



Flexible

Benefits Plan

Plan Year: July 1, 2016 - June 30, 2017
Arranged and Enrolled by Mark III Brokerage, Inc.

Moore County Government is offering employees a comprehensive Benefits plan. The Benefits plan is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Benefits plan allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method may reduce your taxes and may increase your take home pay.

- Plan Year begins July 1, 2016 and ends June 30, 2017

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This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only.

Key Points To Remember

PAY DATE

- The first July payroll date is: **July 14, 2016.**

FIRST CAROLINA HEALTH PLAN

If you need to elect or change your Health plan, you must contact Dawn Spivey at 910.947.6362.

TO ENROLL

- If you need to enroll or make changes to the following benefits, you **MUST see a Mark III Benefits Counselor: Allstate Benefits Cancer, Aflac Accident, Aflac Critical Illness, AUL Short Term Disability, AUL Long Term Disability, Reliastar Term Life, Texas Life.**

AMERITAS DENTAL

As a reminder the dental rates are not included with the health rates. You have a separate payroll deduction for the dental plan. You will also be able to enroll or change your dental election during this enrollment.

For dependent children, a newborn child is considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of his/her 2nd birthday.

WAGeworks FLEXIBLE SPENDING ACCOUNTS

- You must re-elect your Health and or Dependent Care Flexible Spending Accounts each year. These accounts **do not** automatically carry-over to the next year. If you do not re-elect the spending account(s), you will not have the benefit on July 1st.
- The debit card that you will receive will be valid for three (3) years from the issue date as long as you re-elect the Health & or Dependent Care Flexible Spending Accounts each year.

ONCE THE ANNUAL ENROLLMENT ENDS

- Remember that elections made during annual enrollment **cannot be changed once the enrollment period ends** unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.

If you should have a qualifying event, you will have 30 days from the date of the qualifying event to request a change. Please visit your Human Resources Department to make this change.

 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.firstcarolinacare.com or by calling 1-800-811-3298.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1500 individual / \$3000 family for participating providers \$3000 individual /\$6000 family for non-participating providers Does not apply to preventive care, office visits and prescription drugs. Coinsurance and copays do not count toward 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?	Yes, \$150 individual / \$300 family deductible on all brand name prescription drugs	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers: \$3500 individual / \$7000 family-Medical \$1000 individual / \$2000 family-Prescription Drugs For non-participating providers: \$7000 person / \$14000 family-Medical \$2000 person / \$4000 family-Prescription Drugs	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, no precent penalties, balance-billed charges, and health services 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 participating providers, see www.firstcarolinacare.com or call 1-800-811-3298	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 .
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 page 4. 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay / visit	Deductible and 40% coinsurance	none
	Specialist visit	\$70 copay / visit	Deductible and 40% coinsurance	none
	Other practitioner office visit	30% coinsurance for chiropractor	40% coinsurance for chiropractor	none
	Preventive care/screening/immunization	No Charge	Not Covered	Preventive services covered at no cost are defined by federal law and are subject to change
	Diagnostic test (x-ray, blood work)	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
If you have a test	Imaging (CT/PET scans, MRIs)	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Generic drugs	\$4 copay / prescription for 30 day supply \$10 copay / prescription for 90 day supply	You will pay full cost of drugs & submit a reimbursement form to MedImpact. If covered, you can be reimbursed up to the contracted rate of an in network pharmacy.	Certain medications may require prior authorization, step therapy or have quantity limits
If you need drugs to treat your illness or condition	Preferred brand drugs	Rx Deductible then \$45 copay / prescription for 30 day supply \$112.50 copay / prescription for 90 day supply	Same as Out of Network Generic drug benefits.	Certain medications may require prior authorization, step therapy or have quantity limits
	Non-preferred brand drugs	Rx Deductible then \$60 copay / prescription for 30 day supply \$150 copay / prescription for 90 day supply	Same as Out of Network Generic drug benefits.	Certain medications may require prior authorization, step therapy or have quantity limits

FirstCarolinaCare Insurance Company: Plan MC01
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 - 06/30/2017
 Coverage for: **Individual+Family | Plan Type: PPO**

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Physician/surgeon fees	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
If you need immediate medical attention	\$250 copay / visit and 30% coinsurance after Deductible (hospital copayment waived if admitted within 24 hours)	\$250 copay / visit and 30% coinsurance after Deductible (hospital copayment waived if admitted within 24 hours)	\$250 copay / visit and 30% coinsurance after Deductible (hospital copayment waived if admitted within 24 hours)	none
	Emergency room services	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Emergency medical transportation	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
If you have a hospital stay	Urgent care	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Facility fee (e.g., hospital room)	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of \$300. In network cost applies if admitted for emergency medical attention.
	Physician/surgeon fee	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of \$300. In network cost applies if admitted for emergency medical attention.
	Mental/Behavioral health outpatient services	\$35 office visit / other outpatient services Deductible and 30% coinsurance	Deductible and 40% coinsurance / office visit. Other outpatient services Deductible and 40% coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of \$300.
	Substance use disorder outpatient services	\$35 office visit / other outpatient services Deductible and 30% coinsurance	Deductible and 40% coinsurance / office visit. Other outpatient services Deductible and 40% coinsurance	none
	Substance use disorder inpatient services	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of \$300.

Questions: Call 1-800-811-3298 or visit www.firstcarolinacare.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary on our website or call to request a copy.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
if you are pregnant	Prenatal and postnatal care	\$35 for 1st prenatal visit only	Deductible and 40% coinsurance	none
	Delivery and all inpatient services	Deductible and 30% coinsurance	Deductible and 40% coinsurance	In network cost applies if admitted for emergency medical attention. Requires precertification. Failure to obtain will result in penalty of \$300.
	Home health care	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Home Health care benefits limited to 100 visits per year
if you need help recovering or have other special health needs	Rehabilitation services	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Habilitation services	Not Covered	Not Covered	Excluded service
	Skilled nursing care	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Skilled nursing care benefits are limited to 30 days per cause
	Durable medical equipment	Deductible and 30% coinsurance	Deductible and 40% coinsurance	Requires precertification for equipment over \$1500 or any rentals over \$500/month. Failure to obtain will result in penalty of \$300.
if your child needs dental or eye care	Hospice service	Deductible and 30% coinsurance	Deductible and 40% coinsurance	none
	Eye exam	\$35 copay / visit	Not Covered	Limited to 1 vision screening in a primary care providers office each year for children through age 17. For visual impairment screening in children younger than age 5, see Preventive Benefits.
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

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
- Dental care (Adult)
- Routine eye care (Adult)
- Bariatric surgery
- Habilitation services
- Non-emergency care when travelling outside the U.S.
- Cosmetic surgery
- Infertility treatment
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids

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 1-800-811-3298. 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.cclio.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: For all issues except prescription drug issues, call the FirstCarolinaCare Insurance Co. Appeals and Grievance Coordinator, 800-574-8556. For prescription drug appeals and grievances, call the MediImpact Healthcare Systems Appeal Coordinator at 800-788-2949.

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.cclio.cms.gov.

