Table of Contents

Pre-Tax Benefits

BCBS HSA Plan 2

Ameritas Dental Plan High Plan 12

Ameritas Dental Plan Low Plan 15

Community Eye Care Plan 18

Aflac Accident Insurance Plan 20

Allstate Benefits Cancer Plan 25

Aflac Hospital Indemnity Insurance Plan 34

Aflac Critical Illness Insurance Plan 39

After-Tax Benefits

AUL Short Term Disability Plan 44

Sun Life Long Term Disability Plan 48

Sun Life Term Life Plan 52

Boston Mutual Whole Life Plan 57

For Your Reference

Continuation of Benefits 60

Contact Information for Questions and Claims 61

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 31 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.

BlueCross BlueShield of North Carolina: Blue Options

Coverage Period: 07/01/2015 - 06/30/2016

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

Coverage for: Individual + Family **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.bcbsnc.com or by calling **1-877-258-3334**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/**$3,000** family in-network. **$3,000** person/**$6,000** family out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For In-Network **$3,500** person/**$5,000** family. For Out-Of-Network **$7,000** person/**$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/content/providersearch/index.htm or	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 **providers.**

	please call the number on the back of your card	
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about **excluded services.**

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

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

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

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	20% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	-Precertification required
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance/ outpatient	50% coinsurance	-Prior authorization may be required
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	-Precertification required
	Substance use disorder outpatient services	20% coinsurance/ outpatient	50% coinsurance	-Prior authorization may be required
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	-Precertification required
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	No coverage for maternity for dependent children
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	-Precertification may be required
If you need help recovering or have	Home health care	20% coinsurance	50% coinsurance	- Prior authorization may be required for benefits to be provided

Questions: Call 1-877-258-3334 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-258-3334 to request a copy.

P201811 C299841

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

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

Questions: Call 1-877-258-3334 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-258-3334 to request a copy.

P201811 C299841

Excluded Services & Other Covered Services:

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

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

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

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

- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)
- Chiropractic care
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Hearing aids up to age 22
- Private duty nursing

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

Questions: Call 1-877-258-3334 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-258-3334 to request a copy.

P201811 C299841

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 the number listed on your ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-258-3334 or **mybcbsnc.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable. You may also contact North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or 800-546-5664 (outside North Carolina), 919-807-6750 (in North Carolina), if applicable.

Additionally, a consumer assistance program can help you file your appeal. Services provided by Health Insurance Smart NC are available through the North Carolina Department of Insurance. Contact Health Insurance Smart NC, North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, Toll free: (855) 408-1212.

Does This Coverage Provide Minimum Essential Coverage?

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

Does This Coverage Meet the Minimum Value Standard?

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

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

Language Access Services:

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,700
- **You pay** $2,800

Sample care costs:

Sample care costs	Amount
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:

Patient pays	Amount
Deductibles	$1,500
Copays	$0
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$2,800**

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

- **Amount owed to providers:** $5,100
- **Plan pays** $2,800
- **You pay** $2,300

Sample care costs:

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

Patient pays:

Patient pays	Amount
Deductibles	$1,500
Copays	$0
Coinsurance	$700
Limits or exclusions	$50
Total	**$2,300**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Ameritas Dental High Plan

Effective Date: July 1, 2015

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

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

- Evaluations (Two per benefit period)
- Fluoride for Children (Under age 19)
- Full Mouth and Other X-Rays
- Cleanings (Two per benefit period)
- Bitewings (Two per benefit period)
- Space Maintainers

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

- Sealants
- Simple Extractions
- Fillings

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

- Complex Oral Surgery
- Endodontics
- General Anesthesia
- Dentures
- Periodontics
- Repairs - Crowns, Bridges, Dentures
- Crowns
- Bridges

LATE ENTRANT PROVISION
There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees and eligible dependents who do not enroll when first eligible for coverage. The waiting period will be waived for employees and eligible dependents who enroll when first eligible.

ANNUAL MAXIMUM BENEFIT
Type I, II and III Procedures - $1,000 per calendar year per person.

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

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $500.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $500, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,000 in any one year.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 26

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

SECTION 125

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

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

LIMITATIONS/EXCLUSIONS (This is not a complete List)

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

Semi-Monthly Rates

Employee Only	$15.12
Employee + Spouse	$29.84
Employee + Children	$31.62
Family	$46.77

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service
1-800-487-5553

Web Address
www.ameritas.com

Ameritas Dental Low Plan

Effective Date: July 1, 2015

COMBINED CALENDAR YEAR DEDUCTIBLE

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

TYPE I - PREVENTIVE AND DIAGNOSTIC

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

- Evaluations (Two per benefit period)
- Fluoride for Children (Under age 19)
- Full Mouth and Other X-Rays
- Cleanings (Two per benefit period)
- Bitewings (Two per benefit period)
- Space Maintainers

TYPE II - BASIC PROCEDURES

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

- Sealants
- Simple Extractions
- Fillings

LATE ENTRANT PROVISION

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

ANNUAL MAXIMUM BENEFIT

Type I and II Procedures - $1,000 per calendar year per person.

