing Services	\$100 per day while confined
New or Experimental treatment	Actual charges up to \$5000 per 12 month period
Blood, Plasma, & Platelets	Up to \$10,000 per 12 month period
Physician's Attendance	\$50 paid for visit during hospital confinement
At Home Nursing	\$100 per day
Prosthesis	Up to \$2,000 per amputation
Hair Prosthesis	\$25 every 2 years if hair loss experienced
Nonsurgical External Brest Prosthesis	Up to \$50
Ambulance	\$100 benefit paid
Hospice Care	\$100 paid if diagnosed by a physician as terminally ill under covered diseases
Extended Care Facility	\$100 paid for each day a person is confined
Outpatient Lodging	\$50 per day when receiving outpatient radiation, not obtained locally
Non-Local Transportation	\$0.40 per mile of actual cost of round trip on a common carrier
Family Member Lodging & Transportation	Up to \$50 per day for lodging and \$0.40 per mile of the actual cost of round trip on a common carrier





Cancer Plan

Benefits (See full terms and conditions for each benefit in the SPD as each vary.)

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.**

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; Pap Smear, including ThinPrep Pap Test; 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.

A \$100 benefit will be paid per calendar year per covered person age 50 and over and for covered persons age 40 and over who are at high risk for prostate cancer for the following wellness test: PSA Testing/Digital Rectal Examinations.





Cancer Plan

Optional Benefits (full description & qualifications in SPD)

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:

1. Hospital Intensive Care Unit Confinement \$600* - This benefit is for hospital intensive care unit confinement for any illness or accident.
2. Step-Down Hospital Intensive Care Unit Confinement \$300* - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.
3. 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 covered confinement in a hospital intensive-care unit for any covered illness or accident from the day of coverage.**

Coverage & Specified Diseases

Cancer, 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, Legionnaire's 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.





Cancer Plan

Monthly Rates

Option without Cancer Initial Diagnosis & Intensive Care	
Employee	\$20.07
Employee + Child(ren)	\$27.71
Employee + Spouse	\$30.96
Family	\$38.57

Option with Cancer Initial Diagnosis & Intensive Care	
Employee	\$26.06
Employee + Child(ren)	\$36.81
Employee + Spouse	\$41.50
Family	\$52.23





Accident Plan

Aflac Group Accident Insurance Plan

Plan Features

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

Eligibility

Issue Ages

Employee at least age 18

Spouse at least age 18

Children under age 26

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

Guaranteed-Issue

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

Portability

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/Wrist	\$2,250	\$2,000
Foot/Ankle/Knee Cap	\$2,250	\$2,000
Shoulder Blade/Collar Bone	\$1,800	\$1,600
Lower Jaw (Mandible)	\$1,800	\$1,600
Skull (Simple)	\$1,575	\$1,400
Upper Arm/Upper Jaw	\$1,575	\$1,400
Facial Bones (Except teeth)	\$1,350	\$1,200
Vertebral Processes	\$900	\$800
Coccyx/Rib/Finger/Toe	\$360	\$320





Accident Plan

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.





Accident Plan

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

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

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

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

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

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

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

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

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

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





Accident Plan

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

We will pay the amount shown for X-rays or doctor services.

For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident.

We will pay the Medical Fees Benefit:

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

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

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

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

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

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

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

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

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

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

Accident Follow-Up Treatment	
	\$25

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

Physical Therapy	
	\$25

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





Accident Plan

Air Ambulance	\$500
Ambulance	\$100

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

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

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

Blood/Plasma	\$100
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If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	\$500
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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
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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
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If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness	\$60
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This benefit is payable while coverage is in force. 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
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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.





Accident Plan

Hospital Confinement (per day) \$200

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

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

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

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

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

Hospital Intensive Care (per day) \$400

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

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

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

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

Dismemberment means:

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

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

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

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

Common carrier means:

- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; or





Accident Plan

- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

LIMITATIONS AND EXCLUSIONS

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

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- 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.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- Illegal Acts – participating or attempting to participate in an illegal activity or working at an illegal job.
- Sports – participating in any organized sport—professional or semiprofessional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Monthly Premium Rates

Employee	\$16.20
Employee + Spouse	\$23.16
Employee + Child(ren)	\$30.90
Employee + Family	\$37.86





Critical Illness Plan

Aflac Group Critical Illness Insurance Plan

Lump Sum Single Payment Policy / First Occurrence

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available from \$5,000 up to \$50,000 for employees and up to \$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 is available for all eligible employees. The following options are available: Up to **\$30,000** for employees and up to **\$15,000** for spouses with no participation requirement.