Additionally, a state consumer assistance program may be able to help you: <http://www.ncdoi.com/Smart/>
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
877-885-0231 (toll free) / 919-807-6860 / 919-807-6865 (fax)

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

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)	
Amount owed to providers:	\$7,540
Plan pays	\$5,660
Patient pays	\$1,880
Sample care costs:	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$1,500
Co-pays	\$40
Co-insurance	\$220
Limits or exclusions	\$120
Total	\$1,880

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
Amount owed to providers:	\$5,400
Plan pays	\$3,540
Patient pays	\$1,860
Sample care costs:	
Prescriptions	\$2,900
Medical equipment & supplies	\$1,300
Office visits & procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$1,270
Co-pays	\$510
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,860

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

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 in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

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

FirstCarolinaCare Health Insurance ~ per pay period costs (Bi-weekly)

Spouse only ~ \$108.81

Child only ~ \$52.04

Children only ~ \$105.91

Family ~ \$121.56

CUSTOMER CARE

Claim Status or Register for Online Access via ePower - 800.811.3298

Precertification Inquiry - 800.574.8556

Pharmacy Benefits - 800.788.2949

Pharmacy Mail Order - 800.552.6694

ADDRESS: 42 Memorial Drive, Pinehurst, NC 28374



WageWorks HealthCare Flexible Spending Account

Plan Year: July 1, 2016 - June 30, 2017

- **Medical Reimbursement Plan Maximum: \$2,550.00**
- **Medical Reimbursement Plan Minimum: \$260.00**
- **Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year.**

We all buy things like prescriptions, aspirin, and glasses or contacts — not to mention co-pays and braces. And we all like to save money.

A flexible spending account (FSA) can help you save up to 40%* off the cost of goods and services you purchase every day. And because this FSA from WageWorks is so easy to use, there's no hassle, less waiting — and no reason to miss out on enrollment.

Everyday savings

Saving is simple. When you enroll in the program, you set aside some of your pay before taxes to use on eligible expenses. The more you put in, the more you can save — up to thousands of dollars.

Easy as money

The WageWorks FSA makes it easy to access your money. Swipe your WageWorks Health Care Card wherever it's accepted to have eligible expenses deducted directly from your health care FSA. Sign up to schedule (Pay My Provider) payments from your health care or dependent care FSA online. Or send in traditional (Pay Me Back) claims for quick reimbursement.

How your FSA program works

You can use the funds you set aside in your health care FSA to pay for a broad array of eligible expenses incurred by you or your eligible dependents.

Pay for hundreds of expenses – tax-free!

You can use your FSA to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer.

Typically, your health care FSA covers:

- Prescriptions for almost any medical condition
- Over-the-counter health care products like allergy medicine, antacid, antibiotics, aspirin... (and that's just through "a")
- Co-payments, co-insurance, and deductibles — but not insurance premiums
- Dental care, both preventive and restorative
- Orthodontia, child and adult
- Vision care, including eyeglasses, contact lenses, and saline solution
- Eye surgery, including laser vision correction
- Counseling and therapy
- Psychology and psychiatry
- Chiropractic care, acupuncture, and some other alternative treatments

For details and hundreds more eligible expenses, visit www.getwageworks.com/fsa.

Tax savings: see for yourself.

How much you save depends on how much you spend on health care, and on your tax situation. For every \$100 of eligible expenses, most people will save from \$30 to \$40 in taxes. Use the savings calculator at www.getwageworks.com/fsa to estimate your expenses and see for yourself how your savings can add up!

Health Care FSA

Estimated Eligible Expenses	Example	Your Estimate
Prescription drugs	\$240	
Doctor visits	\$180	
Annual dental plan deductible	\$50	
Dental fillings and crowns	\$200	
Orthodontia (braces)	\$1,800	
Prescription glasses	\$150	
Prescription sunglasses	\$150	
Over-the-counter products	\$240	
Suggested plan year election	=\$3,010	=
Taxes (40%*)	x0.40	x0.40
Estimated savings*	=\$1,204	=

** Tax savings amounts are examples provided for illustrative purposes only. They are based on federal, state, and FICA (Social Security) taxes that you do not have to pay through payroll deductions on amounts used to fund your account. Your actual savings may vary depending on your marginal income tax rate, whether you pay state income taxes, and other factors. Some states do not recognize tax exclusions for FSA contributions.*

Customer Service

1.877.924.3967

FAX

1.877.353.9236

Web

www.wageworks.com

E-mail Help

help@wageworks.com

Or mail your claim form and photocopies of your proof of service to:

WageWorks Processing Center, Claims Administrator
PO Box 14053, Lexington, KY 40512



FSA Eligible Expenses

Below is the list of items typically covered by a standard FSA. For a complete list visit www.wageworks.com.

Prescription Requirement for OTC Drug Purchases

A doctor's prescription is required in order to be reimbursed for over-the-counter (OTC) drugs. OTC drugs requiring a prescription are indicated in the following list with the abbreviation "(Rx)."

Acne treatments (over-the-counter) (Rx)	Dental co-insurance	Medical supplies (for treatment of a medical condition)
Acupuncture	Dental co-payment	Medicines (over-the-counter) (Rx)
Adoption (medical expenses related to)	Dental reconstruction (including implants)	Medicines (prescription)
Alcoholism treatment	Dentures, bridges, etc.	Midwife
Allergy & sinus medicine and products (over-the-counter) (Rx)	Diabetic monitor, test kits, strips and supplies	Mileage (for travel to/from eligible healthcare)
Allergy medication (prescription)	Diagnostic services	Monitors & test kits (over-the-counter)
Ambulance and emergency health services	Diaper rash ointments and creams (Rx)	Motion & nausea (over-the-counter) (Rx)
Anesthesia (for non-cosmetic purposes)	Drug addiction treatment	Nasal sprays & strips (over-the-counter) (Rx)
Antacid (over-the-counter) (Rx)	Drugs (prescription)	Non-prescription drugs and medicines (for non-cosmetic purposes) (Rx)
Antibiotic ointment (over-the-counter) (Rx)	Ear drops and wax removal (over-the-counter) (Rx)	Norplant insertion or removal
Aspirin or other pain reliever (over-the-counter) (Rx)	Eye drops and treatments (over-the-counter) (Rx)	Nursing services (wages and taxes)
Asthma medicines or treatments (over-the-counter) (Rx)	Eye examinations	OB/GYN fees
Athletic treatments / braces	Eye related equipment/materials	Occlusal guards to prevent teeth grinding
Bandages and related items (over-the-counter)	Eye surgery or treatment to correct vision	Occupational therapy (related to a medical condition or disability)
Birth control (over-the-counter) (Rx)	Eyeglasses (over-the-counter & prescription)	Office visits (chiro, dental, medical, psych/therapy, vision)
Birth control (prescription)	Fertility monitor (over-the-counter)	Operations (for non-cosmetic purposes)
Blood pressure monitor	Fertility treatment (for employee, spouse or dependent)	Operations (for vision and dental)
Body scans	First aid kit (over-the-counter)	Optometrist / ophthalmologist fees
Braille books & magazines (difference in cost only)	Flu shots	Organ transplants (recipient and donor)
Breastfeeding classes	Gastrointestinal medication (over-the-counter) (Rx)	Orthotics
Breast pumps (for a lactating woman)	Guide dog (dog, training, care)	Ortho keratotomy
Canker & cold sore treatments (over-the-counter) (Rx)	Hearing aids and batteries	Orthodontia (braces and retainers)
Chest rubs (over-the-counter) (Rx)	Hospital services and fees	Orthopedic & surgical supports
Childbirth classes (charges for mother only)	Immunizations	Over-the-counter bandages and related items
Chiropractic office visit or treatment	Incontinence supplies	Over-the-counter healthcare products (Rx)
Cholesterol test kits and supplies	Infertility treatment (for employee, spouse or dependent)	Over-the-counter drugs and medicines (including for motion sickness, sleep aids and sedatives) (Rx)
Christian Science practitioners	Insulin, testing materials and supplies	Over-the-counter products for dental, oral and teething pain (Rx)
Co-insurance (dental, medical, prescription, vision)	Laboratory fees	Over-the-counter vision products
Co-payment (dental, medical, vision)	Lactose intolerance (over-the-counter) (Rx)	Ovulation monitor (over-the-counter)
Cold & flu medicine (over-the-counter) (Rx)	Lamaze classes (charges for mother only)	Oxygen
Concierge medical fees (billed for actual services received)	Laser eye surgery	Pain reliever (over-the-counter) (Rx)
Condoms	Lasik	Parental fees (billed for actual services received for disabled children)
Contact lenses and solutions	Laxatives (over-the-counter) (Rx)	Physical exams
Contraceptives (over-the-counter) (Rx)	Learning disability treatments	Physical therapy
Corn and callus remover (over-the-counter) (Rx)	Lice treatment (over-the-counter) (Rx)	Pregnancy tests (over-the-counter)
Corneal keratotomy	Listening therapy	Prescription co-insurance
Cough drops, cough syrup, sore throat lozenges (over-the-counter) (Rx)	Mastectomy-related special bras	Prescription co-insurance
Counseling (for treatment of a medical condition)	Medical abortion	Prescription drugs (for non-cosmetic purposes)
Crutches, canes, walkers or like equipment (purchase or rental)	Medical co-insurance	Propecia (for treatment of a medical condition)
Deductible for dental, medical, prescription and vision plans	Medical co-payment	Prosthesis
Dental care (for non-cosmetic purposes, including sealants)	Medical equipment (for treatment of medical condition) and repairs	
	Medical monitoring and testing devices	
	Medical records charges	

