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Pre-Tax Plans

After-Tax Plans

For Your Reference

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

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnc.com or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family for in-network; **$4,000** person/**$8,000** family for out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes. $4,000** person/**$6,000** family for in-network; **$8,000** person/**$12,000** family for out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorizations for services, Premiums, balance-billed charges, copayments and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/content/	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term

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	providersearch/index.htm or please call 1-877-275-9787	in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	50% Coinsurance	---none---
	Specialist visit	20% Coinsurance	50% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	20% Coinsurance/ Chiropractic Visit	50% Coinsurance/ Chiropractic Visit	-- Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	50% Coinsurance	-- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	-- No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsnc.com/content/services/formulary/presdrugben.htm	Generic drugs	20% Coinsurance	20% Coinsurance	-- No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug.
	Preferred brand drugs	20% Coinsurance	20% Coinsurance	-- Same as above
	Non-preferred brand drugs	20% Coinsurance	20% Coinsurance	-- Same as above
	Specialty drugs	20% Coinsurance	20% Coinsurance	-- Coverage is limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	20% Coinsurance	20% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	-Precertification may be required
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	50% Coinsurance	Prior Authorization may be required
	Mental/Behavioral health inpatient services	20%Coinsurance	50% Coinsurance	Precertification required
	Substance use disorder outpatient services	20% Coinsurance	50% Coinsurance	Prior Authorization may be required
	Substance use disorder inpatient services	20% Coinsurance	50% Coinsurance	Precertification required
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	50% Coinsurance	---none---
	Delivery and all inpatient services	20% Coinsurance	50% Coinsurance	Precertification may be required
If you need help recovering or have	Home health care	20% Coinsurance	50% Coinsurance	-- Prior authorization required or services will not be covered

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
other special health needs	Rehabilitation services	20% Coinsurance	50% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic, and 30 visits per benefit period for Speech Therapy
	Habilitation services	20% Coinsurance	50% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic, and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	20% Coinsurance	50% Coinsurance	-- Coverage is limited to 60 days per benefit period.-- Precertification required
	Durable medical equipment	20% Coinsurance	50% Coinsurance	-- Prior authorization may be required for benefits to be provided-- Limits may apply
	Hospice services	20% Coinsurance	50% Coinsurance	-- Precertification may be required
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

*HSA/HRA funds, if available, may be used to cover eligible medical expenses
**Self-funded groups may cover this service; check your benefit booklet for details

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

***Self-funded groups may not cover this service; check your benefit booklet for details

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or **mybcbsnc.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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Language Access Services:

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

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,300
- **You pay** $3,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$3,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,100
- **Plan pays** $2,400
- **You pay** $2,700

Sample care costs:

Prescriptions	$2,700
Medical Equipment and Supplies	$1,200
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,100**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$600
Limits or exclusions	$50
Total	**$2,700**

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Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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DISCOUNTED RATES (With Biometric Participation) (Employer HSA Contribution - Up to $1,000)		
	Semi-Monthly	**Monthly**
Employee Only	**$0.00**	**$0.00**
Employee + Children	**$120.00**	**$240.00**
Employee + Spouse	**$225.50**	**$451.00**
Employee + Family	**$271.50**	**$543.00**

NON-DISCOUNTED RATES (Without Biometric Participation) (Employer HSA Contribution - $0)		
	Semi-Monthly	**Monthly**
Employee Only	**$52.00**	**$104.00**
Employee + Children	**$172.00**	**$344.00**
Employee + Spouse	**$277.50**	**$555.00**
Employee + Family	**$323.50**	**$647.00**

*Cleveland County contributes $635.00 per month toward the cost of the premium for each full-time employee. Rates for employees working less than full-time are prorated, based on the percentage of the time worked.

Employees/retirees who are identified for health coaching, case management, pre-diabetes/diabetes program and elect NOT to participate, will be charged the non-discounted premium for the remainder of the plan year.

Employees/retirees who elect to participate in the biometrics program, but fail to meet participation requirements of any component will default to the non-discounted premium for the remainder of the plan year.

Changes in Coverage
Changes in dependent coverage will be governed by IRS regulations for Flexible Benefits Programs, as follows:

Unless a Qualifying Event occurs, changes will be allowed only during Open Enrollment Period (changes effective July 1 of each year). Necessary forms must be completed prior to this date. Contact the Payroll Unit for completion of these forms.

Qualifying events, as determined by IRS, are:

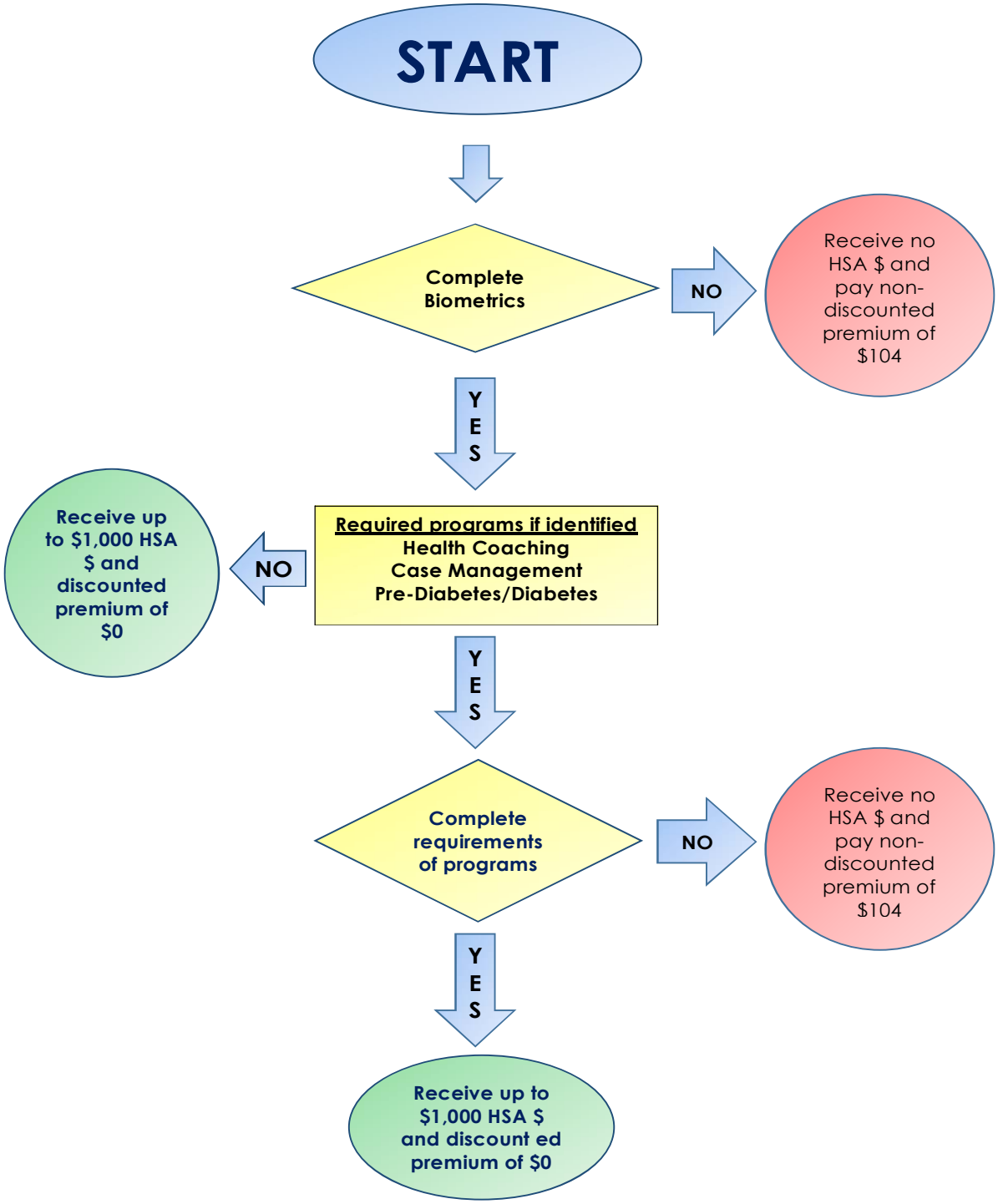
- Birth or Adoption of a Child
- Change in Spouse's Employment
- Child over age 26
- Death of a Spouse or Child
- Divorce
- Eligibility of Spouse for Medicare
- Marriage

It is your responsibility to notify payroll within 30 days when a dependent is not eligible for coverage.