For employee amounts over **\$30,000** and spouse amounts over **\$15,000**:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages

Employee 18-69

Spouse 18-69

Children under age 26

Benefit-eligible employees, working at least **30** hours or more weekly, with at least **90** days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is eligible and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

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





Critical Illness Plan

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

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

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

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

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

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

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

Additional Benefits Rider

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

Heart Event Rider

Covered Surgeries and Procedures	Percentage of Face Amount
Category 1	
Coronary Artery Bypass Surgery	100%





Critical Illness Plan

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





Critical Illness Plan

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. Group Accident and Critical Illness Insurance are underwritten by 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.

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Critical Illness Plan

Monthly Rates

NON-TOBACCO: Employee

	\$5000	\$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

	\$5000	\$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

	\$5000	\$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

	\$5000	\$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





Short-Term Disability Plan

You insure your home, car, and other valuable possessions, so why not also protect what pays for all of 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.

Plan Features

- Choose to insure up to 70% of covered basic monthly earnings to a maximum monthly benefit of \$2,000
- 7 day elimination period for sickness and 0 for injury
- Benefit duration if continually disabled is 13 weeks
- 24 hour coverage on or off the job
- 3/12 Pre-Existing Condition Exclusion. 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 by, or resulting from that injury or sickness; and begins during the 12 months after the person's individual effective date.
- Maternity coverage subject to applicable pre-existing condition exclusion
- Recurrent disability. If you resume work for 30 consecutive workdays, additional disability is considered a new period.
- Annual enrollment for \$500-\$1000 without medical questions.
- 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)

Monthly Premium (13 Weeks)

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





Long-Term Disability Plan

You insure your home, car, and other valuable possessions, so why not also protect what pays for all of 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. Long Term Disability kicks in after 90 consecutive days out of work for a sickness or injury.

Plan Features

- Choose to insure up to 60% of covered basic monthly earnings to a maximum monthly benefit of \$2,000 in \$500 increments. Minimum benefit is \$500.
- 90 day elimination period for sickness or injury.
- Benefit duration of up to 5 years if disabled prior to age 61.
- 24 hour coverage on or off the job.
- 3/12 Pre-Existing Condition Exclusion.
- Annual enrollment for \$500-\$1000 without medical questions.
- 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)

Monthly Premiums

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

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. OneAmerica® is the marketing name for American United Life Insurance Company (AUL)®, a One America company. Products issued and underwritten by AUL.





Term Life Plan

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

To help meet this need, you have the opportunity to elect and pay for additional group life insurance to go along with any other life insurance coverage you may have.

Overview of Benefits Offered

- **Optional Employee Life Insurance:** You have the opportunity to elect additional group life insurance through payroll deduction.
- **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 and support if fulltime student in an accredited school or college.) Handicapped children can continue to be covered with no age limit as long as child is covered prior to 19 or to age 25 if full-time student.
- **Accelerated Life Benefit Option:** Under this option, if you are diagnosed as having 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.

Schedule of Benefits

- **Optional Employee Life Insurance:** 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.
 - Guaranteed issue coverage up to \$100,000 if elected when first eligible.
- **Optional Dependent Life Insurance:** Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.
 - \$10,000 for your spouse up to a maximum of \$100,000. Amounts over \$10,000 require Evidence of Insurability.
 - \$2,000 to \$10,000 per child. No Evidence of Insurability required.





Term Life Plan

Monthly Rates

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

Spouse rates are based on Employee age.