FSA Eligible Expenses (cont.)

Psychiatric care	Sterilization	Vaccinations
Psychoanalysis	Student health fees billed for actual services received (dental, medical, prescription, vision)	Varicose vein removal surgery (for medical care)
Psychologist fees	Sunglasses (prescription)	Vasectomy
Radial keratotomy (RK)	Sunscreen with SPF 15+ and "broad spectrum", sunburn creams & ointments (over-the-counter)	Viagra and similar prescription medications
Reading glasses (over-the-counter)	Surgery (for non-cosmetic purposes)	Vision co-insurance
Removal of benign mole, cyst or tumor	Teeth grinding prevention devices	Vision co-payment
Retin-A (for non-cosmetic purposes)	Therapy (for treatment of a medical condition)	Vitamins (prescription)
Sales tax, shipping and handling fees (for any eligible expenses)	Toothache and teething pain relievers (over-the-counter) (Rx)	Walking aids (canes, walkers, crutches and related supplies)
Smoking cessation (programs, counseling)	Transportation, parking & related travel expenses (essential to receive eligible care)	Wart removal treatments (over-the-counter) (Rx)
Smoking cessation drugs (prescription)	Tubal ligation	Weight loss drugs (for treatment of a medical condition) (Rx)
Smoking cessation gum or patches (over-the-counter) (Rx)	Urological products	Wheelchair and repairs
Speech therapy		Wound care (over-the-counter)
Spermicidals (Rx)		X-ray fees (dental, medical)

FSA "Maybe" Eligible Healthcare Expenses

Certain expenses require additional information in order to determine if they qualify. Products and services classified as "Maybe" require a written statement from your healthcare provider indicating (1) the diagnosis and (2) the medical necessity of the expense. Specialized items also require proof of the difference in cost: (1) the cost of standard, unmodified item, and (2) the cost of special or modified item. If you incur an expense that is classified as "Maybe," you will need to submit the above documentation with your claim.

Allergy treatments and products	Dietary supplements*	Nutritional supplements*
Alternative dietary supplements*	Doula or birthing coach	Orthopedic shoes and inserts (difference in cost only of specialized orthopedic shoe over like non-specialized shoe)
Alternative drugs, medicines and treatment products*	Dyslexia treatment	Reconstructive surgery (following accident or medical procedure or condition)
Alternative healers*	Exercise equipment or program*	Special equipment
Breast reconstruction surgery (following mastectomy)	Fitness programs*	Special foods (gluten-free, salt-free or other for treatment of a medical condition; difference in cost only)
Car modifications*	Health club dues*	Special school (for mental and physical disabilities)
Cord blood storage (for future treatment of a birth defect or known medical condition)	Herbal or homeopathic medicines (over-the-counter)	Swimming lessons*
Cosmetic procedures or surgery for birth defects, accidents, and/or disease	Home improvements*	Transgender treatments / surgery
Dancing lessons*	Humidifier, air filter and supplies	Tuition or educational classes*
Dental veneers	Lodging (limited to \$50 per night for patient to receive medical care and \$50 per night for one caregiver)	Weight loss counseling
Dermatology treatments and products	Magnetic therapy (over-the-counter)	Weight loss program*
	Massage therapy*	
	Modified equipment (difference in cost only)	

* As treatment or required for a medical condition diagnosed by a licensed healthcare professional.

The WageWorks Visa Health Card

Make Saving Convenient

Flexible Spending (FSA) Accounts help you save on health care expenses. The WageWorks Visa® Health Care Card makes it easier and more convenient.

The WageWorks Visa Health Care Card (the Card) makes funds immediately available to you for payment of eligible health care services, goods and prescriptions at health care providers, pharmacies and drugstores, thus reducing the need to submit receipts and wait for reimbursement. You can also use your Card wherever it's accepted to pay for eligible over-the-counter (OTC) items. In order to accept the Card, a merchant must have an IRS-qualified system that can automatically verify transactions at checkout. For a list of qualified merchants, please visit www.sigis.com.

When you use your Card for an eligible item or service, the money is taken directly from your account, so there's no need to submit paper receipts or be reimbursed. For those transactions that can be verified at checkout, you'll just need to save your receipts for the IRS, and your records. In instances where WageWorks can not verify the card transactions using other means we will ask for a receipt.

Quick Facts

- Use your Visa Health Care Card for copays, coinsurance, prescriptions, deductibles, orthodontia, vision care, and hundreds of eligible over-the-counter items. You can visit www.wageworks.com for a general list of eligible expenses².
- Many of your copay, prescription, and recurring expense transactions can be verified without any further action by you.
- You can use your WageWorks Visa Card to pay for eligible health care expenses at all kinds of qualifying merchants, including doctors' offices, grocery stores, discount stores and more.³
- Save all itemized receipts, in case required for tax purposes or for purchase substantiation.

1. Per the IRS Regulation

2. Eligible expenses can vary by employer. Please contact your employer or log on to your account at www.wageworks.com to access your employer's specific eligibility list.

3. For a complete list of participating merchants, visit www.sigis.com.

Using the Card

Know what's eligible before You Pay. Before you use the Card, make sure that whatever you intend to pay for is eligible under IRS regulation and your employer's FSA and/or HRA program. If the Card is used for a non-eligible item or service, you will be required to pay back your account, or risk Card suspension. Log on to your account at www.wageworks.com to access your employer's specific eligibility list.

Know When to and When NOT to Use the Card

WageWorks and its partners have worked hard to make your Card easy to use at approved merchants and health care providers. You can only use your Card to pay for over-the-counter eligible items and prescriptions at these merchants. You can expect, however, to be required to submit a receipt when using the Card for anything other than a copayment at a health care provider's office, dentist or hospital, as the IRS requires that we verify the eligibility of the service performed.

Save Your Receipts

By law, WageWorks is required to verify the eligibility of all purchases made with the Card. Many Card transactions will be verified at the point of purchase, or later through our post-transaction process. If, however, we are unable to determine whether a transaction was for an eligible health care product or service, we will request an itemized receipt to verify your purchase.

Carefully Review Your Account Statements

Your monthly electronic account statement details any transactions requiring receipt or repayment. The best way to avoid any potential problems is to review your statement or access your account online for unverified Card purchases. The "Card Transaction" section shows all Card transactions that are not yet verified, and explains your options for resolving these.

Quickly Resolve Outstanding Card Transactions

Keep your Card and account in good standing by quickly resolving any unverified Card transactions. Unverified Card transactions can be resolved in one of three ways:

- You can submit a copy of the original detailed receipt;
- Submit an equivalent receipt for an eligible purchase not made with the Card; or
- You can repay your account for the outstanding unverified amount.
- Or you can do any combination of the above.