Wellness Program

Cleveland County Government Wellness Program

Across the nation, healthcare costs continue to rise creating a burden for both employers and employees. Cleveland County's voluntary employee wellness program is designed to create a healthier work environment. Employees are focused on improving their personal health and controlling healthcare costs. Participation in the wellness program is completely voluntary and provides employees opportunities to receive premium savings as well as, for those that qualify, County paid HSA (Health Savings Account) contributions of up to $1,000.



Our wellness program is centered on our annual biometric screening which is provided at no cost to employees. By participating in the program, employees will learn more about their personal health, allowing them to take control of any health concerns that may be identified through the biometric screenings. The biometric screening consists of a blood draw/veni puncture, blood pressure reading, weight, and waist measurement. The blood draw is used to determine cholesterol levels and A1C levels. All of these factors are then measured against medical norms to determine any potential health risk.

HSA (Health Savings Account) Employer Contributions

The HSA (Health Savings Account) Employer Contribution is based on your Biometric Screening results. The County will reward you based on biometric performance as outlined in the chart below:

2015-2016 Biometric Parameters

Health Savings Account Employer Fund Contribution

EARN UP TO A TOTAL OF $1,000 HSA DOLLARS!

Risk Factor	High Risk	Moderate Risk	Low Risk
Waist Circumference	$0 HSA > or = 45'' Male > or = 40"Female	$90 HSA 40.1 - 44.99'' Male 35.1 - 39.99'' Female	$187.50 HSA < or = 40'' Male* < or = 35" Female*
Alternative	N/A	Lose 1 – 2 Inches	Lose > 2 Inches*
Prior Year Weigh In Alternative	N/A	$90 HSA Lose 5%	$187.50 HSA Lose 10%*
HSA Bonus	N/A	N/A	***$250 for meeting any low risk waist parameter**
Blood Pressure	$ N/A > 145/95 mmHg	$90 HSA 145/95 - 140/90 mmHg	$187.50 HSA < 140/90 mmHg
Cholesterol Ratio	$ N/A > or = 6.0	$90 HSA 5.51 - 5.99	$187.50 HSA < or = 5.50
Hemoglobin A1C	$ N/A > or = 7.0	$90 HSA 6.5 - 6.99	$187.50 HSA < or = 6.49

Medical Exceptions

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, you may want to request an alternative letter from Ashley Harris, Health Coach, during the biometric screenings. Ashley will contact your physician on your behalf to establish alternative goals.

Employees who choose to participate in the wellness program may be required to engage in the following programs, if identified, in order to be eligible for discounted premiums:

1. **Health Coaching**
2. **Case Management**
3. **Pre-Diabetes/Diabetes Program**

Health Coaching

Health coaches are specially-trained registered nurses who meet one-on-one with employees to work on behavior modification and help set personal health goals to improve their health and reduce future risk.

Employees with 2 risk factors will be required to attend 2 coaching sessions. Employees with 2+ risk factors will attend 4 sessions. These one-on-one sessions are geared toward identifying health goals aimed at improving health concerns identified in Biometric Screening. Ashley Harris, Health Coach, is located in the basement (Room B44) of the County Administration Building, 311 East Marion St. Contact Ashley at (704) 591-1099.

Case Management

Employees may be referred to case management by BCBSNC due to the complexity a health condition (for example, asthma, diabetes, cancer, heart disease, etc.) Employees are connected with a team of healthcare professionals, nurses, social workers, dieticians, etc., for personal one-on-one assistance in removing barriers to better managing their health. Employees identified for this program will be contacted directly by BCBSNC.

Pre-Diabetes or Diabetes Program

Employees identified for either program will be required to participate in this highly successful 12 month YMCA program. The program consists of 16 weekly classes and 8 monthly maintenance sessions. The goal of the program is a 7% weight loss and 150 minutes of weekly exercise. Employees will receive a FREE family YMCA membership for the duration of the program. Contact Jessica Bridges, Director, Diabetes Prevention and Control Program (704) 669-3631 for more information.

Employees may elect to participate in the following Cleveland County wellness programs designed to provide opportunities for employees to improve their health status. Health improvement makes for happier, more productive employees. Health improvement also reduces health costs, allowing the County to reinvest dollars into improved benefits and pay.

DO YOU WANT TO EAT BETTER?
We have a program for you!

Eat Smart, Move More, Weigh Less
ESMMWL is a 15 week online weight management program provided by BCBSNC. Classes are conducted on-line but in real-time with a live instructor. Participants can also communicate with their instructor receiving encouragement and feedback. Participants will track daily intake, weight and physical activity. Register and pay $30 online. If you attend 10/15 sessions and meet tracking requirements you will receive a full $30 refund. Contact Kelly Nordby, Coordinator (919) 707-5397 for more information.

ESMMWL – 2015 Class Series Schedule	April 2015	May 2015	June 2015	August 2015	September 2015	October 2015
Starting Week	4/27/15	5/18/15	6/29/15	8/10/15	8/31/15	10/26/15
Ending Week	8/3/15	8/24/15	10/5/15	11/16/15	12/7/15	2/15/16
Deadline for Registration	4/24/15	5/15/15	6/26/15	8/7/15	8/28/15	10/23/15

Nutrition Counseling Services
Nutrition Counseling is available to Cleveland County Employees. These one-on-one sessions are geared toward addressing the following nutritional challenges, such as weight management, life stages, and various medical conditions. Employees may schedule an appointment with Carol W. Johnson, MS, RDN, LDN at the Cleveland County Administration Building (704) 734-5223. The cost of visits are covered at 100% on behalf of employees/dependents on the health plan.

DO YOU WANT TO MOVE MORE?
We have a program for you!

YMCA Discount Membership

Cleveland County has partnered with the YMCA to offer a phenomenal member discount which is payable by payroll deduction. Cleveland County provides a $10 subsidy toward each employee's membership. Enroll at the Dover YMCA located at 411 Cherryville Highway, Shelby, NC (704) 484-9622. Access will be granted to all three YMCA's in Cleveland County which include the Dover, Kings Mountain & Ruby Hunt locations.

Plans	**Semi-Monthly/Monthly Rates**	
Senior (60+)	$5.00	$10.00
Adult	$6.75	$13.50
Single Parent	$9.00	$18.00
Senior Family (60+)	$11.00	$22.00
Family	$14.00	$28.00
Retirees	Arrange direct bill through YMCA	

DO YOU WANT TO COMMIT TO QUIT?
We have a program for you!