Coverage Amount	Under 25	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49
\$10,000	\$0.95	\$0.95	\$1.15	\$1.55	\$1.75	\$2.35
\$20,000	\$1.90	\$1.90	\$2.30	\$3.10	\$3.50	\$4.70
\$30,000	\$2.85	\$2.85	\$3.45	\$4.65	\$5.25	\$7.05
\$40,000	\$3.80	\$3.80	\$4.60	\$6.20	\$7.00	\$9.40
\$50,000	\$4.75	\$4.75	\$5.75	\$7.75	\$8.75	\$11.75
\$60,000	\$5.70	\$5.70	\$6.90	\$9.30	\$10.50	\$14.10
\$70,000	\$6.65	\$6.65	\$8.05	\$10.85	\$12.25	\$16.45
\$80,000	\$7.60	\$7.60	\$9.20	\$12.40	\$14.00	\$18.80
\$90,000	\$8.55	\$8.55	\$10.35	\$13.95	\$15.75	\$21.15
\$100,000	\$9.50	\$9.50	\$11.50	\$15.50	\$17.50	\$23.50
\$110,000	\$10.45	\$10.45	\$12.65	\$17.05	\$19.25	\$25.85
\$120,000	\$11.40	\$11.40	\$13.80	\$18.60	\$21.00	\$28.20
\$130,000	\$12.35	\$12.35	\$14.95	\$20.15	\$22.75	\$30.55
\$140,000	\$13.30	\$13.30	\$16.10	\$21.70	\$24.50	\$32.90
\$150,000	\$14.25	\$14.25	\$17.25	\$23.25	\$26.25	\$35.25
\$160,000	\$15.20	\$15.20	\$18.40	\$24.80	\$28.00	\$37.60
\$170,000	\$16.15	\$16.15	\$19.55	\$26.35	\$29.75	\$39.95
\$180,000	\$17.10	\$17.10	\$20.70	\$27.90	\$31.50	\$42.30
\$190,000	\$18.05	\$18.05	\$21.85	\$29.45	\$33.25	\$44.65
\$200,000	\$19.00	\$19.00	\$23.00	\$31.00	\$35.00	\$47.00





Term Life Plan

Monthly Rates

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

Coverage Amount	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
\$10,000	\$3.65	\$5.95	\$9.95	\$18.45	\$29.65
\$20,000	\$7.30	\$11.90	\$19.90	\$36.90	\$59.30
\$30,000	\$10.95	\$17.85	\$29.85	\$55.35	\$88.95
\$40,000	\$14.60	\$23.80	\$39.80	\$73.80	\$118.60
\$50,000	\$18.25	\$29.75	\$49.75	\$92.25	\$148.25
\$60,000	\$21.90	\$35.70	\$59.70	\$110.70	\$177.90
\$70,000	\$25.55	\$41.65	\$69.65	\$129.15	\$207.55
\$80,000	\$29.20	\$47.60	\$79.60	\$147.60	\$237.20
\$90,000	\$32.85	\$53.55	\$89.55	\$166.05	\$266.85
\$100,000	\$36.50	\$59.50	\$99.50	\$184.50	\$296.50
\$110,000	\$40.15	\$65.45	\$109.45	\$202.95	\$326.15
\$120,000	\$43.80	\$71.40	\$119.40	\$221.40	\$355.80
\$130,000	\$47.45	\$77.35	\$129.35	\$239.85	\$385.45
\$140,000	\$51.10	\$83.30	\$139.30	\$258.30	\$415.10
\$150,000	\$54.75	\$89.25	\$129.25	\$276.75	\$444.75
\$160,000	\$58.40	\$95.20	\$159.20	\$295.20	\$474.40
\$170,000	\$62.05	\$101.15	\$169.15	\$313.65	\$504.05
\$180,000	\$65.70	\$107.10	\$179.10	\$332.10	\$533.70
\$190,000	\$69.35	\$113.05	\$189.05	\$350.55	\$563.35
\$200,000	\$73.00	\$119.00	\$199.00	\$369.00	\$593.00

Monthly Rates for Dependent Children

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



Whole Life Plan

Whole Life Insurance is an ideal complement to any group term or optional term life insurance your employer might provide. Texas Life's **SOLUTIONS 121** is the life insurance you keep, even if you change jobs or retire as long as you pay premiums. It will help protect your family today, and more importantly tomorrow. And, you won't have to pay for it after age 65 (or 20 years if you purchased the policy after age 45), because it's guaranteed to be paid up.

Plan Features

- Permanent and yours to keep when you change jobs or retire.
- Non-participating Whole Life (no dividends).
- Coverage begins immediately – 2 year suicide & contestability provisions apply (one year in ND).
- Guaranteed death benefit.
- Guaranteed paid-up insurance at age 65, or 20 years if you purchased the policy after age 45.
- If you're actively at work the day you enroll, you can qualify for basic amounts with no additional underwriting.
- Rates shown include Accelerated Death Benefit for Chronic Illness.
- Rates shown include Waiver of Premium for ages 17-59.
- If you desire more coverage, you may qualify by answering just four health questions¹.
- Coverage available for spouse, children, and grandchildren².