Remember, always use the Card Use Verification (CUV) form that comes with your statement to resolve unverified transactions. **If you do not supply the proper documentation or pay back the account after 90 days from the transaction date, your Card privileges may be suspended** and we will deduct the amount that is unverified from the next Pay Me Back reimbursement check. Visit www.wageworks.com/card to learn more.

Additional Information About Using Your Health Care Choice Card

1. **You must activate your card** before you use it. Simply call 866.363.4128 and enter the information requested.
2. **Use your card for eligible health care expenses only.** This card can only be used in places where health care products and services are likely to be sold.
3. **Do not use your card to pay for past or future services.** Tax regulations prohibit you from using this card to pay for services you received before your current coverage period or those you plan to receive in the future.
4. **Each time you use your card, you authorize that you are paying for eligible expenses** incurred by you or an eligible dependent during your current coverage period and that you have not and will not seek reimbursement for these expenses from any other health plan or source.
5. **Save all receipts that describe exactly what you paid for with your card.** We may ask you to submit these to show you used your card for eligible health care expenses.
6. **Debit or credit? Choose credit.** Even though this is not a credit card, choose the credit option. You may also use a PIN (personal identification number) if you have one.
7. **Review your monthly statements.** They contain important information about your account, including if you are required to verify any purchases you made with the card.
8. **Your plan may require you to reimburse your account** in the amount of any card purchase if you cannot show the card was used for eligible health care products and services.

How to order additional cards

1. Log on to www.wageworks.com
 2. Enter your user name and password (or click on “First-Time User? Register Now” to complete the simple online registration process)
 3. Click on the “Health Care” tab
 4. Select “Request Additional Card”
 5. Provide first name, last name and Social Security Number of the person who will use the card
- The first additional card is provided free of charge
 - There is a charge for the second card
 - No more than three cards are available per account (one for you, the employee, and two for use by your eligible dependents)

If You Lose Your Card or if it is Stolen

Contact WageWorks immediately at our toll-free number: 1.877.924.3967.

WageWorks Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important. To ensure we are able to process your reimbursement, please fully complete the WageWorks Pay Me Back Claim Form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

****An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.****

Tips to Complete the Pay Me Back Claim Form

- Read every box and provide all requested information.
- Type or write legibly.
- Provide the legal name your employer has provided in their official records, not your nickname.
- Include your ID Code which is usually the last four digits of your SSN or employee identification number.
- Remember to sign the form. If the account holder's signature is not included, the claim will not be approved.

Things to Remember When Including Receipts

The itemized receipt or documentation must contain:

- o **Provider Name** – Facility name or person who provided the service or, if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy).
- o **Date of Service** – Date services occurred or date item was purchased.
- o **Service Description** – Detailed description of the service provided or item purchased.
- o **Amount** – The amount charged for the services or product and/or the portion not reimbursed through your insurance carrier.
- o **Patient Name** – Person who received the service or whom the item is for. This may be excluded for retail store purchases.

Include an itemized and legible receipt for every expense.

- Explanation of Benefits (EOB's) are recommended especially if your insurance carrier covered a portion of the expense.
- Cancelled or Carbon copies of checks are not acceptable forms of receipt documents.
- Handwritten receipts must have stamped provider information.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

Tips for Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page when faxing the claim form.
- Please allow 2 business days from receipt of your claim for processing.

- You can verify the claim status online at www.wageworks.com after processing.
- You will be notified via email of the status of your claim if we have a valid email address on file. To add or change the default email address, log on to **www.wageworks.com** and select "Edit My Profile" from the welcome screen.
- Make a copy of the form and all attachments; send only copies, keep originals for your records if submitting via postal mail.
- Do not combine and submit a co-worker's claim with yours.

Customer Service

1.877.924.3967

FAX:

1.877.353.9236

Web

www.wageworks.com

E-mail Help

help@wageworks.com

Or mail your claim form and photocopies of your proof of service to:

WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40512



WageWorks OTC Rule Fact Sheet For Health Care Account Participants

Background

The 2010 Affordable Care Act included a new rule that requires a doctor's prescription for the reimbursement of Over-the-Counter (OTC) drugs and medicines from a medical plan.

What Accounts Are Affected by the New OTC Rule?

The law applies to Health Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), Health Savings Accounts (HSAs) and Archer Medical Savings Accounts (Archer MSAs). Health Care Card holders will be able to use their Card to fill OTC prescriptions at IIAS pharmacies. (See the Card question on the back for more detail.) FSA and HRA participants will need to submit either a receipt listing a Rx number or the prescription along with a receipt detailing the purchase in order to submit a claim for reimbursement, or to verify a card purchase at a non-IIAS pharmacy. HSA and Archer MSA participants will need to keep the prescription along with the receipt for their tax records in order to avoid IRS penalties.

When Does the Change Take Effect?

The law took effect on January 1, 2011, which means that any OTC drug or medicine purchase requires a prescription before it can be reimbursed from one of the covered health care accounts.

What Does the Change Mean for Accountholders?

To put it simply, the new rule adds an extra step in the process. Prior to 2011, eligible purchases could be debited directly from the account with a WageWorks Health Care Card at IIAS merchants. And, for purchases at other merchants, all that was required for reimbursement was a valid receipt. Now any accountholder seeking to use their account to pay for OTC medicines will have to first get a prescription, and then purchase the OTC medicine. The OTC drug can be filled as a prescription when presented to the pharmacist, who will then process the purchase as a prescription.

If a participant prefers to submit a claim, then both the receipt and a copy of the prescription will need to be submitted. It's important to remember that you will still be able to use your account for the same OTC drugs and medicines as before. You will just need a prescription dated on or before the purchase date before you can be reimbursed. Visit www.sigis.com for an updated list of IIAS merchants.

What Exactly is a Prescription for an OTC Drug or Medicine?

A prescription for an OTC drug or medicine should be exactly the same as one for a drug or medicine that can only be obtained with a prescription. When you go to your health care provider, simply ask him or her to write you a prescription for the the OTC drug or medicine you use to treat the medical condition you have. The prescription will need to comply with state prescription laws, but generally, if the prescription is written on a prescription pad, it should be sufficient.

Can the WageWorks Health Care Card Be Used to Purchase OTC Drugs and Medicines?

Yes, if a valid prescription is presented at the time of purchase, and the purchase is made at a pharmacy counter and dispensed as a prescription item. With the new law, OTC drugs and medicines have been removed from the list of eligible items that you can purchase with the Card at the general merchandise checkout counter. You are able to purchase OTC medicines at pharmacy counters using your Card. To use your Card at an IAS pharmacy, you will need to present the prescription along with the OTC medicine to a pharmacist; the pharmacist then dispenses and processes the purchase of the OTC medicine in accordance with applicable law. The purchase is then classified as a prescription, and no further action is required. If a purchase is made at a non-IAS pharmacy, then FSA and HRA participants will need to submit either the receipt listing an Rx number or the prescription along with a receipt detailing the purchase for verification and to avoid having the Card suspended.

What Specific OTC Drugs and Medicines Will Require a Prescription and Which Will Not?

As a general rule, any OTC drug or medicine that you take orally or topically will require a prescription. What will not require a prescription are medical devices (such as monitors) and supplies (such as bandages and contact lens solution). Insulin and diabetic supplies are also items that will not require a prescription. For your convenience, we've created a summary list of common items that can and cannot be reimbursed without a doctor's prescription.

Customer Service

1.877.924.3967

FAX:

1.877.353.9236

Web

www.wageworks.com

E-mail Help

help@wageworks.com

Or mail your claim form and photocopies of your proof of service to:

WageWorks Processing Center, Claims Administrator

PO Box 14053, Lexington, KY 40512



WageWorks Dependent Care Flexible Spending Account

Plan Year: July 1, 2016 - June 30, 2017

- **Dependent Care Choice Flexible Spending Account Maximum: \$5,000**
- **The debit card does not apply to the Dependent Care account**

We all pay taxes. Many of us pay for things like day care, afterschool programs, or elder care while we're at work. And we all like to save money.