Tobacco Cessation

Employees are encouraged to refrain from tobacco use as this has been linked to many serious health conditions. In support of employees who take the initiative to quit, tobacco cessation products are available AT NO COST to all full time employees at our Health Department Pharmacy. Employees are also encouraged to meet with our physician at the Wellness Center to develop a quit plan designed specifically for them. Studies show that participation in a support group can dramatically improve success rates for tobacco cessation. Fresh Start Classes are available through the Health Department at no cost to employees. For more information:

Wellness Center		(704) 484-5278
Pharmacy	Chris Breese, Pharmacist	(704) 484-5164
Fresh Start	Joyce King	(704) 484-5266

DO YOU WANT TO STRESS LESS?
We have a program for you!

EAP

Employee Assistance Program (EAP) is a free, CONFIDENTIAL, service that offers support and resources employees may need to address personal or work-related challenges and concerns. An EAP is designed to help with all kinds of life situations such as marital difficulties, family problems, parenting, grief, stress, depression, alcohol/drug abuse, elder care, crisis events, etc. Through your EAP, McLaughlin Young Employee Services, you and your family have access to hundreds of online articles, various elder care and child care locators, a savings center, health and wellness tools, and many interactive resources. Several online, legal and financial services are also available. To speak directly with a representative: Call EAP at (704) 529-1428 or 1-800-633-3353.

To access the work-life web site:

1. Visit www.myemployeeservices.com
2. Click on “Access your Work-Life Services”
3. Username: clevelandcounty2010 & Password: guest

DO YOU WANT TO MANAGE YOUR HEALTH?

We have a program for you!

Preventive Health Screenings

When it comes to treating potentially serious conditions, early diagnosis is key. If a specific condition runs in your family, it may be even more important that you get screened early and often to keep healthy.

Employees are encouraged to get their annual wellness/preventive screenings, which may include the following:

- Colonoscopy
- Flu Shots – provided annually at Health & Benefits Fair for employees covered on the health plan
- Lab Work – employees are encouraged to request that labs be drawn at the wellness center for visits with primary care providers
- Mammogram (Provided on site during the Health & Benefits Fair)
- Physical – provided at the Wellness Center to employees
- Vaccinations

Please note – Preventive care screenings are covered at 100% on our health plan regardless of any diagnosis detected during this preventive test.

Chronic Disease Management Program

Living Healthy with a Chronic Illness Workshop

This FREE workshop will take place once a week for 6 weeks. Each session is 2 ½ hours, and all workshops are facilitated by 2 trained leaders (Cindy Campos, RN & Debra Biddy, RN).

This workshop is appropriate for people living with a wide variety of chronic health conditions, such as arthritis, diabetes, heart disease, depression, anxiety, asthma and other chronic conditions or if you care for someone who has a chronic disease.

Participants will learn:

- techniques to deal with problems such as frustration, fatigue, pain and isolation
- appropriate management of medications
- healthy eating guidelines and exercise tips
- how to make informed treatment decisions
- and MUCH MORE

Workshops will be held on a weekday evening at the Health Dept. Employees may elect to enroll their spouses to attend with them. If you are interested in enrolling or have additional questions please contact Debra Biddy, RN (704) 669-3147 or email debra.biddy@clevelandcounty.com.

Cleveland County Employee Health and Wellness Center
Cleveland County is pleased to provide an Employee Health and Wellness Center (EHWC) for all Cleveland County employees and their family members. Retirees covered under Cleveland County's Health Insurance Plan may also participate.

Services:
EHWC offers a wide variety of healthcare services. These include but are not limited to:

- Sick Care for: Sinusitis, allergies, ear infections, urinary tract infections, insect bites prostatitis, vaginal infections, skin infections, and poison ivy.
- Annual Visits such as: after sports physicals, DOT physicals, sports physicals, and PAP smears.
- Musculoskeletal Complaints such as: Sprained ankles, knees and shoulders, and acute back pain.

Due to their commitment to high quality healthcare, the staff at EHWC strongly encourages EHWC patients to obtain and maintain a relationship with their primary care provider for all chronic healthcare issues. Parents of children less than six months of age should establish a relationship with a pediatrician or a qualified family practitioner for well and sick child visits. In addition, the EHWC does not provide services for:

- Workman's compensation
- ER follow-ups
- Hospital follow-ups
- Post motor vehicle accident care
- Chest Pain

Eligibility:
- Full and part time Cleveland County employees with and without Cleveland County health insurance.
- Spouses and dependent children (under age 26) of full time employees, regardless of whether they have Cleveland County Health insurance.
- Dependent over the age of 26 are not eligible.
- Retired employees with at least 20 years of service (not eligible at age 65) and their spouses and/or dependents if covered with COBRA insurance
- Former Cleveland County employees and their spouses/dependents that have COBRA health insurance coverage.
- Dependents of part time hourly employees and not eligible.
- All patients must have their current personal or insured family member's health insurance card to receive EHWC health services.
- Cleveland County Commissioner, spouses and dependent children to age 26, regardless of whether they have Cleveland County insurance.

Staffing:
Medical professionals staff the EHWC each workday. All personal medical services are ***confidential.***

Center Location and Hours:
The Employee Health and Wellness Center is located at 304 Crawford Street (behind the Ollie Harris Center). The center is open Monday through Friday from 8:00am until 12:00 noon and from 1:30pm to 5:00pm. The telephone number is (704) 484-5278. The center is closed on County observed holidays. Patients are encouraged to make an appointment to ensure timely service since appointments receive priority. An appointment is essential for annual physicals, DOT physicals, sports physicals and patients with multiple concerns.

Use of Sick Leave:
Visits to the Employee Health and Wellness Center will not be subject to sick leave if visiting during County work hours. Sick leave will not be charged to the employee if the employee can return to work after the visit. If the medical staff advises the employee to go home, sick leave usage begins at the time that the employee is released.

Fees:
All employees, retirees and family members will be charged a $5.00 co-pay for all services. Dependents not covered by insurance will have a $5.00 co-pay plus the cost of other services (i.e. lab fees/tests, etc).

The most recent insurance card must be provided to verify current coverage.

Cleveland County Employee Pharmacy Program
Prescriptions are available through a formulary system for county employees and their eligible immediate family members (spouse and dependent children) at the Cleveland County Health Department Pharmacy.

The pharmacy formulary has 3 price categories:
- Category 1 prescriptions are available at no cost for up to a 30 or 90 day supply
- Category 2 prescriptions are available for a $20 fee for up to a 30 day supply or $60 for a maximum 90 day supply
- Category 3 prescriptions are available for a $40 fee for a maximum 30 day supply.

This pharmacy formulary system is available to the following:
- Full-time employees with county insurance and their covered spouses and/or covered dependents
- Percentage employees with county insurance and their covered spouses and/or covered dependents
- Retired employees with at least 20 years of service (not eligible at age 65) and their spouses and/or dependents if covered with COBRA insurance
- Retired employees with less than 20 years of service with COBRA insurance and their spouses and/or dependents if covered with COBRA insurance
- Cleveland County Commissioners with county insurance, their covered spouses and/or covered dependents
- Dependent children over the age of 26 are not eligible

The pharmacy also offers formulary products for the cost plus $5 for a maximum 30 day supply (prices do vary for the following):

- Full-time employees without county insurance (can have other insurance), their spouses, and/or dependents
- Percentage employees without county insurance (can have other insurance), their spouses, and/or dependents
- Part-time hourly employees (spouses and dependents are not eligible) (can have other insurance)
- Present Cleveland County Commissioners not covered under county insurance, their spouses, and/or dependents (can have other insurance)
- Former Cleveland County Commissioners with a minimum of 4 years in office (spouses and dependents are not eligible)
- Dependent children over the age of 26 are not eligible

The Cleveland County Health Department Pharmacy is located at 315 E. Grover Street, Shelby. The phone number is (704) 484-5164, the fax number is (704) 484-5269, and the email address is pharmacy@clevelandcounty.com. Operating hours are Monday-Friday 8am – 5pm (occasionally closed 12:30pm-1:30pm). Payment may be made with cash, personal check, Health Savings Account (HSA) card, debit card, or credit card.