Sample Rates

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

1- Coverage will depend on the answer to these questions

2- Coverage not available on children in WA or on grandchildren in WA and MD. In MD, child must reside with the applicant to be eligible for coverage.

Policy Form ICC11-WLOTO-NI-11 or Form Series WLOTO-NI-11.

18M113-C 1078 R0219 (exp1020)



TEXAS LIFE SOLUTIONS SERIES 121

MONTHLY – WAIVER &
CHRONIC ILLNESS

TIER 1/TIER 2 COMBO — MONTHLY PREMIUMS									
Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages)									PAID UP For UFA* At Attained Age
IFA* ⇒	\$ 10,000		\$ 15,000		\$ 25,000		\$ 30,000		
UFA* ⇒	\$ 10,000		\$ 15,000		\$ 25,000		\$ 30,000		
(ALB)	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	
17	9.67	11.21	12.86	15.16	19.23	23.07	22.42	27.02	65
18	10.03	11.56	13.39	15.69	20.12	23.95	23.48	28.08	65
19	10.03	11.68	13.39	15.87	20.12	24.25	23.48	28.43	65
20	10.26	12.03	13.75	16.40	20.71	25.13	24.19	29.50	65
21	10.38	12.27	13.92	16.75	21.00	25.72	24.54	30.20	65
22	10.62	12.50	14.27	17.11	21.59	26.31	25.25	30.91	65
23	10.97	12.86	14.81	17.64	22.48	27.20	26.31	31.97	65
24	11.09	13.21	14.98	18.17	22.77	28.08	26.66	33.04	65
25	11.32	13.57	15.34	18.70	23.36	28.97	27.37	34.10	65
26	11.80	13.92	16.04	19.23	24.54	29.85	28.79	35.16	65
27	12.15	14.39	16.58	19.94	25.43	31.03	29.85	36.58	65
28	12.62	14.86	17.29	20.65	26.61	32.21	31.27	37.99	65
29	13.09	15.45	18.00	21.54	27.79	33.69	32.68	39.76	65
30	13.33	16.04	18.35	22.42	28.38	35.16	33.39	41.53	65
31	14.04	16.75	19.41	23.48	30.15	36.93	35.51	43.66	65
32	14.75	17.46	20.47	24.54	31.92	38.70	37.64	45.78	65
33	15.34	18.29	21.35	25.78	33.39	40.77	39.41	48.26	65
34	15.69	18.99	21.89	26.85	34.28	42.54	40.47	50.38	65
35	16.28	19.94	22.77	28.26	35.75	44.90	42.24	53.21	65
36	17.11	20.88	24.01	29.68	37.82	47.26	44.72	56.05	65
37	18.05	21.94	25.43	31.27	40.18	49.91	47.55	59.23	65
38	18.88	23.12	26.66	33.04	42.24	52.86	50.03	62.77	65
39	20.29	24.54	28.79	35.16	45.78	56.40	54.28	67.02	65
40	21.00	25.72	29.85	36.93	47.55	59.35	56.40	70.56	65
41	22.18	27.25	31.62	39.24	50.50	63.19	59.94	75.16	65
42	23.24	28.91	33.22	41.71	53.16	67.32	63.13	80.12	65
43	24.42	30.68	34.99	44.36	56.11	71.74	66.67	85.43	65
44	26.07	32.80	37.47	47.55	60.24	77.05	71.62	91.80	65
45	27.73	35.04	39.94	50.92	64.37	82.66	76.58	98.53	65
46	28.79	36.58	41.53	53.21	67.02	86.49	79.76	103.13	66
47	29.97	38.11	43.30	55.52	69.97	90.33	83.30	107.73	67
48	31.27	39.76	45.25	58.00	73.22	94.46	87.20	112.69	68
49	32.68	41.41	47.38	60.48	76.76	98.59	91.45	117.64	69
50	33.74	42.12	48.97	61.54	79.41	100.36	94.63	119.77	70
51	35.04	44.01	50.92	64.37	82.66	105.08	98.53	125.43	71
52	36.46	45.78	53.04	67.02	86.20	109.50	102.77	130.74	72
53	37.99	47.79	55.34	70.03	90.03	114.52	107.38	136.76	73
54	39.64	50.03	57.82	73.39	94.16	120.12	112.33	143.48	74
55	40.35	51.33	58.88	75.34	95.93	123.37	114.46	147.38	75
56	41.77	53.33	61.00	78.35	99.47	128.38	118.70	153.40	76
57	44.01	55.46	64.37	81.53	105.08	133.69	125.43	159.77	77
58	46.02	58.05	67.37	85.43	110.09	140.18	131.45	167.56	78
59	47.67	60.88	69.85	89.68	114.22	147.26	136.40	176.05	79
60	46.20	58.84	67.80	86.75	111.00	142.59	132.60	170.51	80
61	48.68	61.86	71.53	91.29	117.21	150.15	140.05	179.58	81
62	51.06	65.42	75.09	96.64	123.15	159.06	147.18	190.27	82
63	53.33	69.20	78.49	102.31	128.82	168.51	153.98	201.61	83
64	56.46	72.98	83.19	107.98	136.65	177.96	163.38	212.95	84
65	59.27	77.09	87.40	114.13	143.67	188.22	171.80	225.26	85
66	63.05	81.95	93.07	121.42	153.12	200.37	183.14	239.84	86
67	66.83	86.81	98.74	128.71	162.57	212.52	194.48	254.42	87
68	71.26	92.10	105.38	136.65	173.64	225.75	207.77	270.30	88
69	76.01	98.47	112.51	146.21	185.52	241.68	222.02	289.42	89
70	81.19	105.28	120.29	156.41	198.48	258.69	237.58	309.83	90

