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

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

MIT – Hertford County, NC

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2015 - 06/30/2016
 Coverage for: Plan Participant Plan Type: PPO



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.medcost.com or by calling 1-800-795-1023.

Important Questions	Answers		Why this Matters:
What is the overall <u>deductible</u> ?	In-Network \$2,500 / person \$5,000 / family Does not apply to most In-Network office visits, preventative care, and prescription drugs.	Non-Network \$5,000 / person \$10,000 / family	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 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes \$5,500 / person \$11,000 / family	\$11,000 / person \$22,000 / family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balanced-billed charges, health care this plan doesn't cover, and penalties.		Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual <u>limit</u> 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 <u>network of providers</u> ?	Yes. See www.medcost.com or call 1-800-795-1023 for a list of participating providers.		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 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 provider .
Do I need a referral to see a <u>specialist</u> ?	No		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 page 4. See your policy or plan document for additional information about excluded services .

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OMB Control Numbers 1545-2229,
 1210-0147, and 0938-1146

MIT – Hertford County, NC

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay	30% co-insurance	Co-insurance applies after deductible.
	Specialist visit	\$40 co-pay	30% co-insurance	Co-insurance applies after deductible.
	Other practitioner office visit – chiropractic	\$40 co-pay	30% co-insurance	Co-insurance applies after deductible. Maximum 25 visits / plan year.
	Preventive care/screening/immunization	No charge	No charge	Deductible waived. Non-Network maximum \$500 / plan year.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need drugs to treat your illness or condition	Generic drugs	\$4 co-pay Retail \$12 co-pay Mail Order		Covers up to a 30 day supply (retail prescription) or a 31-90 day supply (mail order prescription). FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription) are covered at 100%.
	Preferred brand drugs	\$40 co-pay Retail \$120 co-pay Mail Order		
	Non-preferred brand drugs	\$55 co-pay Retail \$165 co-pay Mail Order		
More information about prescription drug coverage is available at www.medcost.com .	Specialty drugs	25% co-pay (minimum \$50, maximum \$100)		Certain high cost specialty injectable drugs must be purchased and dispensed by the Plan’s Specialty Pharmacy program. Contact Prescription Drug administrator at telephone number on ID Card for more information. These drugs will not be covered by the Medical Plan.
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance
Physician/surgeon fees		30% co-insurance	50% co-insurance	Co-insurance applies after deductible.

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MIT – Hertford County, NC

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 Coverage for: Plan Participant Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If you need immediate medical attention	Emergency room services	\$300 co-pay	\$300 co-pay	Co-pay waived if admitted to hospital from emergency room. Deductible waived.
	Emergency medical transportation	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible.
	Urgent Care	\$40 co-pay	\$40 co-pay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	- Facility	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	- Physician	\$40 co-pay	30% co-insurance	
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Substance use disorder outpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you are pregnant	- Facility			
	- Physician	\$40 co-pay	30% co-insurance	
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Prenatal and postnatal care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Maximum 16 hours / day.
	Rehabilitation services	\$40 co-pay	30% co-insurance	Co-insurance applies after deductible. Includes cardiac, cognitive, and pulmonary.
	Habilitation services	\$40 co-pay	30% co-insurance	Co-insurance applies after deductible. Includes occupational, physical, and speech.
	Skilled nursing care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Maximum 60 days / plan year.
	Durable medical equipment	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
Hospice service	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.	

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	No coverage. Contact your Human Resource Dept. for possible coverage availability.
	Glasses	Not applicable	Not applicable	No coverage. Contact your Human Resource Dept. for possible coverage availability.
	Dental check-up	Not applicable	Not applicable	No coverage. Contact your Human Resource Dept. for possible coverage availability.

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.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (adult) – may be covered; contact your Human Resources Dept. 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) – may be covered; contact your Human Resources Dept. 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

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.)		
<ul style="list-style-type: none"> • Bariatric surgery • Hearing aids (dependent children to age 19 only) 	<ul style="list-style-type: none"> • Infertility treatment (testing only) 	<ul style="list-style-type: none"> • Private-duty nursing

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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 the plan at Group's Phone #(919) 715-9782. 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 x 61565 or www.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 the claims administrator, MBS; P. O. Box 25987; Winston-Salem, NC; 27114-5987; or <http://www.medcost.com>. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance; Health Insurance Smart NC; 430 N. Salisbury Street; Raleigh, NC 27603 or 1-877-885-0231 or <http://www.ncdoi.com>.

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 a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-1023

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-795-1023

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-1023

Navajo (Dine): Dineek ehgo shika at'ohwol ninisingo, kwijigo holne 1-800-795-1023

_____ To see examples of 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 will also 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 \$3,576
- Patient pays \$3,964

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	\$2,500
Co-pays	\$24
Co-insurance	\$1,440
Limits or exclusions	\$0
Total	\$3,964

*Assumed generic filled 2 times through mail order
 **Assumed services provided at independent facility

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

- Amount owed to providers: **\$5,400**
- Plan pays \$3,285
- Patient pays \$2,115

Sample care costs:

Prescriptions*	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures**	\$700
Education***	\$300
Laboratory tests****	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,400
Co-pays	\$640
Co-insurance	\$0
Limits or exclusions	\$75
Total	\$2,115

*Assumed Insulin (Preferred) filled 4x through mail order
 **Assumed 4 visits @ \$100 PCP
 ***Assumed 2 visits @ \$150 Specialist
 ****Assumed 4 visits nutritional counseling @ \$75
 *****Assumed services provided at independent facility

Questions and answers about the 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.
- The 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.

Pays" box in 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 **co-payments**, **deductibles**, and **co-insurance**. You should also consider 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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** 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

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MedCost Health Insurance Rates - 2015-2016

Employee Only	\$0.00
Employee/Spouse	\$652.45
Employee/Child	\$242.39
Employee/Children	\$386.82
Employee/Family	\$967.56

Ameritas Dental Plan

DEDUCTIBLE

Deductible is waived for all preventive services. There is a \$50 lifetime deductible on basic services that everyone has to satisfy upon their first claim under Basic services. Additionally, there is a \$50 calendar year deductible for anyone having Major services. There is no family maximum on the \$50 calendar year deductible and it therefore applies to all members upon their first Major services claim in a calendar year.

TYPE I - PREVENTIVE AND DIAGNOSTIC - Type I benefits are payable at 100% U&C*. No deductible applies.

- Routine Exams (Two per benefit period)
- Cleanings (Two per benefit period)
- Bitewings (Two per benefit period)
- Space Maintainers
- Fluoride for Children (Under age 19)

TYPE II - BASIC PROCEDURES - Type II benefits are payable at **80%** U&C*. \$50.00 lifetime deductible applies.

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

TYPE III - MAJOR PROCEDURES - Type III Benefits are payable at 50% U&C*. \$50.00 calendar year deductible applies.

- Onlays
- Prosthodontics - (fixed bridge; removable complete/partial dentures; 1 in 5 years)
- Crowns (1 in 5 years per tooth)
- Crown Repair

ORTHODONTIA (INCLUDES CHILDREN & ADULTS) - Benefits are payable at 50% U&C with a lifetime per person maximum of \$1,000.00. No deductible applies.