A copy of the pharmacy formulary is available on-line through the Cleveland County Intranet, Cleveland County Wiki, and the public Cleveland County website.
All employees and dependents receiving services from the health department pharmacy are required to complete a patient profile at the first visit.

All prescription refills must be requested 1 business day prior to pick-up or there will be at least a 30 minute wait. Employees and dependents may request refills 24 hours a day via the Pharmacy voicemail system by calling (704) 484-5164.

The most recent insurance card must be provided to verify current coverage. Prescriptions are not processed on insurance. To have prescription expenses applied to your deductible, you must manually submit your receipts to the Employee Coverage Plan.

Cleveland County Employee Optical Services

County employees and family members can enjoy the benefits of an optical program located on the 1st floor of the health department building. A licensed optician will be available every Thursday except the 5th Thursday of each month. Eye exams are not included in the services. Prescriptions will be needed for new glasses; however, duplicate prescriptions from old glasses can be made. In addition, sunglasses can be made and choice and style for eyeglasses is almost unlimited. Glasses purchased through the optical services program are significantly less expensive than those purchased at your doctor’s office. Prices vary according to choice of frames and prescription ordered. Prescriptions come with free adjustments, free glass case, cleaning solutions and cloth.

Direct Reimbursement Dental Plan

This plan is a reimbursement program provided by Cleveland County to help offset the cost of dental expenses for its employees. It is not an insurance program.

Introduction

In an effort to contain costs while providing the best possible care for our employees, Cleveland County provides a type of dental care called the "Direct Reimbursement Dental Plan." We believe that this self-administered plan offers greater flexibility for our employees while providing more value for the dollar amount invested. Eligible employees will be reimbursed on a monthly basis for dental expenses incurred for themselves and their covered dependents after filing the proper claim forms and receipts. Non-excluded dental procedures are covered if provided by a licensed dental professional (see Limitations and Exclusions).

Eligibility

All employees eligible for health insurance coverage through Cleveland County will be eligible for coverage under this dental plan. The effective date for new employees will be the same as for the health insurance. An employee may elect to purchase coverage for his/her eligible dependents.

Eligible Dependents include:

- Your spouse
- Your unmarried child(ren) (natural-born, legally adopted, or stepchildren) covered through the month in which child(ren) turn 26
- Your children over the age of 26 who are unable to maintain employment due to physical or mental disability

Limitations and Exclusions

No payment shall be made for the following:

- Prescription drugs
- Toothbrushes, toothpaste, or mouth rinses
- Expenses covered by Worker's Compensation, Medicare, Medicaid, military service, or another insurance plan
- Expenses incurred solely for cosmetic purposes, rather than for health reasons (i.e., bleaching of teeth)
- Expenses incurred for the replacement of lost or stolen dentures, bridgework, or other removable orthodontic appliances or retainers
- Expenses incurred for the replacement of dentures or bridgework more than once every three years or for the replacement of existing dentures or bridge work less than three years old
- Orthodontic expenses (covered through the month in which child(ren) turn 17)
- Professional fees other than fees of a licensed dental professional
- Claims submitted after the plan year deadline (January 15 of the next calendar year)

Types of Coverage

- Employee Only - Provided by the Employer
- Employee + One Dependent Coverage - Child or Spouse
- Employee + Family Coverage

Costs for the dependent coverage will be established on July 1 of each year. Dependent premiums will be deducted each pay period, at one-half the monthly cost, under the Section 125 Flexible Benefits Program.

Deductible

None.

DENTAL PLAN RATES

	Semi-Monthly	Monthly
Employee Only	**$0.00**	**$0.00**
Employee + 1 Dependent	**$15.00**	**$30.00**
Employee + Family	**$22.50**	**$45.00**

Cleveland County provides $15.00 per month toward the cost of the individual dental premium for employees who are working full-time. Rates for employees working less than full-time are prorated, based on the percentage of time worked.

Benefit Schedule per Covered Individual

Payments shall be made as follows:

Incurred Expense	Percentage Paid	Amount Reimbursed
First $200	**100%**	**$200**
Next $400	**70%**	**$280**
Next $700	**50%**	**$350**
$1,300		**$830**

The maximum reimbursement per covered individual will be $830.00 per calendar year, per covered dependent. This allows for a maximum expense of $1,300.00 in covered procedures, of which $830.00 would be reimbursed to the employee.

PLEASE NOTE: THE DENTAL PLAN YEAR WILL RUN CALENDAR YEAR FROM JANUARY 1 THROUGH DECEMBER 31 OF EACH YEAR.

How to File a Claim

- Obtain claim form from Payroll or the Benefits and Payroll Intranet
- Complete Employee Section of Claim Form and sign
- Have Dentist complete and sign bottom portion of form
- Attach receipt or statement of procedure from Dentist to Claim Form
- Claims will be paid according to the date of service, not the date of payment
- File claims within the same plan year in which they are incurred
- Checks for claims received by the 15th of the month will be issued and disbursed along with the end of the month payroll check
- Checks for claims received after the 15th of each month will be paid at the end of the next month following receipt
- Checks will be generated only once a month
- Claims for the current year must be submitted to payroll by January 15th of the following year

FALSE BILLS OR DOCUMENTS SUBMITTED FOR REIMBURSEMENT WILL BE CONSIDERED A FRAUDULENT ACT AND WILL BE GROUNDS FOR IMMEDIATE DISCIPLINARY ACTION, UP TO AND INCLUDING DISMISSAL.

Changes in Coverage

Changes in dependent dental coverage will be governed by IRS regulations for Flexible Benefits Programs, as follows:

Unless a Qualifying Event occurs, changes will be allowed only during the Open Enrollment Period (changes effective July 1 of each year). Necessary forms must be completed prior to this date. Contact the Payroll office for completion of these forms.

Qualifying events, as determined by the IRS, are:

- Birth or Adoption of a Child
- Change in Spouse's Employment
- Child over age 26
- Death of a Spouse or Child
- Divorce
- Eligibility of Spouse for Medicare
- Marriage

It is your responsibility to notify payroll when a dependent is NOT ELIGIBLE for coverage.

Community Eye Care Vision Plan

Effective Date: July 1, 2015
Vision Plan — Comprehensive Plan

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

The Benefit

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

- An eye examination every 12 months ($10 co-pay)

- An eyewear allowance of $150 (per person) every 12 months ($10 co-pay)

- A contact lens fitting, re-fit or evaluation every 12 months ($30 co-pay)

The eyewear allowance is completely flexible. It can be applied to frames, eyeglass lenses, contact lenses, special lens options, or any combination. As long as you select eyewear having a retail price that's less than or equal to your allowance, your only out-of-pocket expense for the eyewear is the $10 co-pay. If the eyewear you choose is more expensive than $150, you are eligible for attractive discounts on the overage amount from most network providers: 20% for frames and lenses, and 10% for contact lenses.