*IFA = Initial Face Amount. UFA = Ultimate Face Amount. Gray areas require Tier 2 Underwriting.
Underwriting requirements will vary depending on plan year, participation rates and other factors.
For more information see Group Enrollment Guide.

Form: 11Mo35-1 (B2) B-M-3WS



TEXAS LIFE SOLUTIONS SERIES 121

MONTHLY – WAIVER &
CHRONIC ILLNESS

TIER 1/TIER 2 COMBO — MONTHLY PREMIUMS

Includes additional cost for Waiver of Premium Benefit (ages 17-59) & Chronic Illness (all issue ages)									PAID UP For UFA* At Attained Age
IFA* ⇒	\$ 50,000		\$ 75,000		\$ 100,000		\$ 150,000		
UFA* ⇒	\$ 50,000		\$ 75,000		\$ 100,000		\$ 150,000		
(ALB)	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	
17	35.16	42.83	51.09	62.60	67.02	82.36	98.88	121.89	65
18	36.93	44.60	53.75	65.25	70.56	85.90	104.19	127.20	65
19	36.93	45.19	53.75	66.14	70.56	87.08	104.19	128.97	65
20	38.11	46.96	55.52	68.79	72.92	90.62	107.73	134.28	65
21	38.70	48.14	56.40	70.56	74.10	92.98	109.50	137.82	65
22	39.88	49.32	58.17	72.33	76.46	95.34	113.04	141.36	65
23	41.65	51.09	60.83	74.99	80.00	98.88	118.35	146.67	65
24	42.24	52.86	61.71	77.64	81.18	102.42	120.12	151.98	65
25	43.42	54.63	63.48	80.30	83.54	105.96	123.66	157.29	65
26	45.78	56.40	67.02	82.95	88.26	109.50	130.74	162.60	65
27	47.55	58.76	69.68	86.49	91.80	114.22	136.05	169.68	65
28	49.91	61.12	73.22	90.03	96.52	118.94	143.13	176.76	65
29	52.27	64.07	76.76	94.46	101.24	124.84	150.21	185.61	65
30	53.45	67.02	78.53	98.88	103.60	130.74	153.75	194.46	65
31	56.99	70.56	83.84	104.19	110.68	137.82	164.37	205.08	65
32	60.53	74.10	89.15	109.50	117.76	144.90	174.99	215.70	65
33	63.48	78.23	93.57	115.70	123.66	153.16	183.84	228.09	65
34	65.25	81.77	96.23	121.01	127.20	160.24	189.15	238.71	65
35	68.20	86.49	100.65	128.09	133.10	169.68	198.00	252.87	65
36	72.33	91.21	106.85	135.17	141.36	179.12	210.39	267.03	65
37	77.05	96.52	113.93	143.13	150.80	189.74	224.55	282.96	65
38	81.18	102.42	120.12	151.98	159.06	201.54	236.94	300.66	65
39	88.26	109.50	130.74	162.60	173.22	215.70	258.18	321.90	65
40	91.80	115.40	136.05	171.45	180.30	227.50			65
41	97.70	123.07	144.90	182.96	192.10	242.84			65
42	103.01	131.33	152.87	195.35	202.72	259.36			65
43	108.91	140.18	161.72	208.62	214.52	277.06			65
44	117.17	150.80	174.11	224.55	231.04	298.30			65
45	125.43	162.01	186.50	241.37	247.56	320.72			65
46	130.74	169.68	194.46	252.87	258.18	336.06			66
47	136.64	177.35	203.31	264.38	269.98	351.40			67
48	143.13	185.61	213.05	276.77	282.96	367.92			68
49	150.21	193.87	223.67	289.16	297.12	384.44			69
50	155.52	197.41							70
51	162.01	206.85							71
52	169.09	215.70							72
53	176.76	225.73							73
54	185.02	236.94							74
55	188.56	243.43							75
56	195.64	253.46							76
57	206.85	264.08							77
58	216.88	277.06							78
59	225.14	291.22							79