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

ANNUAL MAXIMUM BENEFIT

- Type I, II, and III Procedures - \$2,000* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carry over does not apply).

**Usual and Customary Charge*

AMERITAS REWARDS

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

Benefit Threshold	\$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	\$250	Dental Rewards amount is added to the following year's maximum
Maximum Carryover		No Maximum, there is no limit on the amount of rollover dollars a member can accumulate

RX SAVINGS

Our valued plan members and their covered dependents (even their pets) can save on prescription medications through any Walmart or Sam's Club pharmacy across the nation. This Rx discount is offered at no additional cost, and it is not insurance.

To receive the Walmart Rx discount, Ameritas plan members just need to show their original Ameritas ID card. The identifier is the Ameritas logo. It's that easy. Or members can visit us at ameritasgroup.com and sign into (or create) a secure member account where they can print off an online-only Rx discount savings ID card.

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 26

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

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

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant**. For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

SECTION 125

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

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

ORTHODONTIA LIMITATIONS

(This is not a complete list)

No benefit is payable for expenses incurred:

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

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

Monthly Rates

Employee Only	\$26.88
Employee and Spouse	\$49.71
Employee and Child(ren)	\$68.24
Employee and Family	\$91.07

This insurance is underwritten by Ameritas Life Insurance Corp.

For Claims/Customer Service call Ameritas: 1-800-487-5553
www.ameritas.com



Superior Vision Plan



See yourself healthy.

Vision Plan Benefits for County of Hertford

Co-Pays	
Exam	\$10
Materials ¹	\$25

Monthly Premiums	
Emp. only	\$9.79
Emp. + spouse	\$19.58
Emp. + child(ren)	\$20.56
Emp. + family	\$25.94

Services/Frequency	
Exam	12 months
Frame	24 months
Lenses	12 months
Contact Lenses	12 months

(Based on date of service)

Benefits

	In-Network	Out-of-Network
Exam (Ophthalmologist)	Covered in full	Up to \$44 retail
Exam (Optometrist)	Covered in full	Up to \$39 retail
Frames	\$100 retail allowance	Up to \$50 retail
Lenses (standard) per pair		
Single Vision	Covered in full	Up to \$34 retail
Bifocal	Covered in full	Up to \$48 retail
Trifocal	Covered in full	Up to \$64 retail
Progressive lens upgrade	See description ³	Up to \$64 retail
Contact Lenses ⁴	\$120 retail allowance	Up to \$100 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

¹ Materials co-pay applies to lenses and frames only, not contact lenses

² See your benefits materials for definitions of standard and specialty contact lens fittings

³ Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

⁴ Contact lenses are in lieu of eyeglass lenses and frames benefit

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums⁵ on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	\$13	\$13
Ultraviolet coat	\$15	\$15
Tints, solid or gradients	\$25	\$25
Anti-reflective coat	\$50	\$50
Polycarbonate	\$40	20% off retail
High index 1.6	\$55	20% off retail
Photochromics	\$80	20% off retail

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

⁵ Discounts and maximums may vary by lens type. Please check with your provider.

SuperiorVision.com
Customer Service
800.507.3800

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan.

Please check with your Human Resources department if you have any questions.

North Carolina residents: If you do not have access to an in-network provider within 30 driving miles or 30 days of your appointment request, you may use the services of an out-of-network provider at in-network reimbursement rates.



Superior Vision Services, Inc. P.O. Box 967 Rancho Cordova, CA 95741 800.507.3800 SuperiorVision.com
 The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with
 The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life

NVIGRP 5-07

0515-BSv2/NC

Aflac Accident Insurance

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 CAI7800.

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 at least age 18
- Are a full-time, benefit-eligible employee;
- Are working at least **30** hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be at least age 18 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
- Exploratory surgery
- 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
- 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

- Accidental Death
- Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)
- Dismemberment
- Loss of One or More Fingers and Toes
- 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.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- 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.
- 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.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participating in any organized sport, professional or semi-professional.
- Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
- Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.

Monthly Premium Rates

Employee	\$16.20
Employee and Spouse	\$23.18
Employee and Dependent Children	\$30.90
Employee, Spouse, and Dependent Child(ren)	\$37.86



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.

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

Continental American Insurance Company 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.

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.

Continental American Insurance Company
2801 Devine Street • Columbia, South Carolina 29205
1-800-433-3036 toll-free
1-866-849-2970 fax
www.aflacgroupinsurance.com

Humana Group Cancer & Specified Disease Plan



Group Cancer and Specified Disease Insurance

POLICY FORM HIC-GP-CAN-POL-NC 6/09

Underwritten by Humana Insurance Company

Plan Features

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

Benefit	Low	High
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	\$100 per calendar year	\$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to \$300 per calendar year	Up to \$300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	\$2,500	\$5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Actual Charges	Actual Charges
Non-Local Transportation. Payable for transportation to a Hospital, clinic, treatment center, or from one medical facility to another which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to \$75 per day for lodging. 50 cents per mile if a personal vehicle is used.	Up to \$75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. Ambulance benefits shall include transportation from one medical facility to another. No Lifetime Maximum	Actual Charges	Actual Charges
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to \$3,000	Up to \$3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following expenses incurred by the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual Charges up to \$50 per day for lodging and meals expense for donor to remain near Hospital.	(a) \$200 per day (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to \$50 per day	(a) \$200 per day (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to \$50 per day
Bone Marrow and Stem Cell Transplant We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Actual charges to a combined lifetime maximum of \$15,000	Actual charges to a combined lifetime maximum of \$15,000



BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Benefit	Low	High
<p>Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum</p> <p>For anesthesia in connection with the treatment of skin Cancer. No Lifetime Maximum</p>	<p>Up to 25% of surgical benefit paid.</p> <p>\$100 maximum per Covered Person</p>	<p>Up to 25% of surgical benefit paid.</p> <p>\$100 maximum per Covered Person</p>
<p>Ambulatory Surgical Center. We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum</p>	<p>\$250 Per Day</p>	<p>\$250 Per Day</p>
<p>Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum</p>	<p>Up to \$25 per day, \$600 per calendar year</p>	<p>Up to \$25 per day, \$600 per calendar year</p>
<p>Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum</p>	<p>Up to \$250 per calendar year</p>	<p>Up to \$250 per calendar year</p>
<p>Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum</p>	<p>Actual charges up to \$2,500 per month</p>	<p>Actual charges up to \$5,000 per month</p>
<p>Miscellaneous Therapy Charges. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Item 15 or within 30 days following a covered treatment.</p>	<p>Actual charges up to a lifetime maximum of \$10,000</p>	<p>Actual charges up to a lifetime maximum of \$10,000</p>
<p>Self-Administered Drugs. We will pay the actual expenses incurred for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum</p>	<p>Actual charges up to \$4,000 per month</p>	<p>Actual charges up to \$4,000 per month</p>
<p>Colony Stimulating Factors. We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum</p>	<p>Actual charges up to \$500 per month</p>	<p>Actual charges up to \$500 per month</p>
<p>Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum</p>	<p>Actual charges up to \$200 per day</p>	<p>Actual charges up to \$200 per day</p>
<p>Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum</p>	<p>Up to \$35 per day</p>	<p>Up to \$35 per day</p>
<p>Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum</p>	<p>Up to \$100 per day</p>	<p>Up to \$100 per day</p>
<p>National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the expense incurred if an Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging expenses incurred. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation Benefits of the policy.</p>	<p>Expenses incurred limited to a lifetime maximum up to \$750 for evaluation. Expenses incurred limited to a lifetime maximum up to \$350 for transportation and lodging.</p>	<p>Expenses incurred limited to a lifetime maximum up to \$750 for evaluation. Expenses incurred limited to a lifetime maximum up to \$350 for transportation and lodging.</p>
<p>Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum</p>	<p>Actual Charges</p>	<p>Actual Charges</p>
<p>Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.</p>	<p>\$1,500 lifetime maximum per amputation.</p>	<p>\$1,500 lifetime maximum per amputation.</p>
<p>Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum</p>	<p>Up to \$35 per session</p>	<p>Up to \$35 per session</p>
<p>Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay a Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum</p>	<p>\$300 per day</p>	<p>\$300 per day</p>
<p>Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum</p>	<p>Up to \$50 per day</p>	<p>Up to \$50 per day</p>
<p>At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum</p>	<p>Up to \$100 per day</p>	<p>Up to \$100 per day</p>
<p>New or Experimental Treatment. We will pay the expenses incurred by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum</p>	<p>Up to \$7,500 per calendar year</p>	<p>Up to \$7,500 per calendar year</p>
<p>Hospice Care. If a Covered Person elects to receive hospice care, We will pay the expenses incurred for care received in a Free Standing Hospice Care Center. No Lifetime Maximum</p>	<p>Up to \$50 per day</p>	<p>Up to \$50 per day</p>
<p>Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum</p>	<p>\$200 per day</p>	<p>\$200 per day</p>
<p>Hairpiece. We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.</p>	<p>Actual charge up to a lifetime maximum of \$150</p>	<p>Actual charge up to a lifetime maximum of \$150</p>

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

Other Specified Diseases Covered:

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Addison's Disease • Amyotrophic Lateral Sclerosis • Cystic Fibrosis • Diphtheria • Encephalitis • Epilepsy • Hansen's Disease • Legionnaire's Disease • Lupus Erythematosus • Lyme Disease • Malaria | <ul style="list-style-type: none"> • Meningitis (epidemic cerebrospinal) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Niemann-Pick Disease • Osteomyelitis • Poliomyelitis • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever | <ul style="list-style-type: none"> • Scarlet Fever • Sickle Cell Anemia • Tay-Sachs Disease • Tetanus • Toxic Epidermal Necrolysis • Tuberculosis • Tularemia • Typhoid Fever • Undulant Fever • Whipple's Disease |
|--|--|--|

Payment of Benefits

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

Pre-Existing Condition Limitation

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

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

Exceptions and Other Limitations

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

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

Termination of Coverage

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

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

Portability

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

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

Covered Persons

Covered Person means any of the following:

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

Child (Children)

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

- a. not yet age 25; or
- b. not yet age 26 if a full time student at an accredited school.

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

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

Benefits

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

Hospital Intensive Care Confinement Benefit

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

Double Benefits

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

Emergency Hospitalization and Subsequent Transfer to an ICU

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

Step Down Unit

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

Exceptions and Other Limitations

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

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company.

This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected.

Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact:

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

HUMANA

É Toll Free: 800.845.7519

É Fax: 512-275-9350

É Mailing Address:

Bay Bridge Administrators, LLC

P.O. Box 161690, Austin, Texas 78716

É Claims Email Address: Claims@bbadmin.com

É Website: <http://www.baybridgeadministrators.com/index.php>

Humana Base Cancer Plan - Low & High Options

	Option 1 - Low	Option 2 - High
Room Rate	\$100 per day	\$100 per day
Surgical Schedule	\$3,000 per schedule	\$3,000 per schedule
Radiation, Chemotherapy, Immunotherapy Benefit	Actual charges up to \$2,500 per month	Actual charges up to \$5,000 per month
First Diagnosis Benefit	\$2,500	\$5,000
Colony Stimulating Factors Benefit	\$500 per month	\$500 per month
Wellness Benefit	Actual charges up to \$100 per calendar year	Actual charges up to \$100 per calendar year
Intensive Care Rider	\$325	\$625

Monthly Premium

	Option 1- Low	Option 2 - High
Employee Only	\$23.38	\$30.89
Employee & Children	\$33.20	\$43.36
Employee & Spouse	\$47.60	\$62.87
Employee & Family	\$57.43	\$75.34

Aflac Hospital Indemnity Plan

Effective Date: July 1, 2015

Plan Features

- Benefits are available for spouse and/or dependent children.
- Premiums are paid by convenient payroll deduction.
- The plan covers injuries and sickness.
- Admission and per-day hospital confinement benefits are included.
- Wellness benefit is included.
- Surgery and anesthesia benefits are included.
- High or Low Plan Options: employee may only choose one option

Issue Ages

- Employee: 18–64
- Spouse: 18–64
- Children: under age 26
- Benefit-eligible employees working at least 30 hours per week are eligible to apply. Employees must be actively at work on the date of application and the effective date of coverage. Seasonal and temporary employees are not eligible.

Class I

- All full-time and part-time benefit-eligible employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

Class II

- A Class I primary insured is eligible for Class II coverage if he:
 - Was previously insured under Class I; and
 - Is no longer employed by the policyholder.
- The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate. Only dependents covered under Class I coverage are eligible for continued coverage under Class II. Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.
- The employee may purchase supplemental hospital indemnity coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.
- A spouse is the person married to the employee on the effective date of this coverage. A spouse means the legal spouse who is between the ages of 18 and 64. A spouse must not be hospitalized or unable to perform his or her normal duties or activities on the date of application and the effective date of coverage.
- Dependent child means natural children, stepchildren, foster children, legally adopted children, or children placed for adoption who are under age 26.

Guaranteed-Issue

- During the initial enrollment and for newly eligible employees, coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12- month period. Late enrollees cannot enroll outside of an annual enrollment period and will be underwritten.

Portability

- When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.
- The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.
- The employee may continue the coverage until the earlier of:
 - The date he fails to pay the required premium; or
 - The date the class of coverage is terminated.
- Coverage may not be continued:
 - If the employee fails to pay any required premium; or
 - If the company receives notice of Class I plan termination.

Benefits

<i>Hospital Confinement (per day)</i>	<i>High Option</i>	<i>Low Option</i>
	<i>\$150</i>	<i>\$100</i>

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

The maximum period for which a covered person can collect benefits for hospital confinements resulting from covered sickness or from injuries received in the same covered accident is 180 days. This benefit is payable for only one hospital confinement at a time—even if the confinement is a result of more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.

<i>Hospital Admission (per confinement)</i>	<i>High Option</i>	<i>Low Option</i>
	<i>\$1,500</i>	<i>\$500</i>

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

We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment.