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

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $500.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $500, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,000 in any one year.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

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

ELIGIBLE DEPENDENTS
Provides Coverage On:
- Your Spouse
- Children up to age 26

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

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

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

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

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

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

Semi-Monthly Rates

Employee	$9.22
Employee + Spouse	$17.99
Employee + Children	$23.96
Family	$33.74

FOR CLAIMS/CUSTOMER SERVICE QUESTIONS CONTACT AMERITAS AT:
(800) 487-5553 or www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service
1-800-487-5553

Web Address
www.ameritas.com

Community Eye Care Vision Plan

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

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

The Benefit

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

- An eye examination every 12 months *($20 co-pay)*
- An eyewear allowance of $150 (per person) every 12 months *($0 co-pay)*
- A contact lens fitting, re-fit or evaluation every 12 months *($15 co-pay)*

The eyewear allowance is completely flexible. It can be applied to frames, eyeglass lenses, contact lenses, special lens options, or any combination. As long as you select eyewear having a retail price that's less than or equal to your allowance, you incur no out-of-pocket cost for the eyewear. If the eyewear you choose is more expensive than $150, you are eligible for attractive discounts on the overage amount from most network providers: 20% for frames and lenses, and 10% for contact lenses.

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

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

How to Use Your Benefit

1) Select a provider from the Community Eye Care provider network.
2) Call the provider to make an appointment, and let them know that you have Community Eye Care coverage.
3) See the provider and select your eyewear.
4) Pay the provider your co-pays, plus any discounted amount that exceeds the $150 eyewear allowance.

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

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

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

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

Semi-monthly Rates (24 deductions)	
Employee Only	**$5.15**
Employee + One	**$9.75**
Employee + Family	**$14.63**

Customer Service and Claims Administration

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

www.communityeyecare.net

2359 Perimeter Pointe Parkway
Suite 150
Charlotte, NC 28208

Aflac Accident Plan

*The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a **general summary** of the coverage. This overview is subject to the terms, conditions, and limitations of policy series ACC 7700.*

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 the 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
- Emergency room use
- Surgery and anesthesia
- Casts
- Crutches
- Wheelchairs
- Stitches

These costs add up—fast. 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 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?

- There's no limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Spouse and dependent child coverage is available.
- The plan provides 24-hour protection.
- There are benefits for inpatient and outpatient treatment of covered accidents.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- 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.

What is *guaranteed-issue coverage*? Am I eligible?

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

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

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

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week;
- Have been employed for at least 0 continuous days by the enrollment date; **and**
- Are not a seasonal or temporary employee.

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

What core benefits does the Aflac accident plan feature?

- **Accident Benefits**
  You may receive benefits if you incur one of the following covered events:
    - Fractures
    - Dislocations
    - Paralysis
    - Lacerations
    - Injuries requiring surgery
        - Eye injuries
        - Removal of foreign body
        - Ruptured disc
        - Torn knee cartilage
        - Tendons/ligaments
    - Burns (second- and third-degree)
    - Concussion
    - Coma
    - Internal injuries
    - Exploratory surgery
    - Emergency dental work
- **Medical Fees Benefit**
  You may receive this benefit for up to six treatments per covered accident for physician charges, emergency room services and supplies, and X-rays.
- **Accident Follow-Up Treatment Benefit**
  You may receive this benefit for up to six treatments per covered accident for follow-up treatment.
- **Physical Therapy Benefit**
  You may receive this benefit for up to six treatments per covered accident for physical therapy.

- **Ambulance Benefit**
  You may receive this benefit if you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident.
- **Transportation Benefit**
  You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn't available in your hometown).
- **Blood/Plasma Benefit**
  You may receive this benefit if you receive blood and plasma within 90 days after 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 a 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. Aflac 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.
  - 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.

- Having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

What would my semi-monthly payroll deduction cost be for the Aflac accident plan?

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

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 • 2801 Devine Street • Columbia, South Carolina 29205

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 a major medical program.

800.433.3036 | aflacgroupinsurance.com

Allstate Benefits Group Cancer Plan

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

Group Voluntary Cancer

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

Meeting Your Needs:

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

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

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It can help protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

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

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability †

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

****Primary insured only***

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

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

† ***Enrolling after your initial enrollment period requires evidence of insurability***

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

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

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

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

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

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

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

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

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

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

1 Cancer Facts & Figures, American Cancer Society, 2011.

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

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

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

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

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

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

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

Blood, Plasma, and Platelets

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

Physician's Attendance

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

At Home Nursing

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

Prosthesis

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

Hair Prosthesis

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

Nonsurgical External Breast Prosthesis

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

Ambulance

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

Hospice Care

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

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

Extended Care Facility

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

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

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

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

Waiver of Premium (primary insured only)
If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured employee remains disabled.