*IFA = Initial Face Amount. UFA = Ultimate Face Amount.
Gray areas require Tier 2 Underwriting.
Underwriting requirements will vary depending on plan year, participation rates and other factors. For more information see Group Enrollment Guide.

RATES FOR INDIVIDUAL POLICIES FOR CHILDREN AND GRANDCHILDREN¹

MONTHLY PREMIUMS FOR LIFE INSURANCE COVERAGES SHOWN

Issue Age	\$10,000	\$25,000	Policy is Paid Up at Attained Age	Issue Age	\$10,000	\$25,000	Policy is Paid Up at Attained Age
15d-1	\$6.35	\$11.37	65	9	\$7.21	\$13.53	65
2	\$6.35	\$11.37	65	10	\$7.32	\$13.80	65
3	\$6.46	\$11.64	65	11	\$7.54	\$14.34	65
4	\$6.56	\$11.91	65	12	\$7.75	\$14.88	65
5	\$6.67	\$12.18	65	13	\$7.97	\$15.42	65
6	\$6.78	\$12.45	65	14	\$8.18	\$15.96	65
7	\$6.89	\$12.72	65	15	\$8.40	\$16.50	65
8	\$7.00	\$12.99	65	16	\$8.62	\$17.04	65

¹In WA coverage is not available for children or grandchildren. Policies on children and grandchildren require Tier 2 underwriting.



Continuation of Benefits

If you leave employment

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

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call FBA at: 1-800-437-3539.

Ameritas Dental

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

EyeMed Vision

Under the group vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the same qualifying events listed above. Should you have any questions you may contact FBA at 1-800-437-3539.

Aflac Accident & Critical Illness

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

Allstate Cancer

You may continue your Allstate Cancer policy for yourself and eligible dependents who are covered when you terminate employment. For more information please contact: Allstate at 1-800-521-3535

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.

AUL Short & Long Term Disability

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

Texas Life Whole Life

When you leave employment, you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting Texas Life at: (800) 283-9233 prompt #2.



Contact Information

Flexible Benefit Administrators

1-800-437-FLEX (1-800-437-3539)

Fax: (757) 431-1155

FlexDivision@flex-admin.com

<https://fba.wealthcareportal.com>

Ameritas Dental

1-800-487-5553

Eye Med Vision

1-866-289-0614

Aflac

Customer Service

800-433-3036

Aflacgroupinsurance.com

Allstate Benefits

For questions concerning your policy please call:800-521-3535

For questions concerning claims please call:800-348-4489

American United Life (AUL)One America

Claims Toll-Free Number

855-517-6365

Customer Service

800-553-5318

Texas Life Insurance Company

PO Box 830

Waco, TX 76703-0830

800-283-9233

www.texaslife.com

MetLife Term Life

Customer Service: 1-800-638-6420

Conversion/Portability: 1-877-275-6387

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

MetLife Whole Life (Old Whole Life Coverage)

1-800-634-5007

Mark III Employee Benefits

Cindy Hayden

cindyh@markiiibrokerage.com

1-800-532-1044, Ext. 217

To Download Claim Forms go to the Randolph County Government/
Mark III Website: www.markiiibrokerage.com/randolphcountync





View additional benefits information
or download forms at:
mymarkiii.com

Arranged and Enrolled by Mark III Brokerage, Inc.



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