We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

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

<i>Surgical Benefit (per procedure)</i>	<i>High Option</i>	<i>Low Option</i>
	<i>Up to \$1,500</i>	<i>Up to \$750</i>

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

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

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

<i>Anesthesia Benefits</i>	<i>High Option</i>	<i>Low Option</i>
	<i>Up to \$375</i>	<i>Up to \$187.50</i>

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

<i>Wellness Benefit</i>	<i>High Option</i>	<i>Low Option</i>
	<i>\$50</i>	<i>\$50</i>

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

Pre-Existing Condition Limitation

A pre-existing condition means, within the 12-month period prior to the insured's effective date, conditions for which medical advice or treatment was received or recommended.

We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured's effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition—whichever is less. A claim for benefits for loss starting after 12 months from the effective date of the insured's certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

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

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

Exclusions

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

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

Terminations

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

- The date the plan is terminated, for Class I insureds;
 - The 31st day after the premium due date if the required premium has not been paid;
 - The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
 - The date he is no longer a member of the Class eligible for coverage.
- Insurance for dependents will terminate on the earliest of the following:
- The date the Plan is terminated, for dependents of Class I insureds;
 - The 31st day after the premium due date, if the required premium has not been paid;
 - The date the spouse or dependent child ceases to be a dependent; or
 - The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.
- Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

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.

Monthly Premium Rates

	<i>High Option</i>	<i>Low Option</i>
Employee	\$30.96	\$15.69
Employee and Spouse	\$61.17	\$31.03
Employee and Dependent Child(ren)	\$42.91	\$21.50
Employee and Family	\$73.12	\$36.84

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

Continental American Insurance Company (CAIC) is a wholly-owned subsidiary of Aflac Inc. CAIC underwrites group coverage but is not licensed to solicit business in Guam, Puerto Rico, or the Virgin Islands. In California, group coverage is underwritten by Continental American Life Insurance Company, and in New York group coverage is underwritten by American Family Life Assurance Company of New York.



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 2801 Devine Street
 Columbia, South Carolina 29205
 1-800-433-3036 toll-free
 1-866-849-2970 fax
 Aflacgroupinsurance.com

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 Plan

Benefit Amounts Available:

É Employee: \$5,000, \$10,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000, \$50,000

É Spouse: \$5,000, \$7,500, \$10,000, \$12,500, \$15,000, \$17,500, \$20,000, \$22,500, \$25,000, \$30,000

Guaranteed Issue Amounts:

- Employee: \$10,000
- Spouse: \$5,000

Health Screening Benefit: \$100.00

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:

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

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?

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

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

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

- É Are between the ages of 18 and 69;
- É Are a full-time, benefit-eligible employee;
- É Are working at least 30 hours per week;
- and**
- É 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:

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

- É Stress test on a bicycle or treadmill
- É Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- É Bone marrow testing
- É Breast ultrasound
- É CA 15-3 (blood test for breast cancer)
- É CA 125 (blood test for ovarian cancer)

- É CEA (blood test for colon cancer)
- É Chest X-ray
- É Colonoscopy
- É Flexible sigmoidoscopy
- É Hemocult stool analysis
- É Mammography
- É Pap smear
- É PSA (blood test for prostate cancer)
- É Serum protein electrophoresis (blood test for myeloma)
- É Thermograph

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

You should know that the plan includes:

É **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.

É **A pre-existing condition limitation.** A *pre-existing condition* is a sickness or physical condition which, within the 12-month period prior to your plan's effective date, either: (1) resulted in you receiving medical advice or treatment; or (2) caused symptoms for which an ordinarily prudent person would seek medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a Pre-existing Condition.

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

É Intentionally self-inflicted injury or action;

É Suicide or attempted suicide while sane or insane;

É Illegal activities or participation in an illegal occupation;

É 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;

É Substance abuse; **or**

É Diagnosis and/or treatment received outside the United States.



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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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Aflac Critical Illness without Cancer Monthly Rates

Mark III Accounts - Monthly (12pp/yr)

NONTOBACCO - Employee

Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$ 5.43	\$ 7.36	\$ 9.29	\$ 11.22	\$ 13.15	\$ 15.08	\$ 17.01	\$ 18.94	\$ 20.87	\$ 22.80
30-39	\$ 6.69	\$ 9.88	\$ 13.06	\$ 16.25	\$ 19.44	\$ 22.63	\$ 25.82	\$ 29.00	\$ 32.19	\$ 35.38
40-49	\$ 10.01	\$ 16.51	\$ 23.02	\$ 29.53	\$ 36.03	\$ 42.54	\$ 49.04	\$ 55.55	\$ 62.06	\$ 68.56
50-59	\$ 14.56	\$ 25.62	\$ 36.68	\$ 47.74	\$ 58.80	\$ 69.85	\$ 80.91	\$ 91.97	\$ 103.03	\$ 114.09
60-69	\$ 24.10	\$ 44.70	\$ 65.30	\$ 85.90	\$ 106.50	\$ 127.10	\$ 147.70	\$ 168.31	\$ 188.91	\$ 209.51

NONTOBACCO - Spouse

Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$ 5.43	\$ 6.40	\$ 7.36	\$ 8.33	\$ 9.29	\$ 10.26	\$ 11.22	\$ 12.19	\$ 13.15
30-39	\$ 6.69	\$ 8.28	\$ 9.88	\$ 11.47	\$ 13.06	\$ 14.66	\$ 16.25	\$ 17.85	\$ 19.44
40-49	\$ 10.01	\$ 13.26	\$ 16.51	\$ 19.77	\$ 23.02	\$ 26.27	\$ 29.53	\$ 32.78	\$ 36.03
50-59	\$ 14.56	\$ 20.09	\$ 25.62	\$ 31.15	\$ 36.68	\$ 42.21	\$ 47.74	\$ 53.27	\$ 58.80
60-69	\$ 24.10	\$ 34.40	\$ 44.70	\$ 55.00	\$ 65.30	\$ 75.60	\$ 85.90	\$ 96.20	\$ 106.50

TOBACCO - Employee

Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$ 6.45	\$ 9.40	\$ 12.34	\$ 15.29	\$ 18.24	\$ 21.19	\$ 24.14	\$ 27.08	\$ 30.03	\$ 32.98
30-39	\$ 8.57	\$ 13.63	\$ 18.70	\$ 23.76	\$ 28.83	\$ 33.89	\$ 38.96	\$ 44.03	\$ 49.09	\$ 54.16
40-49	\$ 16.43	\$ 29.35	\$ 42.28	\$ 55.20	\$ 68.13	\$ 81.05	\$ 93.98	\$ 106.90	\$ 119.83	\$ 132.75
50-59	\$ 25.36	\$ 47.23	\$ 69.09	\$ 90.95	\$ 112.81	\$ 134.68	\$ 156.54	\$ 178.40	\$ 200.26	\$ 222.13
60-69	\$ 42.90	\$ 82.30	\$ 121.70	\$ 161.11	\$ 200.51	\$ 239.91	\$ 279.31	\$ 318.71	\$ 358.11	\$ 397.51