A flexible spending account (FSA) lets you save on dependent care expenses using pre-tax dollars. You can spend it any way you like, on a wide range of care for eligible members of your family. And because this FSA from WageWorks is so easy to use, there's no hassle — **and no reason to miss out on enrollment.**

Everyday savings

Saving is simple. When you enroll in the program, you set aside some of your pay before taxes to use on eligible expenses. The more you put in, the more you save on your tax bill — up to thousands of dollars.

Easy. Flexible. Fast.

Wondering if an FSA might be a hassle? **Don't.** This program is built for maximum convenience, from great time-saving features like monthly direct payments to providers and easy online tracking, to fast turn around of your claim reimbursements.

Make it your own

It's your account; you decide how to use it. Just enroll in the program, estimate what you'll spend on dependent care, and choose how much to set aside.

Your Employer and WageWorks

This program is sponsored by your Employer and brought to you by WageWorks — the nation's leading provider of consumer-directed savings and spending accounts. WageWorks sets the standard for convenience and flexibility with easy access to your account, no-hassle payment options, comprehensive online tools, and expert support. Millions of employees nationwide enjoy the WageWorks advantage to save money and make smart choices about their health care, dependent care, and commuter expenses.

Savings and convenience, As easy as one, two

It's your money. The program just helps you save it from taxes and spend it on care for your family.

Estimate it. Your FSA works by setting aside a portion of each paycheck before taxes are deducted. When you enroll, you decide just how much to contribute, based on what you estimate you'll need. It's easy with the online calculators at **www.wageworks.com**. You see your savings in the form of **reduced tax withholding.**

Spend it. You can spend the funds in your FSA whenever you choose during the plan year — on a wide range of dependent care needs.

Use **Pay My Provider** to make direct payments online. Schedule automatic monthly payments to your providers for regular expenses like day care. Or use **Pay Me Back** to send in traditional claims for quick reimbursement.

Pay for many kinds of care — tax-free!

Your dependent care FSA covers these types of expenses for your eligible dependents while you and your spouse work. Eligible expenses are defined by the IRS and your employer. Typically, your FSA covers:

- Babysitting or au pair services
- Before- and after-school programs
- Day care and nursery schools
- Pre-school programs
- Elder care services

For details about eligible expenses, visit www.wageworks.com.

Tax savings: see for yourself

How much you save depends on how much you spend on dependent care and on your tax situation. For every \$100 of eligible expenses, most people will save from \$30 to \$40 in taxes. Here’s an example — try it yourself to see how your savings add up.

Dependent Care FSA

Estimated Eligible Expenses	Example	Your Estimate
Day care / nursery school		
Babysitting / au pair		
Before- and after-school programs	\$3,600	
Summer day care	\$1,400	
Pre-school		
Elder care		
Suggested plan year election	=\$3,010	=
Taxes (40%*)	x0.40	x0.40
Estimated savings*	=\$2,000	=

** Tax savings amounts are examples provided for illustrative purposes only. They are based on federal, state, and FICA (Social Security) taxes that you do not have to pay through payroll deductions on amounts used to fund your account. Your actual savings may vary depending on your marginal income tax rate, whether you pay state income taxes, and other factors. Some states do not recognize tax exclusions for FSA contributions.*

Customer Service ~ 1.877.924.3967
FAX ~ 1.877.353.9236
Web ~ www.wageworks.com
E-mail Help ~ help@wageworks.com

DEPENDENT CARE PAY ME BACK CLAIM INSTRUCTIONS

Your claim is important to us. To ensure we are able to approve your claim, please fully complete the WageWorks Dependent Care Pay Me Back Claim Form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

**** An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.****

Tips for Filling out the Pay Me Back Claim Form

- Read every box and provide all requested information pertaining to you and your claim.
- Provide the legal name your employer has for you in their official records, not your nickname.
- Provide your ID Code which is usually the last four digits of your SSN.
- Make sure you sign the form. If the account holder's signature is not present, we cannot process your claim.
- Dependent Care Provider's signature can be substituted for a receipt from the provider; however, the provider must sign the form where indicated. Either the provider's signature on the claim form or an itemized receipt from the provider is required, not both.
- At the end of the tax year, you are required to provide IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Things to Remember When Submitting Receipts

- The receipt or documentation must contain:
 - **Provider Name** – Facility name or person who provided the service.
 - **Dates of Service** – Service start and end date for services provided.
 - **Service Description** – Detailed description for services provided.
 - **Amount** – The amount incurred for the services.
 - **Dependent Name** – Person who received the service.
- Cancelled or carbon copies of checks are not acceptable forms of receipt documents. Please do not submit.
- Overnight Camps are not eligible expenses.
- Include a receipt for every expense.
- Handwritten receipts must have stamped provider information.
- Send copies of your receipts; keep the originals for your records.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- **Do not use a highlighter to highlight the dollar amount on the receipt.**

Tips for Submitting the Pay Me Back Claim Form

- Do not use a cover page when faxing.
- Please allow 2 business days from receipt of your claim for processing.
- You can verify the claim status online at www.wageworks.com after processing.
- You will be notified via email of the status of your claim if we have a valid email address on file.
- Make a copy of the form and all attachments for your records if submitting via postal mail.
- Do not combine and submit a co-workers claim with yours.



Go Mobile with WageWorks®



EZ RECEIPTS

Managing your healthcare benefits is easier than ever with WageWorks. Wherever life takes you – whether it’s commuting to work, taking care of your family’s health or managing a child’s or dependent’s daycare – you know you can count on WageWorks to make it more affordable.

Now, with our enhanced EZ Receipts® mobile application, we’ve made it faster and more convenient. EZ Receipts enables you to submit healthcare claims and to upload receipts for healthcare transactions right from your smartphone, access help features right at your fingertips and get immediate email confirmations for claims.

No more filling out forms and mailing them in – easily submit claims and receipts online. Just pick up your smartphone to manage your WageWorks FSA, Dependent Care, or HRA account with the EZ Receipts Mobile App. EZ Receipts is compatible with iPhone, Android and Blackberry.

WITH EZ RECEIPTS YOU CAN:

- File a Claim or Submit a Receipt and get reimbursed fast
- Use the Shortcut Buttons to speed your way through the process
- Get easy access to transactions
- Check your current healthcare and dependent care account balance
- Submit WageWorks Healthcare Card receipt
- Have your daycare provider sign directly in the app

TO USE THE WAGeworks EZ RECEIPTS, YOU WILL NEED:

- ✓ A WageWorks healthcare or dependent care account
- ✓ An existing online username and password for your www.wageworks.com account
- ✓ Your device connected to the Internet



HERE'S HOW IT WORKS:

Manage your account in a quick, convenient, easy-to-use way:



- 1 Use your Healthcare Card for eligible purchases. Keep a copy of your receipt.
- 2 Snap a picture of your receipt on your mobile phone with the EZ Receipts mobile application.
- 3 EZ Receipts will automatically submit your receipt to WageWorks for reimbursement. You can use the EZ Receipts mobile app with any account – HSA, FSA, HRA and HIA.
- 4 **That's it! EZ Receipts does the rest!**



To download the app and learn more, go to www.wageworks.com/aboutmobile

Ameritas Dental

Effective Date: July 1, 2016

DEDUCTIBLE (Based on a Benefit Plan Year)

- \$50.00 per individual for Type 2 (Basic) and Type 3 (Major) Procedures Waived for Preventive & Diagnostic
- \$100 (Per Family)

TYPE 1- PREVENTIVE AND DIAGNOSTIC

Type 1 benefits are payable at 90% U&C*. No deductible applies.