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

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

Monthly Rates

Employee Only	**$ 9.62**
Employee + One	**$19.24**
Employee + Family	**$28.50**

How to Use Your Benefit

1) Select a provider from the Community Eye Care provider network.

2) Call the provider to make an appointment, and let them know that you have Community Eye Care coverage.

3) See the provider and select your eyewear.

4) Pay the provider your co-pays, plus any discounted amount that exceeds the $150 eyewear allowance.

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

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

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

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

Customer Service and Claims Administration

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

www.communityeyecare.net

2359 Perimeter Pointe Parkway
Suite 150
Charlotte, NC 28208

Aflac Accident Insurance Plan

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a **general summary** of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI7700.

What is Aflac accident insurance? Why should I consider it?

Aflac accident insurance provides benefits for the treatment of injuries suffered as the result of a covered accident. These benefits are payable regardless of any other insurance you may have.

Many families don't budget for out-of-pocket costs associated with accidents. While we all hope to steer clear of accidents, at some point most of us will probably take a trip to the local emergency room. When you (or a covered family member) are injured in an accident, the last things on your mind are the charges that may be accumulating for services like the following:

- ***Ambulance ride***
- ***Casts***
- ***Emergency room use***
- ***Wheelchairs***
- ***Surgery and Anesthesia***
- ***Crutches***
- ***Stitches***
- ***Bandages***

These costs add up- fast. While major medical insurance can help with the cost of treatment, **what about the out-of-pocket expenses that pile up** while you or a loved one is out of work as a result of a covered accident? Aflac accident insurance **benefits are paid directly to you (unless otherwise assigned) to use as you see fit.** You can use the benefits to help with mortgage or rent payments, groceries, car payments- however you like.

What are some of the highlights of the Aflac accident plan?

- ***No limit on the number of claims you can file.***
- ***An annual Wellness Benefit is included.***
- ***Benefits available for spouse and/or dependent children.***
- ***Provides 24-hour protection (on and off-the-job)***
- ***Benefits for both inpatient and outpatient treatment of covered accidents.***
- ***Guaranteed Issue (which means you may qualify for coverage without having to answer health questions).***
- ***Payroll Deduction - Premiums are paid by convenient payroll deduction.***
- ***Coverage will be effective the date you sign the enrollment form.***
- ***Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.***

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers

What is guaranteed-issue coverage?

Guarantee-issue refers to certain types of coverage that may be issued without your having to answer health questions. Guaranteed-issue coverage is offered during your employer's initial enrollment period (and for new hires after the enrollment period).

Am I eligible for Aflac accident coverage? What about my family?

You are eligible to apply for Aflac accident coverage if you:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least **20** hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 64 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does Aflac accident plan feature?

- **Accident Benefits**

  You may receive benefits if you incur one of the following covered events:

  - Fractures
  - Dislocations
  - Paralysis
  - Lacerations
  - Injuries requiring surgery
    - Eye injuries
    - Removal of foreign body
    - Ruptured disc
    - Torn knee cartilage
    - Tendons/ligaments
  - Burns (second- and third-degree)
  - Concussion
  - Coma
  - Internal injuries
  - Exploratory surgery
  - Emergency dental work

- **Medical Fees Benefit**

  You may receive this benefit for up to six treatments per covered accident for physician charges, emergency room services and supplies, and X-rays.

- **Accident Follow-Up Treatment Benefit**

  You may receive this benefit for up to six treatments per covered accident for follow-up treatment.

- **Physical Therapy Benefit**

  You may receive this benefit for up to six treatments per covered accident for physical therapy.

- **Ambulance Benefit**

  You may receive this benefit if you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident.

- **Transportation Benefit**

  You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn't available in your hometown).

- **Blood/Plasma Benefit**

  You may receive this benefit if you receive blood and plasma within 90 days of a covered accident.

- **Prosthesis Benefit**

  You may receive this benefit if a covered accident requires the use of a prosthetic device (hearing aids, wigs, or dental aids-including (but not limited to) false teeth-are not covered).

- **Appliance Benefit**

  You may receive this benefit for use of medical appliance due to injuries received in a covered accident (payable for crutches, wheelchairs, leg braces, back braces, and walkers).

- **Family Lodging Benefit**

  If you are required to travel more than 100 miles for inpatient treatment of injuries suffered in a covered accident, you may receive this benefit for an immediate family member's lodging (payable up to 30 days per accident while the insured is confined to the hospital).

- **Wellness Benefit**

  You may receive this benefit for one routine examination or other preventive testing once each 12-month period (payable for one covered person annually). Benefits are payable for the following:

  - Annual physical exams
  - Mammograms
  - Pap smears
  - Eye examinations
  - Immunizations
  - Flexible sigmoidoscopies
  - PSAs
  - Ultrasounds
  - Blood screenings

- **Hospital Admission Benefit**

  You may receive this benefit if you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the accident.

- **Hospital Confinement Benefit (per day)**

  You may receive this benefit on the first day of hospital confinement for up to 365 days. The confinement must begin within 90 days after the date of the accident (payable once per confinement).

- **Hospital Intensive Care (per day)**

  You may receive this benefit up to 30 days per covered accident (payable in addition to the Hospital Confinement Benefit).

- **Accidental-Death and -Dismemberment Benefit**
  - o Accidental Death
  - o Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)
  - o Dismemberment
  - o Loss of One or More Fingers and Toes
  - o Partial Amputation of Fingers or Toes

What else do I need to know about the Aflac accident plan?

You should know that the plan includes a **pre-existing condition limitation.** A *pre-existing condition* is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.

Certain Exclusions. *No benefits are payable for loss resulting from:*

- ***Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered when you are in such service.***
- Å ***Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.***
- Å ***Participating or attempting to participate in an illegal activity or working at an illegal job.***
- Å ***Committing or attempting to commit suicide, while sane or insane.***
- Å ***Injuring or attempting to injure yourself intentionally.***
- Å ***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.***
- Å ***Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica except under the Accidental Common Carrier Death Benefit.***
- Å ***Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.***
- Å ***Participating in any organized sport, professional or semi-professional.***
- Å ***Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.***
- Å ***Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.***
- Å ***Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.***

Semi-Monthly Rates		
24 Hour Coverage	**Low Option**	**High Option**
Employee	$5.18	$9.40
Employee and Spouse	$7.31	$12.91
Employee and Dependent Child(ren)	$8.89	$15.71
Employee, Spouse, and Dependent Child(ren) - (Family)	$11.02	$19.22

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

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205

Customer Service
800.433.3036
www.aflacgroupinsurance.com

This brochure is a brief description of coverage, and is not a contract. Read your certificate carefully for exact terms and conditions. This brochure is subject to the terms, conditions, and limitations of Policy Series CAI2800NC.

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

Aflac Critical Illness Insurance

Effective Date: July 1, 2015

Guaranteed Issue Amounts: Employee- $20,000 Spouse- $10,000

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI2800.

What is Aflac critical illness insurance? Why should I consider it?
Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack (Coronary Artery Bypass Surgery)
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

What are some of the highlights of the Aflac critical illness plan?

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is 5,000 to $30,000.
- Each dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

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Am I eligible for Aflac critical illness coverage? What about my family?

You are eligible to apply for Aflac critical illness coverage if you:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 20 hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does the Aflac critical illness plan feature?