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

<u>ADDITIONAL BENEFITS</u>
Wellness
A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15-3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer);

CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA Testing and Digital Rectal Exams - if over 50 or over 40 and at high risk for prostate cancer; (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

<u>OPTIONAL BENEFITS</u>

Cancer Initial Diagnosis (First Occurrence)

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

Intensive Care (Low and High Plans Only)*

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

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

***This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.**
****This benefit is not disease-specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**

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

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

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

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision, the date you are no longer in an eligible class, or the date your class is no longer eligible. We will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse’s coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person,

the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished in writing when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

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

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

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

The policy is Limited Benefit Cancer and Specified Disease Insurance. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than January 15, 2016. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, call your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

Allstate Benefits is the marketing name used by
American Heritage Life Insurance Company
(Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.
Allstate Benefits, *The Workplace Marketer* ©
1776 American Heritage Life Drive, Jacksonville, Florida 32224
Customer Care Center: 1.800.521.3535
www.allstate.com or AllstateBenefits.com

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

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

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

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

Allstate®

Benefits

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
- Full-time, benefit-eligible employees working at least 20 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

Hospital Confinement (per day)	*High Option*	*Low Option*
	$150	*$100*

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.

Hospital Admission (per confinement)	*High Option*	*Low Option*
	$1,500	*$500*

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.

Surgical Benefit (per procedure)	*High Option*	*Low Option*
	Up to $1,500	*Up to $750*

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.

Anesthesia Benefits	*High Option*	*Low Option*
	Up to $375	*Up to $187.50*

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.

Wellness Benefit	*High Option*	*Low Option*
	$50	*$50*

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:
1. The date the plan is terminated, for Class I insureds;
2. The 31st day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
4. 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:
1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. 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.

Semi-Monthly Premium Rates

	High Option	*Low Option*
Employee	$15.48	$7.85
Employee and Spouse	$30.59	$15.52
Employee and Dependent Child(ren)	$21.46	$10.76
Employee and Family	$36.57	$18.43

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

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

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.

Customer Service
800.433.3036
www.aflacgroupinsurance.com

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. This brochure is subject to the terms, conditions, and limitations of Policy Series CA8500-MP(VA).

Aflac Critical Illness Plan

*The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a **general summary** of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CI 2800.*

What is Aflac critical illness insurance? Why should I consider it?

Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

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

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

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

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5000 to $50,000 for employees. The benefit amount for spouses range from $5,000 to $25,000.
- Each dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

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

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

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week;
- Have been employed for at least 0 continuous days by the enrollment date; **and**
- Are not a seasonal or temporary employee.

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

What core benefits does the Aflac critical illness plan feature?

- **First Occurrence Benefit**

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

- **Additional Occurrence Benefit**

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

- **Reoccurrence Benefit**

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

- **Heart Benefit**

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

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

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

- **Health Screening Benefit**

  After the waiting period, you may receive a maximum of $100 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

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

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

You should know that the plan includes:

- A **30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.
- A **pre-existing condition limitation.** A *pre-existing condition* is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.
- **Certain exclusions.** No benefits are payable for loss resulting from:
  - Intentionally self-inflicted injury or action;
  - Suicide or attempted suicide while sane or insane;
  - Illegal activities or participation in an illegal occupation;
  - War - participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service.
  - Substance abuse; **or**
  - Diagnosis and/or treatment received outside the United States.

Guaranteed Issue – $10,000 for Employee and $5,000 for Spouse

What would my semi-monthly payroll deduction cost be for the Aflac critical illness plan?

Semi-Monthly Cost for Your Coverage *if You Do Not Use Tobacco*										
Age	**Benefit Amount**									
	$5,000	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18–29	$2.68	$3.60	$4.53	$5.45	$6.38	$7.30	$8.23	$9.15	$10.08	$11.00
30–39	$3.28	$4.80	$6.33	$7.85	$9.38	$10.90	$12.43	$13.95	$15.48	$17.00
40–49	$4.85	$7.95	$11.05	$14.15	$17.25	$20.35	$23.45	$26.55	$29.65	$32.75
50–59	$6.73	$11.70	$16.68	$21.65	$26.63	$31.60	$36.58	$41.55	$46.53	$51.50
60–69	$9.75	$17.75	$25.75	$33.75	$41.75	$49.75	$57.75	$65.75	$73.75	$81.75

Semi-Monthly Cost for Your Spouse's Coverage *if Your Spouse Does Not Use Tobacco*									
Age	**Benefit Amount**								
	$5,000	**$7,500**	**$10,000**	**$12,500**	**$15,000**	**$17,500**	**$20,000**	**$22,500**	**$25,000**
18–29	$2.68	$3.14	$3.60	$4.06	$4.53	$4.99	$5.45	$5.91	$6.38
30–39	$3.28	$4.04	$4.80	$5.56	$6.33	$7.09	$7.85	$8.61	$9.38
40–49	$4.85	$6.40	$7.95	$9.50	$11.05	$12.60	$14.15	$15.70	$17.25
50–59	$6.73	$9.21	$11.70	$14.19	$16.68	$19.16	$21.65	$24.14	$26.63
60–69	$9.75	$13.75	$17.75	$21.75	$25.75	$29.75	$33.75	$37.75	$41.75