- Routine Exam (Two per benefit year)
- Space Maintainers
- Cleanings (Two per benefit period)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Fluoride for Children (Two per benefit period for children under age 19)
- Bitewings (Two per benefit year)
- Sealants (Age 15 and under)

TYPE 2- BASIC PROCEDURES

Type 2 benefits are payable at 60% U&C*. \$50.00 deductible applies.

- Restorative Amalgams
- Restorative Composites
- Endodontics (Nonsurgical)
- Endodontics (Surgical)
- Periodontics (Nonsurgical)
- Periodontics (Surgical)
- Denture Repair
- Simple Extractions
- Complex Extractions
- Anesthesia

TYPE 3- MAJOR PROCEDURES

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

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

***Usual & Customary**

ANNUAL MAXIMUM BENEFIT

Type 1, Type 2, and Type 3 Procedures: \$1,000 per plan year per person.

LATE ENTRANT PROVISION

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

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
- Child(ren) to the age of 26 years

NOTE: For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by:

- a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or
- b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

PREDETERMINATION OF BENEFITS

A treatment plan filing is recommended for a proposed course of treatment.

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.

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.

CHANGING ELECTIONS

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.

CERTIFICATE OF INSURANCE

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

BI-WEEKLY RATES

Employee Only	\$0
Employee + Spouse	\$14.92
Employee + Children	\$14.92
Employee + Family	\$29.83

**For Claims/Customer Service call Ameritas at: 1.800.487.5553
Website: www.ameritasgroup.com**

This insurance is underwritten by Ameritas Life Insurance Corp.



Community Eye Care

Effective Date: July 1, 2016

Moore 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 (\$10 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 (\$10 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-credentialed provider still receive their full benefit. The member simply submits a claim to Community Eye Care and is reimbursed for the full cost of their exam (minus the exam 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.

Bi-Weekly Rates

Employee Only	\$4.95
Employee + One	\$9.40
Employee + Family	\$13.85

Member Services, Provider Services, Provider Listings, and Claims Services:
1.888.254.4290

Community Eye Care
2359 Perimeter Pointe Parkway
Suite 150
Charlotte, NC 28208

FAX: 704.426.6044
Website: www.communityeyecare.net



Vision Benefits Made Simple

Allstate Benefits Group Cancer

Effective Date: July 1, 2016

• **Wellness claims may be filed: Each calendar year**

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 for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It can help 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 dependent 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 for qualified employees

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. 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**

Cancer Facts & Figures, American Cancer Society, 2014

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.²

Your Benefit Coverage

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

Specified Diseases

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

Continuous Hospital Confinement

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

Government or Charity Hospital

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

Surgery**

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

² ***Cancer Facts & Figures, American Cancer Society, 2014.***

Second Opinion

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

Physical or Speech Therapy

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

Anesthesia

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

Ambulatory Surgical Center

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

Radiation/Chemotherapy for Cancer

Up to a \$10,000 (Low and Mid) 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 and Mid) 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 and Mid) 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 and Mid) 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; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

Extended Care Facility

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

Outpatient Lodging

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

Non-Local Transportation

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

Family Member Lodging and Transportation

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

Waiver of Premium (primary insured only)

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

Bone Marrow or Stem Cell Transplant*

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

ADDITIONAL BENEFIT

Wellness

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

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

A one time benefit of \$3,000 (Mid Option - \$10,000) 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 Options only)**

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

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

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

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

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

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

Allstate Benefits Group Cancer

Low Option without Cancer Initial Diagnosis and Intensive Care

Insureds	Bi-Weekly Rates
Employee	\$9.28
Employee + Child(ren)	\$12.80
Employee + Spouse	\$14.30
Family	\$17.80

Low Option with Cancer Initial Diagnosis and Intensive Care

Insureds	Bi-Weekly Rates
Employee	\$12.04
Employee + Child(ren)	\$17.00
Employee + Spouse	\$19.16
Family	\$24.12

Mid Option with Cancer Initial Diagnosis

Insureds	Bi-Weekly Rates
Employee	\$13.74
Employee + Child(ren)	\$19.46
Employee + Spouse	\$21.70
Family	\$27.42

High Option without Cancer Initial Diagnosis and Intensive Care

Insureds	Bi-Weekly Rates
Employee	\$14.36
Employee + Child(ren)	\$20.16
Employee + Spouse	\$21.94
Family	\$27.72

High Option with Cancer Initial Diagnosis and Intensive Care

Insureds	Bi-Weekly Rates
Employee	\$17.12
Employee + Child(ren)	\$24.36
Employee + Spouse	\$26.80
Family	\$34.02

Issue Ages: 18 and older while actively at work.

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

Eligibility- Family members eligible for coverage include: you; your 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"; and Allstate Benefits 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 terminates due to your failure to make required premium payments.

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

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

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

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; or intentional self-inflicted injury; or intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. 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 if paid under the cancer and specified disease ambulance benefit.

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

The policy is Limited Benefit Cancer and Specified Disease Insurance. The policy 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 for minimum essential coverage under the Affordable Care Act.

This material is valid as long as information remains current, but in no event later than August 1, 2018. Group Cancer and Specified Disease benefits provided by policy GVCP3, or state variations thereof. The policy is underwritten by American Heritage Life Insurance Company. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

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



Allstate®

Benefits

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), the underwriting company and 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

Customer Claims : 1.800.348.4489

www.allstate.com or

allstatebenefits.com

Aflac Accident - Low & High Options

Effective Date: July 1, 2016

• Wellness claims may be filed: Each calendar year

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

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.

Underwritten by Continental American Insurance Company
A proud member of the Aflac family of insurers

- 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 40 hours per week;
- Have been employed for at least 90 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:

- | | |
|------------------------------------|------------------------------|
| o Fractures | o Injuries requiring surgery |
| o Dislocations | o Eye injuries |
| o Paralysis | o Removal of foreign body |
| o Lacerations | o Ruptured disc |
| o Burns (second- and third-degree) | o Torn knee cartilage |
| o Concussion | o Internal injuries |
| o Coma | o Exploratory surgery |
| o 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 - \$60.00**

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:

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

- **Hospital Admission Benefit**

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

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

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

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

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

- **Accidental-Death and-Dismemberment Benefit**

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

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

You should know that the plan includes:

- **A pre-existing condition limitation.** Pre-existing Condition means within the 12-month period prior to the Effective Date of the Certificate and attached Riders, as applicable.

- o We will not pay benefits for any loss, injury or total disability which is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the Effective Date of the Certificate and attached riders, as applicable.

- o A claim for benefits for loss starting after 12 months from the Effective Date of a certificate and attached riders, as applicable, will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

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

- o 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. Aflac will return the prorated premium for any period not covered when you are in such service.

- o Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

- o Participating or attempting to participate in an illegal activity or working at an illegal job.

- o Committing or attempting to commit suicide, while sane or insane.
- o Injuring or attempting to injure yourself intentionally.
- o 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).
- o Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- o Participating in any organized sport, professional or semi-professional.
- o Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
- o Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.
- o Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
- o Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.
- o 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 will my payroll deduction be for the Aflac accident plan?

Bi-Weekly Premium

24 Hour Coverage	Low Option	High Option
Employee	\$4.78	\$8.68
Employee and Spouse	\$6.75	\$11.92
Employee and Dependent Child(ren)	\$8.20	\$14.50
Employee, Spouse, and Dependent Child(ren) - (Family)	\$10.17	\$17.74

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

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Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan. As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

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

Continental American Insurance Company
Columbia, South Carolina
800.433.3036 | aflacgroupinsurance.com



Aflac Critical Illness Insurance (without cancer)

Effective Date: July 1, 2016

- **Health Screening Benefit may be filed: Each calendar year**
- **Guaranteed Issue Amounts: Employee- \$10,000 Spouse- \$5,000**

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

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

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

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

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

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

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from \$5,000 to \$50,000 for employees. The benefit amount for spouses is \$5,000 to \$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.