First Occurrence Benefit

After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit

After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

Reoccurrence Benefit

You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months.

Heart Benefit

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

- Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- Mitral valve replacement or repair
- Aortic valve replacement or repair
- Surgical treatment of abdominal aortic aneurysm
- AnjioJet clot busting*
- Balloon angioplasty (or balloon valvuloplasty)*
- Laser angioplasty*
- Atherectomy*
- Stent implantation*
- Cardiac catherization*
- Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- Pacemaker insertion*

** Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.*

Health Screening Benefit

After the waiting period, you may receive a maximum of $100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- 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

What else do I need to know about the Aflac critical illness plan?

You should know that the plan includes:

A 30-day waiting period. This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.

A pre-existing condition limitation. A pre-existing condition is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.

Certain exclusions. No benefits are payable for loss resulting from:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service;
- Substance abuse; or
- Diagnosis and/or treatment received outside the United States.

GROUP CRITICAL ILLNESS

CI G

Mark III - Semimonthly (24pp./yr.)

NONTOBACCO - Employee

AGES	$ 5,000	$ 10,000	$ 15,000	$20,000	$25,000	$ 30,000	$ 35,000	$ 40,000	$ 45,000	$ 50,000
18-29	$ 2.76	$ 3.77	$ 4.78	$ 5.79	$ 6.80	$ 7.81	$ 8.82	$ 9.82	$ 10.83	$ 11.84
30-39	$ 3.44	$ 5.14	$ 6.83	$ 8.52	$ 10.21	$ 11.91	$ 13.60	$ 15.29	$ 16.99	$ 18.68
40-49	$ 5.22	$ 8.69	$ 12.16	$ 15.63	$ 19.10	$ 22.57	$ 26.04	$ 29.51	$ 32.98	$ 36.45
50-59	$ 7.60	$ 13.45	$ 19.29	$ 25.14	$ 30.99	$ 36.84	$ 42.68	$ 48.53	$ 54.38	$ 60.23
60-69	$ 12.67	$ 23.59	$ 34.51	$ 45.43	$ 56.35	$ 67.27	$ 78.19	$ 89.11	$ 100.03	$ 110.96

NONTOBACCO - Spouse

AGES	$ 5,000	$ 7,500	$ 10,000	$ 12,500	$ 15,000	$17,500	$20,000	$22,500	$25,000	$30,000
18-29	$ 2.76	$ 3.26	$ 3.77	$ 4.27	$ 4.78	$ 5.28	$ 5.79	$ 6.29	$ 6.80	$ 7.81
30-39	$ 3.44	$ 4.29	$ 5.14	$ 5.98	$ 6.83	$ 7.68	$ 8.52	$ 9.37	$ 10.21	$ 11.91
40-49	$ 5.22	$ 6.96	$ 8.69	$ 10.43	$ 12.16	$ 13.90	$ 15.63	$ 17.37	$ 19.10	$ 22.57
50-59	$ 7.60	$ 10.52	$ 13.45	$ 16.37	$ 19.29	$ 22.22	$ 25.14	$ 28.06	$ 30.99	$ 36.84
60-69	$ 12.67	$ 18.13	$ 23.59	$ 29.05	$ 34.51	$ 39.97	$ 45.43	$ 50.89	$ 56.35	$ 67.27

TOBACCO - Employee

AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 3.30	$ 4.86	$ 6.41	$ 7.97	$ 9.52	$ 11.08	$ 12.63	$ 14.18	$ 15.74	$ 17.29
30-39	$ 4.42	$ 7.10	$ 9.77	$ 12.45	$ 15.12	$ 17.80	$ 20.47	$ 23.15	$ 25.82	$ 28.49
40-49	$ 8.60	$ 15.46	$ 22.31	$ 29.17	$ 36.02	$ 42.88	$ 49.73	$ 56.59	$ 63.44	$ 70.30
50-59	$ 13.34	$ 24.93	$ 36.52	$ 48.11	$ 59.70	$ 71.29	$ 82.88	$ 94.47	$ 106.06	$ 117.66
60-69	$ 22.64	$ 43.53	$ 64.42	$ 85.31	$ 106.21	$ 127.10	$ 147.99	$ 168.88	$ 189.77	$ 210.66

TOBACCO - Spouse

AGES	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000	$30,000
18-29	$ 3.30	$ 4.08	$ 4.86	$ 5.64	$ 6.41	$ 7.19	$ 7.97	$ 8.74	$ 9.52	$ 11.08
30-39	$ 4.42	$ 5.76	$ 7.10	$ 8.44	$ 9.77	$ 11.11	$ 12.45	$ 13.78	$ 15.12	$ 17.80
40-49	$ 8.60	$ 12.03	$ 15.46	$ 18.89	$ 22.31	$ 25.74	$ 29.17	$ 32.60	$ 36.02	$ 42.88
50-59	$ 13.34	$ 19.14	$ 24.93	$ 30.73	$ 36.52	$ 42.32	$ 48.11	$ 53.91	$ 59.70	$ 71.29
60-69	$ 22.64	$ 33.09	$ 43.53	$ 53.98	$ 64.42	$ 74.87	$ 85.31	$ 95.76	$ 106.21	$ 127.10

Rates do not include cancer benefit.

Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

No benefit reduction at age 70.

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

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We've got you under our wing.®

Note: 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.

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Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

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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.

Allstate Benefits Group Cancer Plan

Effective Date: July 1, 2015

In the United States, about 1,665,540 new cancer cases were expected to be diagnosed in 2014. [1]

Group Voluntary Cancer

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

Meeting Your Needs:

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

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

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

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

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

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

**Primary insured only*

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

[1] Cancer Facts & Figures, American Cancer Society, 2014

Enrolling after your initial enrollment period requires evidence of insurability

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[2]

Your Benefit Coverage

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

Specified Diseases

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

Continuous Hospital Confinement

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

Government or Charity Hospital

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

Surgery

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

Second Opinion

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

[2] Cancer Facts & Figures, American Cancer Society, 2014

Physical or Speech Therapy

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

Anesthesia

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

Ambulatory Surgical Center

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

Radiation/Chemotherapy for Cancer

Up to a $10,000 (Low) or $20,000 (High) benefit will be paid per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

Anti-Nausea Benefit

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

Inpatient Drugs and Medicine

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

Hematological Drugs

Up to a $200 (Low) or $400 (High) benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

Medical Imaging

Actual cost up to a $500 (Low) or $1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services

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

New or Experimental Treatment

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

Blood, Plasma, and Platelets

Up to a $10,000 (Low) or $20,000 (High) benefit will be paid per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance

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

At Home Nursing

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

Prosthesis

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

Hair Prosthesis

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

Nonsurgical External Breast Prosthesis

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

Ambulance

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

Hospice Care

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services: (1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center.

Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or (2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

Extended Care Facility

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

Outpatient Lodging

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

Non-Local Transportation

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

Family Member Lodging and Transportation

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

Waiver of Premium (primary insured only)

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

*Bone Marrow or Stem Cell Transplant**

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

***This benefit is payable only once per covered person per calendar year.**

Additional Benefits

Wellness

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

Optional Benefits

Cancer Initial Diagnosis (First Occurrence)

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

*Intensive Care***

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

A. Hospital Intensive Care Unit Confinement $600* - This benefit is for hospital intensive care unit confinement for any illness or accident.

B. Step-Down Hospital Intensive Care Unit Confinement $300*- This benefit is for step down hospital intensive care unit confinement for any illness or accident.

C. Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

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

Eligibility

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

Portability Privilege

Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination; and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage

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

Pre-Existing Condition, Exclusions and Limitations

Allstate Benefits does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn, adopted or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. Allstate Benefits does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations

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

Coverage Subject to the Policy

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

The policy is Limited Benefit Cancer and Specified Disease Insurance

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

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than November 1, 2017. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. The policy and rider are underwritten by American Heritage Life Insurance Company. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

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

Allstate®
Benefits

Allstate Benefits, The Workplace Marketer ®
1776 American Heritage Life Drive, Jacksonville, Florida 32224
Customer Care Center: 1.800.521.3535
www.allstate.com or AllstateBenefits.com.

Semi-Monthly Rates

Low Option without Optional Benefits	
Insureds	**Semi-Monthly Rates**
Employee	$10.04
Employee + Child(ren)	$13.86
Employee + Spouse	$15.48
Family	$19.29

Low Option with Optional Benefits	
Insureds	**Semi-Monthly Rates**
Employee	$13.03
Employee + Child(ren)	$18.41
Employee + Spouse	$20.75
Family	$26.12

High Option without Optional Benefits	
Insureds	**Semi-Monthly Rates**
Employee	$15.55
Employee + Child(ren)	$21.83
Employee + Spouse	$23.76
Family	$30.02

High Option with Optional Benefits	
Insureds	**Semi-Monthly Rates**
Employee	$18.54
Employee + Child(ren)	$26.38
Employee + Spouse	$29.03
Family	$36.85

AUL Short Term Disability

Effective Date: July 1, 2015

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

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

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

Advantages of shopping at work include:

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

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

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycan happen.org/research/CDA_LTD_ Claims_Survey_2011.asp

90% of disabilities are caused by illness.

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

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

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

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

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

Class Description

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

Disability

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

Monthly Benefit

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

Elimination Period

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

Benefit Duration

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) weeks.

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

Recurrent Disability

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

Exclusions and Limitations

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

Annual Enrollment

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

Employees who elect to increase their Benefit Duration may do so only during the annual enrollment period subject to the pre-existing exclusion. The pre-existing exclusion will apply to the increased benefit duration.

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 if insurability.

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).

You have 31 days from your date of termination to submit an application to port your coverage.

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

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

Customer Service:
800-553-5318

Disability Claims:

866-258-8744

Fax: 207-591-3048

Disability Claims E-mail: claims@disabilityrms.com

www.employeebenefits.aul.com

ONEAMERICA®

AMERICAN UNITED LIFE INSURANCE COMPANY®
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AUL Life Short-Term Disability
Semi-Monthly (24-Pay) Rates

Benefit Duration: 13 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.29
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.54
$1,600	$16.57
$1,700	$17.61
$1,800	$18.64
$1,900	$19.68
$2,000	$20.71

Benefit Duration: 26 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$7.50
$600	$9.00
$700	$10.50
$800	$12.00
$900	$13.50
$1,000	$15.00
$1,100	$16.50
$1,200	$18.00
$1,300	$19.50
$1,400	$21.00
$1,500	$22.50
$1,600	$24.00
$1,700	$25.50
$1,800	$27.00
$1,900	$28.50
$2,000	$30.00

Benefit Duration: 52 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$9.86
$600	$11.83
$700	$13.80
$800	$15.77
$900	$17.74
$1,000	$19.71
$1,100	$21.69
$1,200	$23.66
$1,300	$25.63
$1,400	$27.60
$1,500	$29.57
$1,600	$31.54
$1,700	$33.51
$1,800	$35.49
$1,900	$37.46
$2,000	$39.43

Metlife Term Life Plan

Effective Date: July 1, 2015, *Pending underwriting approval

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 birth of age to age 19 (to age 26 if wholly dependent upon you for maintenance and support if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit, as long as the child is covered prior to age 19 or to age 26 if a full-time student.

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

Eligibility
You will be eligible for this program the first of the month following 30 days of continuous employment as an employee of Cleveland County if you are a full-time employee working 20 hours or more per week.

Enrollment
Enrollment is simple - just fill out the election card provided by your employer. You have 31 days to enroll yourself and dependents without evidence of insurability.

Statement of Health
Increases in coverage, Optional Employee coverage over the lesser of 3 times your Basic Annual Earnings or $250,000, Optional Dependent Spouse coverage over $20,000, re-entry in the plan and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to MetLife.

Beneficiary
You have the right to designate the beneficiary of your choice. The beneficiary elected on your life enrollment form designates your beneficiary for optional coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update one's beneficiary designation as necessary.

When Your Insurance Starts
Your Optional Employee Life Insurance becomes effective the first of the month following the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work. In addition, in order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have been "hospitalized" in the last three months prior to your enrollment date.

The term “hospitalized” includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term “hospitalized”.

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

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

Termination of Coverage

All insurance under this plan will terminate upon the earlier of the date you retire, the date your employment ends, or the latest date for which premium has been paid. Dependents’ coverage ends the end of the month for which premium has been paid at attainment of age, the last day of the month of employee’s termination/retirement in which premium has been paid and the last day of the month dependent ceases to be employees dependent for which premium has been paid. Nevertheless, if you or a covered dependent should die within 31 days thereafter, the life insurance will still be paid to the beneficiary.

Disability - Continued Protection

Prior to Age 60 - If an insured becomes totally disabled prior to age 60 and the 9 month waiting period has been satisfied, the amount of life insurance will be continued without payment of premium provided evidence of disability is submitted annually. The waiver of premium provision terminates at death or at age 65, whichever is earlier.

Conversion

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance, except a term policy, issued by MetLife. If you wish to continue with a term policy, please refer to the section below on Portability. The amount of the individual contract may not be more than the amount of your life coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance, Dependent Spouse Life Insurance, and Dependent Child Life Insurance.

Portability

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to both Optional Employee and Dependent

Qualifying Events Include:
- Termination of Employment
- Retirement
- Change in employee class resulting in termination of Optional Life Benefits.

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

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

Suicide Exclusion
No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage. Likewise, no Optional Dependent Life Benefits are payable if the insured dependent commits suicide within two years from the effective date of this coverage.

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

SCHEDULE OF BENEFITS

Optional Employee Life Insurance

Your choice of coverage up to the lesser of $500,000 or 5 times salary in increments of $10,000. Guaranteed Issue coverage up to the lesser of $250,000 or 3 times salary if elected when first eligible.

Optional Spouse Life Insurance

Your choice of coverage up to $100,000 in increments of $5,000
- Guaranteed Issue coverage up to $20,000 if elected when first eligible.
- Spouse coverage may not exceed Optional Employee Life Insurance coverage.

Optional Child Life Insurance

Your choice of coverage up to $10,000 in increments of $2,000
- For children from birth to age 6 months, coverage amount is $1,000
- Election amount covers each of your eligible children

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.