TOBACCO - Spouse

Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$ 6.45	\$ 7.92	\$ 9.40	\$ 10.87	\$ 12.34	\$ 13.82	\$ 15.29	\$ 16.77	\$ 18.24
30-39	\$ 8.57	\$ 11.10	\$ 13.63	\$ 16.16	\$ 18.70	\$ 21.23	\$ 23.76	\$ 26.30	\$ 28.83
40-49	\$ 16.43	\$ 22.89	\$ 29.35	\$ 35.81	\$ 42.28	\$ 48.74	\$ 55.20	\$ 61.66	\$ 68.13
50-59	\$ 25.36	\$ 36.29	\$ 47.23	\$ 58.16	\$ 69.09	\$ 80.02	\$ 90.95	\$ 101.88	\$ 112.81
60-69	\$ 42.90	\$ 62.60	\$ 82.30	\$ 102.00	\$ 121.70	\$ 141.40	\$ 161.11	\$ 180.81	\$ 200.51

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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Aflac Critical Illness with Cancer Monthly Rates

Mark III Accounts - Monthly (12pp/yr)

NONTOBACCO - Employee

Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$ 6.38	\$ 9.26	\$ 12.14	\$ 15.02	\$ 17.90	\$ 20.78	\$ 23.66	\$ 26.54	\$ 29.42	\$ 32.30
30-39	\$ 8.14	\$ 12.78	\$ 17.41	\$ 22.05	\$ 26.69	\$ 31.33	\$ 35.97	\$ 40.60	\$ 45.24	\$ 49.88
40-49	\$ 13.31	\$ 23.11	\$ 32.92	\$ 42.73	\$ 52.53	\$ 62.34	\$ 72.14	\$ 81.95	\$ 91.76	\$ 101.56
50-59	\$ 20.91	\$ 38.32	\$ 55.73	\$ 73.14	\$ 90.55	\$ 107.95	\$ 125.36	\$ 142.77	\$ 160.18	\$ 177.59
60-69	\$ 35.70	\$ 67.90	\$ 100.10	\$ 132.30	\$ 164.50	\$ 196.70	\$ 228.90	\$ 261.11	\$ 293.31	\$ 325.51

NONTOBACCO - Spouse

Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$ 6.38	\$ 7.82	\$ 9.26	\$ 10.70	\$ 12.14	\$ 13.58	\$ 15.02	\$ 16.46	\$ 17.90
30-39	\$ 8.14	\$ 10.46	\$ 12.78	\$ 15.09	\$ 17.41	\$ 19.73	\$ 22.05	\$ 24.37	\$ 26.69
40-49	\$ 13.31	\$ 18.21	\$ 23.11	\$ 28.02	\$ 32.92	\$ 37.82	\$ 42.73	\$ 47.63	\$ 52.53
50-59	\$ 20.91	\$ 29.61	\$ 38.32	\$ 47.02	\$ 55.73	\$ 64.43	\$ 73.14	\$ 81.84	\$ 90.55
60-69	\$ 35.70	\$ 51.80	\$ 67.90	\$ 84.00	\$ 100.10	\$ 116.20	\$ 132.30	\$ 148.40	\$ 164.50

TOBACCO - Employee

Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$ 8.05	\$ 12.60	\$ 17.14	\$ 21.69	\$ 26.24	\$ 30.79	\$ 35.34	\$ 39.88	\$ 44.43	\$ 48.98
30-39	\$ 11.32	\$ 19.13	\$ 26.95	\$ 34.76	\$ 42.58	\$ 50.39	\$ 58.21	\$ 66.03	\$ 73.84	\$ 81.66
40-49	\$ 23.78	\$ 44.05	\$ 64.33	\$ 84.60	\$ 104.88	\$ 125.15	\$ 145.43	\$ 165.70	\$ 185.98	\$ 206.25
50-59	\$ 37.86	\$ 72.23	\$ 106.59	\$ 140.95	\$ 175.31	\$ 209.68	\$ 244.04	\$ 278.40	\$ 312.76	\$ 347.13
60-69	\$ 67.05	\$ 130.60	\$ 194.15	\$ 257.71	\$ 321.26	\$ 384.81	\$ 448.36	\$ 511.91	\$ 575.46	\$ 639.01

TOBACCO - Spouse

Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$ 8.05	\$ 10.32	\$ 12.60	\$ 14.87	\$ 17.14	\$ 19.42	\$ 21.69	\$ 23.97	\$ 26.24
30-39	\$ 11.32	\$ 15.22	\$ 19.13	\$ 23.04	\$ 26.95	\$ 30.86	\$ 34.76	\$ 38.67	\$ 42.58
40-49	\$ 23.78	\$ 33.91	\$ 44.05	\$ 54.19	\$ 64.33	\$ 74.46	\$ 84.60	\$ 94.74	\$ 104.88
50-59	\$ 37.86	\$ 55.04	\$ 72.23	\$ 89.41	\$ 106.59	\$ 123.77	\$ 140.95	\$ 158.13	\$ 175.31
60-69	\$ 67.05	\$ 98.83	\$ 130.60	\$ 162.38	\$ 194.15	\$ 225.93	\$ 257.71	\$ 289.48	\$ 321.26

Rates include cancer benefit.

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

No benefit reduction at age 70

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Continental American Insurance Company
2801 Devine Street | Columbia, South Carolina 29204

AUL Short-Term Disability Plan

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

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

Lost wages

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

Advantages of shopping at work include:

Affordable group rates

Convenient payroll deduction

Guaranteed issue for timely 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.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2011.asp)

90% of disability are caused by illness.

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

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

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

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

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

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

Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability

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

Monthly Benefit

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

Elimination Period

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

Benefit Duration

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

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

Recurrent Disability

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

Portability

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

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

Annual Enrollment

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

Exclusions and Limitations

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

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

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

Customer Service

1.800.553.5318

Disability Claims

1.866.258.8744

Fax: 1.207.591.3048

Disability Claims Email: claims@disabilityrms.com

www.employeebenefits.aul.com



AUL Short-Term Disability Monthly Rates

Benefit Duration:

13 Weeks

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

AUL Long-Term Disability Plan

LTD Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Long Term Disability Insurance.

LTD Monthly Benefit

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

LTD Elimination Period

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

LTD Benefit Duration

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

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

LTD Total Disability Definition

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

LTD Mental & Nervous / Drug & Alcohol

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

Special Conditions

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

Other Income Offsets

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

Waiver of Premium

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

Pre-Existing Condition Exclusion

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

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

Portability

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

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

Annual Enrollment

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

Exclusions and Limitations

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

Voluntary Long Term Disability	
Monthly Benefit	Monthly Rate
\$500	\$6.40
\$1,000	\$12.80
\$1,500	\$19.20
\$2,000	\$25.60

Customer Service

800-553-5318

Disability Claims

866-258-8744

Fax: 207-591-3048

Disability Claims Email: claims@disabilityrms.com

www.employeebenefits.aul.com

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

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

USAbLe Term Life Plan

Employees must be in an eligible class as defined in the Application for Group Insurance, and actively at work and working on a full time basis in order to be eligible for coverage. Dependents must be eligible as defined in the Application for Group Insurance and must be neither home-confined nor hospital confined on the effective date.