Semi-Monthly Cost for Your Coverage *if You Use Tobacco*										
Age	**Benefit Amount**									
	$5,000	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
18–29	$3.15	$4.55	$5.95	$7.35	$8.75	$10.15	$11.55	$12.95	$14.35	$15.75
30–39	$4.18	$6.60	$9.03	$11.45	$13.88	$16.30	$18.73	$21.15	$23.58	$26.00
40–49	$7.90	$14.05	$20.20	$26.35	$32.50	$38.65	$44.80	$50.95	$57.10	$63.25
50–59	$11.58	$21.40	$31.23	$41.05	$50.88	$60.70	$70.53	$80.35	$90.18	$100.00
60–69	$17.05	$32.35	$47.65	$62.95	$78.25	$93.55	$108.85	$124.15	$139.45	$154.75

Semi-Monthly Cost for Your Spouse's Coverage *if Your Spouse Uses Tobacco*									
Age	**Benefit Amount**								
	$5,000	**$7,500**	**$10,000**	**$12,500**	**$15,000**	**$17,500**	**$20,000**	**$22,500**	**$25,000**
18–29	$3.15	$3.85	$4.55	$5.25	$5.95	$6.65	$7.35	$8.05	$8.75
30–39	$4.18	$5.39	$6.60	$7.81	$9.03	$10.24	$11.45	$12.66	$13.88
40–49	$7.90	$10.98	$14.05	$17.13	$20.20	$23.28	$26.35	$29.43	$32.50
50–59	$11.58	$16.49	$21.40	$26.31	$31.23	$36.14	$41.05	$45.96	$50.88
60–69	$17.05	$24.70	$32.35	$40.00	$47.65	$55.30	$62.95	$70.60	$78.25

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 • 2801 Devine Street • Columbia, South Carolina 29205

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 a major medical program.

800.433.3036 | aflacgroupinsurance.com

AUL Short-Term Disability Plan

Effective Date**:* ***July 1, 2015

Why do you need Disability Insurance? Consider this . . .

Statistics show you are much more likely to be injured in an accident than to die from one.

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.[1]
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.[1]
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.[1]

While many people survive accidental injuries, many others live with serious illnesses.

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.[2]
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three are up dramatically! Things that use to kill now disable.[5]

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

1 National Safety Council, Injury Facts, 2003 Edition
2 American Cancer Society, Cancer Facts & Figures 2004
3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update
4 American Lung Association, Lung Disease Data 2003
5 National Underwriter, May 2002

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 a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly 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 for a sickness and zero (0) days for injury.

Benefit Duration
This is the period of time that benefits will be payable for disability. The benefit duration is 26 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.

Annual Enrollment
Employees who 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.

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

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

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

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

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

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

Customer Service
800-553-5318

Disability Claims
866-258-8744
Fax: 207-591-3048

For a copy of your policy certificate, claim form, or application to port form, please visit
www.markiiibrokerage.com/yanceycountync.

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

AUL Short-Term Disability
Semi-Monthly Rates

Benefit Duration*:*
26 weeks

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

Sun Life Long-Term Disability Plan

Effective Date: July 1, 2015
This benefit is employer paid.

Group Long Term Disability, underwritten by Sun Life offers to pay benefits to insureds who are totally disabled and because of injury or sickness cannot perform the material and substantial duties of their regular occupation, is not working in any occupation, and is under the regular attendance of a physician for that injury or sickness.

Long Term Disability insurance is needed by employees as an opportunity to substitute a percentage of income lost should they become sick or injured. Under Sun Life's contract, the monthly benefit is paid directly to the insured who can use the benefit to help with ongoing personal expenses.

Features and Benefits

- Affordability
- Partial Disability benefits
- Normal pregnancy and certain complication of pregnancy included within the definition of sickness
- Benefits for disability due to mental illness can be payable up to 12 months
- Benefits for disability due to drug and alcohol abuse can be payable up to 12 months
- Survivor benefit
- Waiver of premium
- Portability

Following completion of any waiting period, employees are eligible to apply for coverage if they are Actively-at-work and working a minimum of 30 hours per week. If the employee does not apply for coverage within 31 days of becoming eligible, evidence of insurability and medical underwriting is required.

Elimination Period
Elimination period is a period of consecutive days of total disability for which no benefit is payable. The elimination period is 180 days and begins on the first day of total disability.

Maximum Benefit Duration
Up to the greater of the Employee's Social Security Full Retirement Age (SSFRA) or age 65, if disabled prior to age 60. If disabled after age 60, on the scale as outlined below from the contract:

Age When Total Disability Begins	Maximum Duration
Less Than Age 60	**Greater of: SSFRA or To Age 65**
60	5 Years
61	4 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

Maximum Monthly Benefit
60% of covered monthly earnings not to exceed a maximum monthly benefit of $5,000.00, and then reduced by other income benefits. All eligible full time employees are able to apply for the coverage and the premium rate is based upon age.