MetLife

Semi-Monthly Rates
Employee and Spouse Coverage
(Spouse rate based on Employee age)

Age	Rate	10	20	30	40	50	60	70	80	90	100
Under 25	*0.03*	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
25-29	*0.04*	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00
30-34	*0.045*	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
35-39	*0.065*	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40-44	*0.095*	$0.95	$1.90	$2.85	$3.80	$4.75	$5.70	$6.65	$7.60	$8.55	$9.50
45-49	*0.15*	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00
50-54	*0.226*	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25	$22.50
55-59	*0.36*	$3.60	$7.20	$10.80	$14.40	$18.00	$21.60	$25.20	$28.80	$32.40	$36.00
60-64	*0.56*	$5.60	$11.20	$16.80	$22.40	$28.00	$33.60	$39.20	$44.80	$50.40	$56.00
65-69	*0.965*	$9.65	$19.30	$28.95	$38.60	$48.25	$57.90	$67.55	$77.20	$86.85	$96.50
70+	*1.74*	$17.40	$34.80	$52.20	$69.60	$87.00	$104.40	$121.80	$139.20	$156.60	$174.00

Age	Rate	110	120	130	140	150	160	170	180	190	200
Under 25	*0.03*	$3.30	$3.60	$3.90	$4.20	$4.50	$4.80	$5.10	$5.40	$5.70	$6.00
25-29	*0.04*	$4.40	$4.80	$5.20	$5.60	$6.00	$6.40	$6.80	$7.20	$7.60	$8.00
30-34	*0.045*	$4.95	$5.40	$5.85	$6.30	$6.75	$7.20	$7.65	$8.10	$8.55	$9.00
35-39	*0.065*	$7.15	$7.80	$8.45	$9.10	$9.75	$10.40	$11.05	$11.70	$12.35	$13.00
40-44	*0.095*	$10.45	$11.40	$12.35	$13.30	$14.25	$15.20	$16.15	$17.10	$18.05	$19.00
45-49	*0.15*	$16.50	$18.00	$19.50	$21.00	$22.50	$24.00	$25.50	$27.00	$28.50	$30.00
50-54	*0.226*	$24.75	$27.00	$29.25	$31.50	$33.75	$36.00	$38.25	$40.50	$42.75	$45.00
55-59	*0.36*	$39.60	$43.20	$46.80	$50.40	$54.00	$57.60	$61.20	$64.80	$68.40	$72.00
60-64	*0.56*	$61.60	$67.20	$72.80	$78.40	$84.00	$89.60	$95.20	$100.80	$106.40	$112.00
65-69	*0.965*	$106.15	$115.80	$125.45	$135.10	$144.75	$154.40	$164.05	$173.70	$183.35	$193.00
70+	*1.74*	$191.40	$208.80	$226.20	$243.60	$261.00	$278.40	$295.80	$313.20	$330.60	$348.00

Age	Rate	210	220	230	240	250	300
Under 25	*0.03*	$6.30	$6.60	$6.90	$7.20	$7.50	$9.00
25-29	*0.04*	$8.40	$8.80	$9.20	$9.60	$10.00	$12.00
30-34	*0.045*	$9.45	$9.90	$10.35	$10.80	$11.25	$13.50
35-39	*0.065*	$13.65	$14.30	$14.95	$15.60	$16.25	$19.50
40-44	*0.095*	$19.95	$20.90	$21.85	$22.80	$23.75	$28.50
45-49	*0.15*	$31.50	$33.00	$34.50	$36.00	$37.50	$45.00
50-54	*0.226*	$47.25	$49.50	$51.75	$54.00	$56.25	$67.50
55-59	*0.36*	$75.60	$79.20	$82.80	$86.40	$90.00	$108.00
60-64	*0.56*	$117.60	$123.20	$128.80	$134.40	$140.00	$168.00
65-69	*0.965*	$202.65	$212.30	$221.95	$231.60	$241.25	$289.50
70+	*1.74*	$365.40	$382.80	$400.20	$417.60	$435.00	$522.00

Semi-Monthly Rates- Child Coverage				
$2,000	$4,000	$6,000	$8,000	$10,000
$0.26	$0.52	$0.78	$1.04	$1.30

AD&D Rates

Employee - $0.08/$10,000

Spouse - $0.07/$10,000

Children - $0.05/$2,000

Texas Life Whole Life Plan- Solutions 121

Common Issue Date: August 1, 2015

*Any policy issued prior to 08/01/2015, please reference your certificate for details as this booklet chapter does not pertain to you.

An ideal complement to any group term and optional term life insurance your employer might provide, Texas Life's SOLUTIONS 121 is the life insurance you keep, even when you change jobs or retire as long as you pay the premiums. It will help protect your family, both today and, more importantly, tomorrow. Even better, you won't even have to pay for it after age 65 (or 20 years if you're 46 years of age or older), because it's guaranteed to be paid up.[1]

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements.

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

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

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

15M002-C 1001 CI&Waiver (exp0117) Policy Form WLOTO-NI or ICC11-WLOTO-NI-11

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

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

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

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

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

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

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

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

Sample Rates

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

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

SOLUTIONS Review

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

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

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

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

3. Facts About Life, LIMRA International (2011)

Continuation of Benefits

To Continue Your Medical and/or Dental Plan

Under the group medical and dental plans you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, you will receive notification from Interactive Medical Systems (IMS), your COBRA administrator, with premium and continuation options. Should you have any questions, you may contact IMS at 800-426-8739.

AUL Short-Term Disability

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

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

To Convert Your Term Life Insurance

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well.

Once your employment terminates, your information is sent to MetLife and an information packet will be sent to you in the mail. This packet will contain information you need to file for portability or conversion. Once you receive your packet, please contact MetLife at 1-877-275-6387 to find a MetLife representative in your area.

It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.

To Continue Other Policies

You may continue your policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, please contact Aflac Group, Allstate Benefits, and Texas Life directly.

Contact Information for Questions, Claims, and Portability

Aflac

(Continental American Insurance Company a proud member of the Aflac family of insurers)
PO Box 427
Columbia, SC 29202
Customer Service
800-433-3036
csc@caicworksite.com

Allstate Benefits

1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your policy please call:
800-521-3535
For questions concerning your claim please call:
800-348-4489
or e-mail claimsresearch@allstate.com

American United Life (AUL)

Short-Term Disability
Claims Toll-Free Number
866-258-8744
Customer Service
800-553-5318
For AUL Short-Term Disability claims, please use Group ID “G00610402.”

Assurity Life

PO Box 82533
Lincoln, NE 68501
866-289-7337
Wellness Claims:
888-358-8808 x23

BlueCross BlueShield of NC

Customer Service
877-258-3334
www.bcbsnc.com

MetLife Insurance Company

Benefits Line: 866-492-6983
Conversion: 877-275-6387
Group Universal Life: 800-438-6388

Texas Life Insurance Company

PO Box 830
Waco, TX 76703-0830
800-283-9233

Mark III Brokerage

211 Greenwich Rd
Charlotte, NC 28211
800-532-1044
www.markiiibrokerage.com/clevelandcountync

Employee Benefit Providers

Cleveland County Optical
704-484-5230

Employee Health & Wellness Center
704-484-5278

Health Department Pharmacy
704-484-5164

Liberty Mutual (Auto/Home)
704-544-9789
www.libertymutual.com/clevelandcounty

Local Government Federal Credit Union
704-482-4492
888-732-8562
www.lgfcu.org

McLaughlin & Young Group (EAP)
800-633-3353
www.mygroup.com

Nationwide Retirement Solutions (457)
877-677-2678
www.nrsforu.com

Nutrition Counseling Services
704-734-5223
www.eatinghealthier.net

Prudential Retirement (401K & 457)
866-627-5267
www.ncplans.prudential.com

Retirement System
877-627-3287
www.myncretirement.com

State Employees' Credit Union (HSA)
704-482-4492
888-732-8562
www.ncsecu.org

YMCA
(Dover- Shelby location)
704-484-9622
www.clevecoymca.org

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