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers

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

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

- o Are between the ages of 18 and 69;
- o Are a full-time, benefit-eligible employee;
- o Are working at least 40 hours per week;
- o 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:

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

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

• Health Screening Benefit

After the waiting period, you may receive a maximum of \$100.00 for any one covered screening test per calendar year (regardless of the test results).

This benefit is payable for you (the employee) and your covered spouse, **not for dependent children**. Covered screening tests include the following:

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

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

You should know that the plan includes:

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

- **Pre-existing condition limitation and exception.** A Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition.

A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

- **Certain exclusions.** No benefits are payable for loss resulting from:
 - o Intentionally self-inflicted injury or action;
 - o Suicide or attempted suicide while sane or insane;
 - o Illegal activities or participation in an illegal occupation;
 - o 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.
 - o Substance abuse; or
 - o Diagnosis and/or treatment received outside the United States.

**CAIC Group Critical Illness
Employee and Spouse - Bi-Weekly Rates**

NON - TOBACCO - Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.47	\$3.32	\$4.18	\$5.03	\$5.88	\$6.74	\$7.59	\$8.45	\$9.30	\$10.15
30-39	\$3.02	\$4.43	\$5.84	\$7.25	\$8.65	\$10.06	\$11.47	\$12.88	\$14.28	\$15.69
40-49	\$4.48	\$7.34	\$10.20	\$13.06	\$15.92	\$18.78	\$21.65	\$24.51	\$27.37	\$30.23
50-59	\$6.21	\$10.80	\$15.39	\$19.98	\$24.58	\$29.17	\$33.76	\$38.35	\$42.95	\$47.54
60-69	\$9.00	\$16.38	\$23.77	\$31.15	\$38.54	\$45.92	\$53.31	\$60.69	\$68.08	\$75.46

NON -TOBACCO - Spouse

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$2.47	\$2.90	\$3.32	\$3.75	\$4.18	\$4.60	\$5.03	\$5.46	\$5.88
30-39	\$3.02	\$3.73	\$4.43	\$5.13	\$5.84	\$6.54	\$7.25	\$7.95	\$8.65
40-49	\$4.48	\$5.91	\$7.34	\$8.77	\$10.20	\$11.63	\$13.06	\$14.49	\$15.92
50-59	\$6.21	\$8.50	\$10.80	\$13.10	\$15.39	\$17.69	\$19.98	\$22.28	\$24.58
60-69	\$9.00	\$12.69	\$16.38	\$20.08	\$23.77	\$27.46	\$31.15	\$34.85	\$38.54

TOBACCO - Employee

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.91	\$4.20	\$5.49	\$6.78	\$8.08	\$9.37	\$10.66	\$11.95	\$13.25	\$14.54
30-39	\$3.85	\$6.09	\$8.33	\$10.57	\$12.81	\$15.05	\$17.28	\$19.52	\$21.76	\$24.00
40-49	\$7.29	\$12.97	\$18.65	\$24.32	\$30.00	\$35.68	\$41.35	\$47.03	\$52.71	\$58.38
50-59	\$10.68	\$19.75	\$28.82	\$37.89	\$46.96	\$56.03	\$65.10	\$74.17	\$83.24	\$92.31
60-69	\$15.74	\$29.86	\$43.98	\$58.11	\$72.23	\$86.35	\$100.48	\$114.60	\$128.72	\$142.85

TOBACCO - Spouse

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-29	\$2.91	\$3.55	\$4.20	\$4.85	\$5.49	\$6.14	\$6.78	\$7.43	\$8.08
30-39	\$3.85	\$4.97	\$6.09	\$7.21	\$8.33	\$9.45	\$10.57	\$11.69	\$12.81
40-49	\$7.29	\$10.13	\$12.97	\$15.81	\$18.65	\$21.48	\$24.32	\$27.16	\$30.00
50-59	\$10.68	\$15.22	\$19.75	\$24.29	\$28.82	\$33.36	\$37.89	\$42.43	\$46.96
60-69	\$15.74	\$22.80	\$29.86	\$36.92	\$43.98	\$51.05	\$58.11	\$65.17	\$72.23

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

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

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

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Continental American Insurance Company

Columbia, South Carolina

800.433.3036 | aflacgroupinsurance.com

Aflac Value Added Services

NOTE: If you currently have the Aflac Accident and or Critical Illness plan, you automatically have access to the benefits provided in this summary at no extra cost to you. If you apply for either of these benefits, you will have access to the value added services listed.

Need help with healthcare?

We've got your lifeline.

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



We've enhanced your plan without adding cost.

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

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

These three services are now embedded in your group plan — at no extra charge. Best of all, you can start using them as soon as your Aflac coverage starts.

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD January 1, 2016.

Questions? Call 855-423-8585



**DID YOU
KNOW?**

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

Get more without spending more.



More than just peace of mind.

Health Advocacy from Health Advocate

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

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



More than just cash benefits.

Medical Bill Saver™ from Health Advocate

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

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



More than just care.

Telemedicine from MeMD

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

- Create your account at www.MeMD.me
- When you have a health issue, log on and request a provider consultation
- You can request consultations via webcam, app or phone
- Get ePrescriptions,* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- \$35.00 per visit!

Questions? Call **855-423-8585**

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

aflacgroupinsurance.com | 1.800.433.3036

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. Continental American Insurance Company | Columbia, South Carolina



AUL Short Term Disability

Effective Date: July 1, 2016

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 40 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

Disability

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

Monthly Benefit

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

Elimination Period

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

Benefit Duration

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

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

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

Recurrent Disability

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

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.

Portability

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

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

Please refer to the Mark III website (address located on the cover of this booklet) for a copy of your certificate, a claim form or application to port form.

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions, subject to 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 may do so only during the annual enrollment period subject to the pre-existing exclusion.

Customer Service

1.800.553.5318

Website: www.employeebenefits.aul.com

Disability Claims

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200, South Portland, ME 04106

Toll Free~ **855.517.6365**

Fax~ **844.287.9499**

OneAmerica.claims@customdisability.com



AMERICAN UNITED LIFE
INSURANCE COMPANY®
a ONEAMERICA® company

AUL Life Short Term Disability Bi-Weekly Rates

Benefit Duration:

13 Weeks

Monthly Benefit	Bi-Weekly Rates
\$500	\$4.78
\$600	\$5.74
\$700	\$6.69
\$800	\$7.65
\$900	\$8.60
\$1,000	\$9.56
\$1,100	\$10.51
\$1,200	\$11.47
\$1,300	\$12.43
\$1,400	\$13.38
\$1,500	\$14.34
\$1,600	\$15.29
\$1,700	\$16.25
\$1,800	\$17.21
\$1,900	\$18.16
\$2,000	\$19.12

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

AUL Long Term Disability

Effective Date: July 1, 2016

LTD Class Description

All Full-Time Eligible Employees working a minimum of 40 hours per week, electing to participate in the Voluntary Long-Term Disability.

LTD Monthly Benefit

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

LTD Elimination Period

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

LTD Benefit Duration

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

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

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

LTD Mental & Nervous / Drug & Alcohol:

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

Special Conditions

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

Other income Offsets

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

Waiver of Premium

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

Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to, 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 Or Continuity of Coverage will apply if the employee was insured under the employers prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period

This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit IF:

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and
2. The Person changes from one AUL short-term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period.

The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short-term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short-term disability plan's Pre-Existing Condition Limitation.

Portability

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

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

Please refer to the Mark III website (address located on the cover of this booklet) for a copy of your certificate, a claim form or application to port form.