Pre-Existing Condition Exclusion
Benefits are not payable if the insured's disability begins in the first 12 months following the effective date of coverage and the disability is caused by, contributed to, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed for which the insured received medical treatment, consultation, care, or services including diagnostic measures or was prescribed drugs or medicines in the 3 months just prior to the insurance effective date.

Partial Disability Benefit
Partial disability is when because of injury or sickness the insured cannot perform the material and substantial duties of his regular occupation on a full time basis, but is performing at least one of the material and substantial duties of his regular occupation or another occupation on a part or full time basis, current monthly income is less than 80% of his indexed pre-disability earnings due to the same injury or sickness causing the disability, and is under the regular attendance of a physician for that injury and sickness. When proof is received showing an insured is partially disabled, partial disability benefits can be payable following completion of the longer of the elimination period or 30 consecutive days of total disability.

Survivor Benefit
Eligible survivor's may be entitled to a lump sum benefit when proof acceptable to Sun Life is received that the insured died after disability, had continued for 180 or more consecutive days and while the insured was receiving a monthly benefit. The lump sum benefit can be an amount equal to three times the insured's last gross monthly benefit.

Waiver of Premium
Premiums for an insured can be waived during any period that disability benefits are paid.

Accumulation of Elimination Period
If disability ceases during the elimination period for not more than 30 days, then the disability will be treated as continuous.

Recurrent Disability Provision
If the insured resumes his regular occupation on a full-time basis and performs each material and substantial duty of that occupation for less than 6 months, a recurrent disability will be part of the same period of disability. The recurrent disability must be the direct result of the injury or sickness that caused the prior disability. The insured will not have to complete a new elimination period. Benefit payments will be subject to the terms of the contract for the prior disability.

Pregnancy
Sickness is an illness, bodily disorder or disease, mental illness, normal pregnancy, and complications of pregnancy which is a concurrent disease or abnormal conditions significantly affecting the usual medical management of pregnancy; or any condition requiring non-elective caesarean section delivery.

Mental Illness Conditions
Monthly benefits for disability due to mental illness are not payable beyond the maximum benefit duration. If the maximum benefit duration is longer than 24 months, benefits for disability due to mental illness will not exceed 24 months of monthly benefit payments unless the insured is in a hospital or institution at the end of the 12 month period, and confinement begins during the Elimination Period; or during the 12 months following the Elimination Period; and confinement is for at least 14 consecutive days.

Alcohol and Drug Abuse
Monthly benefits for disability due to drug and alcohol abuse are not payable beyond the maximum benefit duration. In addition, if the maximum benefit duration is longer than 24 months, benefits for disability due to drug and alcohol abuse will not exceed 24 months of monthly benefit payments.

General Exclusions
Coverage is not provided for any disability due to events including but not limited to:
- Intentionally self-inflicted injuries
- War, declared or undeclared, or any act of war
- Active participation in a riot, rebellion, or insurrection
- Committing or attempting to commit an assault, felony or other illegal act
- Operation of any motorized vehicle while intoxicated
- Pre-existing conditions

Notes:
This invitation to inquire allows interested employees an opportunity to inquire further about group insurance coverage and is limited in its description of the losses for which benefits may be payable. The contract has exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued. The contract may contain a waiting or elimination period between the effective date of the contract and the effective date of coverage, and between the date a loss occurs and the date benefits begin to be payable for the loss.

If a choice of the amount of benefits is offered, the amount of benefits provided depends upon the coverage selected and premium can vary with the amount of benefits selected. If a range of benefit levels is present, the insured is only entitled to the benefit level shown in the contract.

Any payable benefit based on a percentage of an employee's covered earnings is subject to Sun Life's approval, contract maximums, contract reductions, and according to contract terms and conditions.

An eligible employee's age will be determined as of the anniversary date. Premium rates for each employee will increase for events such as when the employee enters a new age category.

The language contained herein is for general informational purposes only. Please refer to the carrier policy/certificate for a complete list of benefits, limitations and exclusions.

For questions or information about your coverage, call Sun Life Group Customer Service Center at (800) 247-6875

Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved.
www.sunlife-usa.com

Sun Life Group Term Life Plan

Effective Date: July 1, 2015

Basic Life Insurance
This insurance coverage is provided by your employer at no premium cost to you.

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

To help meet this need, you have the opportunity to elect and pay for additional group life insurance under the voluntary portion of you Cafeteria Benefits program to go along with any other life insurance coverage you may have. Coverage is also available for your eligible dependents.

Features
Sun Life's coverage features easy eligibility and simple enrollment procedures. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and less worries about a lapse in coverage due to missed payments.

Low Cost
Your premium cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group term life insurance. Additionally, the system absorbs the cost of administering the life insurance coverage which issued and underwritten by Sun Life - a leader in the field of group insurance.

Eligibility
You will be eligible to apply for insurance up to the guaranteed issue amount if you are a permanent, full-time employee.