Reductions and Terminations

Life benefits will reduce by 50% at age 70, and benefits terminate at retirement. Accidental Death and Dismemberment benefits will reduce by 50% at age 70, and benefits terminate at retirement.

Voluntary Group Term Life

This program offers life insurance in increments of \$10,000 as selected by the employee. The employee may also select coverage on his/her spouse and children. Rates are based upon the employee or spouse's age at the time coverage is issued. As the employee and/or spouse moves into a new age bracket, rates increase accordingly in the same month of the original policy effective date following the age change.

Eligible Employee

All permanent, active employees as defined by employer classes who have completed the waiting period established by the Policyholder are eligible unless limited by conditions pertaining to their employment. The term "employees" includes all persons who work for the Policyholder at least the minimum number of hours per week shown on the group application.

No director, officer, consultant or other person not actively at work on behalf of the Employer will be considered an Employee unless he meets the above conditions.

Eligible Dependents

An employee's spouse and unmarried children who are not working on a full -time basis, depend upon the employee for more than 50% of his support, and under 26 years of age (or to the age shown in the Dependent Life section of the Schedule of Benefits in this proposal if the dependent is a full-time student)..

Amount of Insurance

Employee Benefit:

Each employee may select any amount desired in units of \$10,000 from a minimum of \$10,000 to a maximum of \$300,000.

Spouse Benefit:

With the election of employee benefits, coverage for spouse may be selected in units of \$10,000 from a minimum of \$10,000 to maximum of \$300,000.

Benefit for Children:

Children between the ages of 6 months and 26* years may be covered for \$ 5,000 or \$10,000.

Children age live birth to 6 months - \$1,000

Children age 6 months but less than 26 years* - \$ 5,000 or \$10,000

Death Benefit

The face amount of the policy, as determined by the schedule and as applied for and approved by US-Able Life is payable to the employee's beneficiary in the event of his death. The life insurance will be paid in a lump sum.

Active Work or Actively at Work

The Insured reports for work at his usual place of employment and is able to perform all the duties of his regular occupation for the entire normal work day. If the Insured is not actively at work on the date insurance or any increase in insurance is scheduled to take effect, it will take effect on the day the Insured returns to active work. If insurance is scheduled to take effect on a non-working day, the Insured's active work status will be based on the last working day before the scheduled effective date of insurance.

Beneficiary

Each employee may name anyone he desires, except the employer, as the beneficiary or beneficiaries to whom his life insurance is to be paid.

Right of Conversion

When the employee's coverage ceases, an employee may have the right to convert coverage. There is a 31-day conversion period; during this 31-day period and subject to the terms of the group policy, he may convert his group life insurance without evidence of insurability to an individual life insurance policy (except term insurance) without disability or other supplemental benefits.

Eligibility

In regards to U.S. or Canadian citizens working outside of the U.S. or Canada, or non-U.S. citizens working in the U.S., the following definitions apply. An eligible person means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
 - a. resides in the U.S. or Canada; or
 - b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
 - a. has a valid permanent residency visa;
 - b. participates in U.S. Social Security; and
 - c. is covered by Workers' Compensation.

Suicide Limitation

This provision applies to Voluntary Life only. If an Insured, whether sane or insane, dies by suicide within one year of the Insured's original effective date of insurance, the death benefit will be limited to the amount of premiums paid for his insurance.

After having been insured for one year, if the insured employee, whether sane or insane, dies by suicide within one year of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to employees insured on the effective date of the policy:

1. if the policy replaces another group life policy, the one year limitation on death by suicide shall be reduced by the number of months the insured employee was continuously insured by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Waiver of Premium (Extended Life Insurance Benefits)

The employee's life insurance will continue in force without premium payment while he becomes totally disabled provided:

1. he is insured under this plan and is actively at work on or after the effective date of the plan; and
2. his total disability begins before age 60; and
3. total disability has continued without interruption for at least six (6) months during which time premiums have been paid; and
4. he provides us with proof of total disability as required; and
5. he is still totally disabled when he submits the proof of disability.

The amount of insurance continued will be the amount in force on the date the insured employee becomes totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance or amendments to the group master policy. This amount will not be increased while the insured employee remains totally disabled.

The insured employee will no longer be eligible for the Extended Life Insurance Benefits, and his life insurance will terminate on the earliest of the following dates:

1. the date the insured employee ceases to be totally disabled;
2. the last day of the 60 day period following our request for proof of total disability, if he does not give us proof or he refuses to take a medical exam; or
3. the date the insured employee attains age 65. He will be entitled to the Right of Conversion as of that date.

Continuity of Coverage for Waiver of Premium upon Transfer of Insurance Carriers

In order to prevent loss of coverage because of a transfer of insurance carriers, this policy will provide waiver of premium benefits for certain employees and covered dependents, if applicable, who meet the following qualifications if a transfer of carriers would result in loss of group life insurance coverage.

We will continue an insured's group life insurance in force without premium payment if the insured becomes totally disabled provided:

1. he was insured under the prior carrier at the time of transfer; and
2. his total disability began before age 60; and
3. his total disability has continued without interruption for at least six (6) months during which time premiums were paid to the prior carrier and us; and
4. he provides us with proof of total disability as required; and
5. he is still totally disabled when submitting proof of disability; and
6. this policy remains in force.

Termination of Insurance

Insurance will terminate automatically at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy or a specific benefit terminates;
3. the date the insured ceases to be a member of an eligible class;
4. the date the insured ceases to be actively at work, or
5. if the insured continues coverage under the Waiver of Premium provision, the date specified under "Termination of the Extended Insurance Benefit."

Accelerated Benefit Plan

The accelerated benefit is advance payment of the insured's amount of life insurance under the group policy subject to the maximum and minimum benefit requirement stated below. An insured may request payment of an accelerated benefit in the event that he is diagnosed with a terminal illness which is expected to result in his death within 12 months, and from which he is not expected to recover.

The receipt of accelerated benefit payments may adversely affect the insured's eligibility for Medicaid or other government benefits or entitlements.

Accelerated Benefit Eligibility

Insured employees or dependents are eligible if they are under age 70 and insured for a minimum benefit of \$10,000 of life insurance under the policy.

Amount of Accelerated Benefit

The accelerated benefit will be paid only once and in one lump sum to the insured before death occurs. The maximum accelerated benefit will be the lesser of:

1. 75% of the insured's life insurance amount; or
2. \$250,000.

If the insured's life insurance amount is scheduled for a reduction within 12 months after the date he requests the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount. The minimum accelerated benefit for the insured member or insured dependent will be \$7,500.

Effect of Payment of An Accelerated Benefit Payment On Group Policy Provisions

The amount of life insurance under the group policy will be reduced by the amount of any accelerated benefit that has been previously paid. As a result, the following will be based on the reduced life insurance amount:

1. the amount of insurance payable to the beneficiary when the insured dies;
2. the amount of life insurance an insured can convert under the group policy; and
3. the premiums payable for the insured's life insurance under the group policy after an accelerated benefit is paid, if such premiums are not waived.

The payment of an accelerated benefit will not affect the amount of the insured's Accidental Death and Dismemberment Benefits under the group policy, if any.

Exclusions

We will not pay an accelerated benefit if:

1. the insured has made an absolute assignment of his life insurance under the group policy and we do not receive written consent by the absolute assignee;
2. all or part of the life insurance under the group is to be paid to the insured's child(ren) or former spouse as part of a court approved divorce agreement;

3. the insured has made an irrevocable beneficiary designation of his life insurance and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends Under This Benefit

Insurance will end at the earliest of:

1. the date the accelerated benefit is paid to the insured or on his behalf;
2. the date the insured's life insurance ends under the group policy; or
3. the policy anniversary on which the insured is age 70

On-line Will Preparation

This policy includes a free on-line will preparation service to employees. The Estate Guidance Program offered through ComPsych allows employees to create an on-line will. The will helps to control who gets control of property, who will be the guardian of children and who will manage the estate upon an employee's death.

Living Will preparation and Durable Power of Attorney documents are also free.

Emergency Medical Travel Assistance Coverage

USABLE Life makes traveling worry-free with a comprehensive global emergency services program from Assist America. Your covered employees can travel anywhere in the world knowing they are still connected to quality medical care and emergency assistance, 24/7.

USABLE Life understands that whether your employees are traveling on business or pleasure, unexpected events can occur. That's why USABLE Life brings provides the enhanced benefits of Assist America, a service travelers turn to each day for help with medical emergencies away from home.

What is Assist America?

Assist America is a global emergency medical travel assistance company. Anytime your employee, their spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country-with or without the employee present*-they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on an employee's behalf. Services include:

- Medical Consultation & Referral
- Medical Monitoring
- Prescription Assistance
- Hospital Admission Guarantee
- Emergency Medical Evacuation
- Compassionate Visit
- Care of Minor Children
- Medical Repatriation
- Return of Mortal Remains
- Emergency Trauma Counseling

- Legal & Interpreter Referrals
- Much more

Services are available 24 hours a day, 365 days a year, anywhere in the world.

This program, provided to you through USABLE Life:

- Alleviates the stress of being sick or injured away from home for the employee and employer-Assist America takes care of everything
- Provides protection and peace of mind for traveling employees and their families
- Introduces a popular “living benefit” that builds good will between employers and employees
- Protects a company’s greatest assets, its employees, by ensuring they receive appropriate medical care according to the industry’s highest standards
- Eliminates large, unpredictable evacuation/repatriation expenses
- Works with employees’ health insurance plans

Assist America pays for all of the assistance services it provides with no caps, limits or charge-backs to anyone and with no exclusions for pre-existing conditions, adventure sports, geographic risk or alcohol-related incidents.

*Spouses traveling on behalf of their employer are excluded.

Portability

This section applies to the Voluntary Life Insurance Benefit only.

Portability Benefit

The insured employee may continue his and his spouse’s voluntary term life insurance if employment terminates and he meets the following requirements on the date his employment terminates:

1. he is not disabled*; and
2. he either:
 - a. is not retired and is under age 70; or
 - b. is retired and is under age 65.

Coverage will be continued under the policy for employees who elect continuation of coverage under this portability provision. Portability is not available upon policy cancellation.

* Not applicable in North Carolina

A spouse’s term life insurance may not be continued if the insured employee’s term life insurance is not continued. Dependent children are not eligible for the Portability provision; however, the dependent children’s coverage may be converted under the “Conversion Privilege” provisions of the policy.

When Portability Ends

An insured employee's continued coverage under this provision will end automatically on the earliest of the following:

- the date the last period ends for which a premium payment is made;
- the premium due date following the employee's attainment of age 70;
- if coverage continued due to the insured employee's retirement prior to age 65, on the premium due date following attainment of age 65;
- the date the insured employee become a full-time member of the armed forces of any country; or
- spouse coverage will end on the premium due date following the date the spouse ceases to be dependent as defined in the policy, or
- spouse coverage will end on the premium due date following the spouse's attainment of age 65.

When the insured employee's insurance under the portability provision ends, he and his spouse will be eligible to convert insurance to an individual policy under the "Conversion Privilege" provisions.

Other Policy Provisions

The Life Insurance - Waiver of Premium and the Group Life Accelerated Benefit provisions will not apply to insurance continued under the Portability provision.

SCHEDULE OF BENEFITS

BASIC LIFE INSURANCE and AD&D:

- Employee - \$10,000 (No Cost To You)
- Dependent - \$1,000 spouse / \$1,000 child (Cost: \$.50 per month)
(available without employee voluntary life coverage)

EMPLOYEE & SPOUSE VOLUNTARY LIFE INSURANCE:

(\$10,000 to \$300,000 in increments of \$10,000).

\$10,000, \$20,000, *\$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, **\$100,000, \$110,000, \$120,000, \$130,000, \$140,000, \$150,000, \$160,000, \$170,000, \$180,000, \$190,000, \$200,000, \$210,000, \$220,000, \$230,000, \$240,000, \$250,000, \$260,000, \$270,000, \$280,000, \$290,000, \$300,000.

CHILD(REN) VOLUNTARY LIFE INSURANCE:

\$5,000 or \$10,000

*\$30,000 maximum guaranteed issue amount for spouse. No guaranteed issue over age 69.

**\$100,000 maximum guaranteed issue amount for employees. No guaranteed issue over age 69.

Must purchase at least \$10,000 voluntary life on employee in order to purchase spouse or child coverage.
(Spouse coverage is limited to 100% of the employees amount).



***US Able Life
US Able Corporate Center
P.O. Box 1650
Little Rock, Arkansas 72203***

Toll Free: (800) 648-0271

Or: (501) 375-7200

Fax: (501) 235-8404

Hertford County
Voluntary Group Term Life (VGTL) Rates
Monthly Premium

This program offers life insurance in increments of \$10,000 as selected by the employee. The employee may also select coverage on his/her spouse and children. Rates are based upon the employee or spouse's age at the time coverage is issued. As the employee and/or spouse moves into a new age bracket, rates increase accordingly in the same month of the original policy effective date following the age change.