Enrollment
Enrollment is simple - just fill out, date and sign the enrollment card provided by your employer. Make sure you supply all required information and return the required forms to your employer's benefits office timely. That's all to apply. You will be notified as to when coverage starts. Employee currently approved for group life insurance will not have to fill out a new enrollment card, however, you may wish to consider updating your beneficiary designation.

Beneficiary
You have the right to designate the beneficiary of your choice under your coverages. You are automatically the beneficiary under the dependent life insurance.

When Insurance Starts
Your Basic Life Insurance becomes effective on the date of your eligibility if you are actively at work; otherwise and when eligible, on the first day of the coverage month after you return to active work.

Coverage will not become effective for any dependent who is confined in a medical facility on the date coverage would otherwise become effective. If you meet the eligibility requirements described in the policy on the date of enrollment and for your Voluntary Life Insurance to begin, coverage will become effective on the next first day of a coverage month provided you are actively at work; otherwise on

the day you return to active work. If you enroll for Voluntary dependent life insurance, that coverage may become effective on the day your Voluntary Life Insurance becomes effective for any dependents who meet the eligibility requirements outlined in the policy. If you or any dependents do not satisfy the eligibility requirements described in the policy on the date of enrollment or prior to coverage beginning, that person will not become insured until such person has undergone medical underwriting and furnished evidence of insurability satisfactory to Sun Life.

Reductions at Age 65 & Over
Your benefit will begin reducing at age 65 as follows:

Age Attained	Remaining Percentage of Original Amount
65	65%
70	45%
75	30%
80	20%
85	15%
90	10%

Termination of Coverage
All insurance under Sun Life's policies will terminate for events including but not limited to retirement, termination of employment, when the policy terminates, when eligibility requirements are not met, or when you request termination. Nevertheless, if you should die within the conversion application period, you existing life insurance may still be paid to the designated beneficiary. If any of your covered dependents should die within their conversion application period, the amount of life insurance on such dependent may be payable to you.

Disability
Your insurance may be continued under the waiver of premium provision during periods of total disability provided the employer continues premium payments on your behalf prior to application and approval of the waiver of premium benefit. However, your insurance will be subject to the policy reduction schedule.

Accelerated Life Benefit Option
Sun Life's policy has included an Accelerated Life Benefit (ALB) as part of your group life insurance. Under this benefit, if you are permanently and totally disabled and diagnosed with a terminal condition you may be eligible to receive a portion of you group life insurance coverage at such a difficult time. Please refer to Sun Life's group life insurance certificate for further eligibility details.

Portability Privilege Benefit
If, prior to age 70, the Employee's Life Insurance ceases due to termination of his employment, the Employee may apply for portable coverage on his own life up to the amount of Life Insurance that ceased, to a maximum of $500,000. An Employee is not eligible to port if:
- he is age 70 or older; or
- he retires; or
- his employment hours with the Employer have been reduced; or
- he remains in employment with the Employer, other than a full-time basis; or
- his insurance is being continued under the Waiver of Premium provision.

If the Employee elects to port any amount of his Life Insurance, he may also apply to port any AD&D or Dependent Life Insurance that ceased due to his termination of employment.

An Employee whose coverage has been continued on Waiver of Premium under this Policy is not eligible to apply for portable coverage.

An Employee who elects to convert his coverage to an individual policy under the Conversion Privilege is not eligible to apply for portable coverage.

Application for Portable Coverage

1. Written application must be made to Sun Life within 31 days following the date the Life Insurance ceases.
2. Portable coverage will be effective on the date that Sun Life approves the Employee's Application for portable coverage.
3. Portable coverage will be provided under a group term life policy providing death and accidental death and dismemberment benefits only, without waiver of premium or Accelerated Death benefits.
4. The premium will be the current rate Sun Life charges for the standard class of risk and age the insured belongs to under the Portable Group Life Policy.
5. If the application for Portable Coverage is declined by Sun Life, the Employee will be given 31 days, commencing on the date the application is declined, to convert to an individual policy under the Conversion Privilege.

07P-LH-PORT

Termination of Portable Coverage

Portable coverage will terminate on the occurrence of the earliest of the following:
- the date for which the last premium has been paid by the Employee; or
- the date the Employee attains age 70; or
- the date the portable group insurance policy terminates.

When Portable Coverage terminates, the Employee will have the right to convert the amount of coverage to an individual policy

Suicide Limitation

The amount of the Voluntary or dependent life insurance benefits that are payable will be limited to premiums paid if the insured commits suicide within two years from the effective date of the coverage.

Group Policy and Certificate

If you become approved for coverage, you will receive a certificate outlining the benefits offered under the policy.

Plan Administrator
Yancey County Government
110 Town Square, Room 11
Burnsville, NC 28714

Claims Procedure

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

Schedule of Benefits

Basic Life Insurance	$15,000
Basic Term Dependent Life	LIFE AMOUNT
Spouse	$5,000
Child:	
Live Birth to under 6 months	$1,000
6 months to 19 years or 25 if a full-time student	$2,500

Cost - $1.66 per unit

Voluntary Life Insurance

$10,000 to $500,000 not exceed 5 times the annual salary of the employee. Elections are made in increments of $10,000.*

To be approved for Employee life insurance coverage over $150,000, you must undergo medical underwriting and furnish evidence of insurability satisfactory to Sun Life. Increases in coverage or late enrollees must also provide evidence of insurability prior to receiving coverage.

*See “Reductions at age 65 & Over”

Voluntary Spouse Life Insurance

$5,000 to $250,000 up to 50 percent of the employee’s voluntary life amount.

To be approved for $25,000 in coverage and above, your spouse must undergo medical underwriting and furnish evidence of insurability, and spouse’ coverage may not exceed the Employee’s voluntary life insurance amount.

Voluntary Dependent Child Insurance

See rate table on the following page.

Semi-Monthly Premium Cost for Voluntary Coverage
(spouse costs are based on employee age and spouse volume)
Per $1,000 of Life Insurance

Age (last birthday as of anniversary date)	Cost
Under Age 30	.065
30-34	.065
35-39	.080
40-44	.110
45-49	.160
50-54	.250
55-59	.395
60-64	.505
65-69	.860
70+	2.255

Dependent Children Cost (Eligibility: live birth to age 19 or 25 if a full time student)	Life/AD&D
$2,500*	.35
$5,000*	.70
$10,000*	1.39

*Benefit for Live Birth to 6 months - $1,000

The language contained herein is for general informational purposes only. Please refer to the carrier policy/certificate for a complete list of benefits, limitations and exclusions.

For questions or information about your coverage, call Sun Life Group Customer Service Center at (800) 247-6875

Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved.
www.sunlife-usa.com

Boston Mutual Life Insurance
Employee Life Option (ELOP) Life Plus

BML Whole Life Coverage is effective on the date the application is signed.

GUARANTEED BENEFITS, LEVEL PREMIUMS AND POLICY VALUES
The Employee Life Option is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in whole life insurance with the advantages of cash accumulation at current interest rates. This policy is an endowment at 95 with coverage to age 95.

AFFORDABLE, FLEXIBLE PROTECTION
You choose the amount of insurance or the amount of premium that best suits your needs and budget. All eligible employees and their spouses through age 72 may purchase coverage under the Basic Plan. Weekly deductions range from $2.00-$30.00 per week.

Insurance is also available for your spouse, unmarried dependent children and grandchildren even if you choose not to buy coverage on yourself.

POLICY VALUES*
As long as premiums are paid, your ELOP Basic Plan offers a guaranteed cash value that can grow over the years. The cash value can be used to supplement retirement income, for emergency cash, as an education fund or to provide a paid-up insurance benefit. While this value can never be less than the guaranteed amount, ELOP gives you the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when your policy is issued is guaranteed for the first year. On each policy anniversary date, you will receive an annual statement outlining your policy's accumulated value and changes in the interest rate, if any.
* *The actual cash value may be decreased by loans or withdrawals.*

CONSTANT COVERAGE
ELOP participants are protected worldwide, 24 hours a day. Your policy is owned by you and supplements any other insurance you may have.

BENEFITS YOU CAN KEEP
Once purchased, your ELOP plan remains in force as long as premiums continue to be paid; and your permanent plan premiums cannot be increased. If you change jobs or retire, as long as you continue to pay premiums, your insurance will remain in force without interruption. Boston Mutual will bill you at home and you may choose from several payment options — annual, semi-annual, quarterly, monthly coupon book or monthly automatic check plan.

ACCIDENTAL DEATH BENEFIT (ADB)
This option could *double or even triple* your ELOP death benefit. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage (up to $100,000). This extra protection is available at affordable rates. Any Basic Plan participant age 5 years through age 60 is eligible for this benefit.

PAYOR WAIVER OF PREMIUM
This benefit pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55 at a cost of 10% of the basic premium for each policy. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.

QUESTIONS AND ANSWERS

CAN I BUY THIS PLAN ON MY OWN?
No! This plan is available only to employees of companies that provide the convenience of payroll deduction for the ELOP plan. Because your employer has chosen to offer ELOP, you receive the advantages of more liberal underwriting and the convenience of payroll deduction. All of this results in savings that reduce the cost of the policies.

DOES THIS POLICY REPLACE MY PRESENT GROUP INSURANCE?
No! ELOP coverage is independent of and supplements your present group insurance program.

IF I LEAVE MY EMPLOYER WHAT HAPPENS TO MY ELOP PLAN?
You can take the ELOP plan with you when you leave with no change in cost or benefits. We will bill you at home.

WHAT HAPPENS IF I CAN'T PAY MY PREMIUM AS A RESULT OF A LEAVE OF ABSENCE OR TERMINATION FROM MY EMPLOYER?
Your policy includes the "Automatic Premium Loan" provision which will be used to pay your premium at the end of your grace period, provided you have accumulated cash value.