Benefit Amount	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000.00	\$0.86	\$1.30	\$1.72	\$2.80	\$4.52	\$7.32	\$12.48	\$17.86	\$28.82	\$47.30	\$78.70
\$20,000.00	\$1.72	\$2.60	\$3.44	\$5.60	\$9.04	\$14.64	\$24.96	\$35.72	\$57.64	\$94.60	\$157.40
\$30,000.00	\$2.58	\$3.90	\$5.16	\$8.40	\$13.56	\$21.96	\$37.44	\$53.58	\$86.46	\$141.90	\$236.10
\$40,000.00	\$3.44	\$5.20	\$6.88	\$11.20	\$18.08	\$29.28	\$49.92	\$71.44	\$115.28	\$189.20	\$314.80
\$50,000.00	\$4.30	\$6.50	\$8.60	\$14.00	\$22.60	\$36.60	\$62.40	\$89.30	\$144.10	\$236.50	\$393.50
\$60,000.00	\$5.16	\$7.80	\$10.32	\$16.80	\$27.12	\$43.92	\$74.88	\$107.16	\$172.92	\$283.80	\$472.20
\$70,000.00	\$6.02	\$9.10	\$12.04	\$19.60	\$31.64	\$51.24	\$87.36	\$125.02	\$201.74	\$331.10	\$550.90
\$80,000.00	\$6.88	\$10.40	\$13.76	\$22.40	\$36.16	\$58.56	\$99.84	\$142.88	\$230.56	\$378.40	\$629.60
\$90,000.00	\$7.74	\$11.70	\$15.48	\$25.20	\$40.68	\$65.88	\$112.32	\$160.74	\$259.38	\$425.70	\$708.30
\$100,000.00	\$8.60	\$13.00	\$17.20	\$28.00	\$45.20	\$73.20	\$124.80	\$178.60	\$288.20	\$473.00	\$787.00
\$110,000.00	\$9.46	\$14.30	\$18.92	\$30.80	\$49.72	\$80.52	\$137.28	\$196.46	\$317.02	\$520.30	\$865.70
\$120,000.00	\$10.32	\$15.60	\$20.64	\$33.60	\$54.24	\$87.84	\$149.76	\$214.32	\$345.84	\$567.60	\$944.40
\$130,000.00	\$11.18	\$16.90	\$22.36	\$36.40	\$58.76	\$95.16	\$162.24	\$232.18	\$374.66	\$614.90	\$1,023.10
\$140,000.00	\$12.04	\$18.20	\$24.08	\$39.20	\$63.28	\$102.48	\$174.72	\$250.04	\$403.48	\$662.20	\$1,101.80
\$150,000.00	\$12.90	\$19.50	\$25.80	\$42.00	\$67.80	\$109.80	\$187.20	\$267.90	\$432.30	\$709.50	\$1,180.50
\$160,000.00	\$13.76	\$20.80	\$27.52	\$44.80	\$72.32	\$117.12	\$199.68	\$285.76	\$461.12	\$756.80	\$1,259.20
\$170,000.00	\$14.62	\$22.10	\$29.24	\$47.60	\$76.84	\$124.44	\$212.16	\$303.62	\$489.94	\$804.10	\$1,337.90
\$180,000.00	\$15.48	\$23.40	\$30.96	\$50.40	\$81.36	\$131.76	\$224.64	\$321.48	\$518.76	\$851.40	\$1,416.60
\$190,000.00	\$16.34	\$24.70	\$32.68	\$53.20	\$85.88	\$139.08	\$237.12	\$339.34	\$547.58	\$898.70	\$1,495.30
\$200,000.00	\$17.20	\$26.00	\$34.40	\$56.00	\$90.40	\$146.40	\$249.60	\$357.20	\$576.40	\$946.00	\$1,574.00
\$210,000.00	\$18.06	\$27.30	\$36.12	\$58.80	\$94.92	\$153.72	\$262.08	\$375.06	\$605.22	\$993.30	\$1,652.70
\$220,000.00	\$18.92	\$28.60	\$37.84	\$61.60	\$99.44	\$161.04	\$274.56	\$392.92	\$634.04	\$1,040.60	\$1,731.40
\$230,000.00	\$19.78	\$29.90	\$39.56	\$64.40	\$103.96	\$168.36	\$287.04	\$410.78	\$662.86	\$1,087.90	\$1,810.10
\$240,000.00	\$20.64	\$31.20	\$41.28	\$67.20	\$108.48	\$175.68	\$299.52	\$428.64	\$691.68	\$1,135.20	\$1,888.80
\$250,000.00	\$21.50	\$32.50	\$43.00	\$70.00	\$113.00	\$183.00	\$312.00	\$446.50	\$720.50	\$1,182.50	\$1,967.50
\$260,000.00	\$22.36	\$33.80	\$44.72	\$72.80	\$117.52	\$190.32	\$324.48	\$464.36	\$749.32	\$1,229.80	\$2,046.20
\$270,000.00	\$23.22	\$35.10	\$46.44	\$75.60	\$122.04	\$197.64	\$336.96	\$482.22	\$778.14	\$1,277.10	\$2,124.90
\$280,000.00	\$24.08	\$36.40	\$48.16	\$78.40	\$126.56	\$204.96	\$349.44	\$500.08	\$806.96	\$1,324.40	\$2,203.60
\$290,000.00	\$24.94	\$37.70	\$49.88	\$81.20	\$131.08	\$212.28	\$361.92	\$517.94	\$835.78	\$1,371.70	\$2,282.30
\$300,000.00	\$25.80	\$39.00	\$51.60	\$84.00	\$135.60	\$219.60	\$374.40	\$535.80	\$864.60	\$1,419.00	\$2,361.00

Child Rates:

All eligible children can be covered for one premium.

- Coverage: \$10,000 Monthly Premium: \$3.00
- Coverage: \$5,000 Monthly Premium: \$1.50

Texas Life Whole Life Plan- Solutions 121

Common Issue Date: August 1, 2015

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

TEXASLIFE INSURANCE
COMPANY

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

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)

Continuing Your Benefits

Upon Termination of Employment

To Continue Your Medical, Dental and/or Vision Plan

Under the group medical, dental, and vision plans you and your covered dependents are eligible to continue coverage through COBRA. For COBRA information, call 800.852.7040 then press option 3 for the COBRA Department.

AUL Short-Term and/or Long-Term Disability

Once an employee is on the AUL disability plan for 12 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to Port your coverage by calling **1.800.553.5318**.

USAbLe Term Life

When you leave 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. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 30 days from the date of termination. For more information and a quote, please contact USAbLe at **800.648.0271**. 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 **Aflac Group Accident, Aflac Group Critical Illness, Aflac Group Hospital Indemnity, Humana Cancer, and Texas Life** policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home.

For more information, contact:

Humana at 1.800.521.3535

Aflac Group at 1.800.433.3036

Texas Life at 1.800.283.9233

Contact Information for Questions and Claims

MedCost Benefit Services

Customer Service - 800-795-1023
mbscs@medcost.com

Ameritas Dental

Customer Service
1-800-487-5553
www.ameritas.com

Superior Vision

11101 White Rock Rd.
Rancho Cordova, CA 95670
800-507-3800
www.superiorvision.com

Aflac Group

PO Box 427
Columbia, SC 29202
Customer Service
1-800-433-3036
www.aflacgroupinsurance.com

Humana Cancer

Customer Service:
1-855-448-6982
Claims Email address: claims@bbadmin.com
Claims Fax Number:
512-275-9350
Claims Mailing Address:
Humana
Attn: WVB Claims
PO BOX 13068
Green Bay, WI 54307-3068

American United Life (AUL)/OneAmerica

Claims Toll-Free Number

1-866-258-8744

Customer Service

1-800-553-5318

USABLE

Group Term Life

800-648-0271

www.usablelife.com

Texas Life Insurance Company

PO Box 830

Waco, TX 76703-0830

800-283-9233

Mark III Brokerage

211 Greenwich Rd

Charlotte, NC 28211

1-800-532-1044

www.markiiibrokerage.com/hertfordcountync