WHAT OPTIONS DOES MY ELOP POLICY PROVIDE AT RETIREMENT?
Depending on how long your policy has been in force, you have the following options: (1) continue your premium payments and value accumulation; (2) opt for a paid-up policy; (3) decide to turn your policy in for its accumulated cash value.

CAN I INCREASE MY COVERAGE IN THE FUTURE?
You may apply for additional coverage in the future if you are actively at work with the employer - sponsored company and will be subject to the ELOP underwriting guidelines.

CAN I TAKE A LOAN ON MY POLICY?
Yes. You may borrow all or part of your loan value at an 8% fixed interest rate.

DOES THE ELOP COVERAGE HAVE A SURRENDER CHARGE?
If you discontinue your plan before the 21st policy year, there will be a surrender charge. The amount of this charge decreases every year. No charge is made if you decide to terminate your coverage after it has been in force for at least 20 years.

WILL ELOP BENEFITS BE PAID FOR SUICIDE?
If suicide occurs during the first 2 years your policy is in effect, benefits will not be paid, but any premiums paid will be refunded. After 2 years, benefits will be paid if death is caused by suicide.

CONSIDER....

IF YOU HAVE A FAMILY
The ELOP plan enables you to build a cash reserve for yourself, your spouse and your children for less than 1 hour's pay per week. It is a sound way to protect your family without exceeding your present budget.

IF YOU'RE SINGLE WITH NO DEPENDENTS
For a single working person insurance is the foundation for future financial planning. The longer you wait to buy insurance the more expensive it will be. The flexibility of the ELOP plan enables you to expand your coverage to meet future responsibilities.

IF YOU ARE OLDER AND NEARING RETIREMENT
A lot of obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your ELOP plan can be continued after retirement.

No matter where you are in your life and career, you will benefit from ELOP – Life Insurance that Works for Life.

GUARANTEED ISSUE

Employee: up to $15 per week

Spouse: up to $3/ $5* per week
•Must be able to answer NO to “During the past six months, has your spouse been seen or treated, including testing, in a hospital or any other medical facility, excluding physicians’ offices for routine medical care?”

*Employee must purchase $5 in order for the spouse to be eligible for $5

Children: up to $3 per week
•Child must be between ages 15 days and 25 years old to be eligible for coverage.

Grandchildren: up to $3 per week
•Grandchildren must be between ages 15 days and 15 years old to be eligible for coverage.

For questions concerning this policy please contact:

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, MA 02021

(800) 669-2668 • (781) 828-7000
Extension 222 - Customer Service

Web site: www.bostonmutual.com

BOSTON MUTUAL
LIFE INSURANCE COMPANY SINCE 1891

Policy Series ICC13 END-95(ESO) (3/13) and END-95 (ESO) 3/13

Continuation of Benefits

Upon Termination of Employment

Medical and Dental Plans

Under the group medical and dental plans, you and your covered dependents are eligible to continue medical coverage through COBRA if you experience certain "qualifying events".

If you and your dependents are enrolled in these plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plans, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. For more Cobra information, call your ***Human Resources Department at*** **828-682-3971.**

SUN LIFE FINANCIAL TERM LIFE

When you leave employment with Yancey County prior to age 65, you may apply for portable coverage during the 31 day conversion period, instead of converting to an individual policy. This coverage is group term life and may be continued for 10 years or to age 65 whichever comes first. You must provide a statement of good health in order to qualify for portable coverage.

You may also convert your life insurance to an individual policy. The application for conversion must be made within 31 days of your termination from employment. You do not have to submit Evidence of Insurability to convert to an individual policy. For details, please call ***Sun Life at 1-800-247-6875****.*

To Continue Other Policies

You may continue your Aflac Accident, Aflac Hospital Indemnity, Aflac Critical Illness, Allstate Benefits Cancer, AUL Short Term Disability, and Boston Mutual Whole 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:

Allstate Benefits at **1-800-521-3535**

Aflac at **1-800-433-3036**

AUL at **1-800-553-5318**

Boston Mutual at **1-800-669-2668**

Contact Information for Questions and Claims

BlueCross BlueSheild of NC
Customer Service
1-877-258-3334
www.bcbsnc.com

Ameritas Dental
1-800-487-5553
www.ameritas.com

Community Eye Care
Customer Service
1-888-254-4290
Fax: 704-426-6044
www.communityeyecare.net
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208

Aflac
2801 Devine Street • Columbia, South Carolina 29205
Customer Service
1-800-433-3036
Aflacgroupinsurance.com

Allstate Benefits
1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your policy please call:
1-800-521-3535
For questions concerning your claim please call:
1-800-348-4489
or e-mail claimsresearch@allstate.com

Sun Life Financial
Customer Service Center 1-800-247-6875
www.sunlife-usa.com

American United Life (AUL)
Claims Toll-Free Number
1-866-258-8744
Customer Service
1-800-553-5318

Boston Mutual Life Insurance Company
120 Royall Street • Canton, MA 02021
1-800- 669-2668
781- 828-7000
www.bostonmutual.com