Annual Enrollment

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

Exclusions and Limitations

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

Voluntary Long Term Disability

Monthly Benefit Amount	Bi-weekly Deduction
\$500	\$2.95
\$1,000	\$5.91
\$1,500	\$8.86
\$2,000	\$11.81

Customer Service

1.800.553.5318

Website: www.employeebenefits.aul.com

Disability Claims

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200, South Portland, ME 04106

Toll Free~ **855.517.6365**

Fax~ **844.287.9499**

OneAmerica.claims@customdisability.com



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a ONEAMERICA® company

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Voya Financial (ReliaStar) Term Life

Effective Date: (when approved by underwriting)

ALERT: If you are an existing employee and you are increasing your current coverage amount or if you are applying for coverage the very first time (did not apply when first hired) you are required to complete a health statement. This applies to your dependents as well.

EMPLOYER PLAN

Your Employer will provide Basic Life coverage from Voya Financial Life. If you qualify for Basic Life, you may also apply for Additional Life coverage to supplement your Basic Life amount.

ELIGIBILITY

To be eligible for this plan:

- You must be insured for Basic Life.
- You must be an active employee of County of Moore regularly working 40 or more hours per week or active permanent part-time employee regularly working 20 or more hours per week, or active Commissioner of the County of Moore excluding temporary or seasonal employees, full time members of the armed forces, leased employees or independent contractors
- Your spouse or children must not be full-time members of the armed forces of any country.

ADDITIONAL EMPLOYEE COVERAGE AMOUNT

You may elect Additional Life coverage in units of \$10,000 to a maximum of \$300,000. If you wish to become insured for an amount of Additional Life in excess of \$50,000 the excess **will be subject to medical underwriting approval. All late applications and requests for coverage increases are also subject to medical underwriting approval.** Dependents Life Insurance from Voya Financial is also included in this plan.

ADDITIONAL SPOUSE COVERAGE AMOUNT

This coverage is available in units of \$10,000 to a maximum of \$150,000, but not to exceed 100% of the employees combined Basic and Additional Life coverage. **If you elect an amount for your spouse greater than \$10,000, the excess will be subject to medical underwriting approval. All late applications and requests for coverage increases will also require medical underwriting approval.**

****Commissioners are not eligible for the additional spouse coverage.****

ADDITIONAL COVERAGE AMOUNT FOR CHILDREN

You may elect \$2,000; \$5,000 or \$10,000 of Dependents Life Insurance for your eligible children. This amount may not exceed 100% of the employees combined Basic and Additional Life coverage. **All late applications will be subject to medical underwriting approval.**

EMPLOYEE RATES

<u>Employee Age on January 1</u>	<u>Rate (Per \$1000 of Total Coverage)</u>
<29	\$0.060
30-34	\$0.100
35-39	\$0.125
40-44	\$0.160
45-49	\$0.240
50-54	\$0.390
55-59	\$0.676
60-64	\$0.940
65-69	\$1.680
70-74	\$2.720
75+	\$2.720

To calculate your premium:

$$\text{Amount Elected} \div \$1,000 = \text{x \$ } \underline{\hspace{2cm}} \text{ (from chart) = \$ } \underline{\hspace{2cm}} \text{ Your monthly cost}$$

<p>Write this amount on the Life Requested Amount line on your Enrollment and Change Form</p>	<p>Add this amount to the coverage provided by your employer. Write the total amount on the Life Requested Amount line on your Enrollment and Change form</p>
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SPOUSE RATES- Premiums for Additional Spouse coverage must be calculated on the age of the Moore County Employee.

<u>Employee Age on January 1st</u>	<u>Rate (Per \$1000 of Total Coverage)</u>
<29	\$0.060
30-34	\$0.100
35-39	\$0.125
40-44	\$0.160
45-49	\$0.240
50-54	\$0.390
55-59	\$0.676
60-64	\$0.940
65-69	\$1.680
70-74	\$2.720
75+	\$2.720

To calculate the premium for your spouse:

$$\text{Amount Elected} \div \$1,000 = \text{x \$ } \underline{\hspace{2cm}} \text{ (from chart) = \$ } \underline{\hspace{2cm}} \text{ Your monthly cost}$$

Write this amount on the Dependent Life Spouse Requested Amount line on your enrollment and Change Form

VOLUNTARY MONTHLY CHILD RATES	(cost based on 26 pay periods)
\$2,000 RATE \$0.40 PER MEMBER	\$.19
\$5,000 RATE \$1.00 PER MEMBER	\$.46
\$10,000 RATE \$2.00 PER MEMBER	\$.92

EMPLOYEE COVERAGE EFFECTIVE DATE

Please contact your Human Resources Department for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An eligibility waiting period
- Evidence of insurability is required for employees who enroll more than 31 days after eligibility and for elective increases.
- An active work requirement. This means that if you are not actively at work on the day before the scheduled effective date of insurance (including Dependents Life Insurance), your insurance will not become effective until the day after you complete 1 full Day of active work as an eligible employee.

AGE REDUCTIONS

Under this plan, employee & spouse benefit amounts reduce to 50% at age 70.

SUICIDE EXCLUSION

This plan includes an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death. This is subject to state variations.

WAIVER OF PREMIUM PROVISION

Voya Financial waives your Life Insurance premium that becomes due while you are totally disabled. The premium will be waived if you satisfy certain conditions. When Voya Financial waives a premium, the amount of Life Insurance equals the amount that would have been provided if you had not become totally disabled. That amount will reduce or stop according to the Schedule of Benefits in effect on the date total disability begins.

When Voya Financial waives a premium it includes Life Insurance, Accelerated Death Benefit and Waiver of Premium. It does not include Dependent Insurance, or any other benefits as elected under this certificate which were effective at the time of disability.

Voya Financial requires written notice of claim and proof of total disability to waive your premium. All of the following conditions must also be met:

- Total disability must begin before your 60th birthday.
- You are insured for the Waiver of Life Insurance Premium Disability Benefit on the date you become totally disabled.
- You continue to be totally disabled.
- Your insurance is in force when you suffer the sickness or accidental injury causing the total disability.
- All premiums are paid up to the date the Waiver of Premium is approved by Voya Financial.

Voya Financial needs written notice of a claim before it waives any premium. This notice must be received –

- While you are living,
- While you are totally disabled, and

- Within one year from the date total disability begins. If you cannot give Voya Financial notice within one year, your claim is still valid if you show you gave Voya Financial notice as soon as reasonably possible.

Voya Financial needs proof of your total disability before any premiums can be waived. Voya Financial may require you to have a physical exam by a doctor it chooses. Voya Financial pays for that exam. Voya Financial can only require one exam a year after premiums have been waived for 2 full years.

When Voya Financial approves your proof of total disability, premiums are waived as of the date you became totally disabled.

WHEN SPOUSE AND CHILD COVERAGE ENDS

Your dependent's insurance stops on the earliest of the following dates:

- The date the Dependent's Insurance part of the Group Policy stops.
- The date the Group Policy terminates.
- The end of the period for which you made your last premium contribution for Dependent's Insurance if you did not make the next required contribution when due.
- The date your insurance stops.
- The date you retire.
- The date your dependent's insurance is converted under the Conversion Right.
- The date your insured dependent is no longer a dependent or student dependent as defined.
- The date your Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit provision of the Group Policy.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Voya Financial pays this benefit if you suffer a covered loss due to a covered accident.

All of the following conditions must be met:

- You are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the date of the accident
- The cause of the loss is not excluded

ADDITIONAL FEATURES:

These features may offer additional benefits when an AD&D Insurance Benefit is payable

- Loss through Paralysis
- Safe Driver

- Coma
- Education
- Transportation
- Child Care
- Occupational Assault (employee only)
- Exposure & Disappearance

Please refer to your Summary Plan Description for specific descriptions.

EXCLUSIONS

No benefit is paid for loss directly or indirectly caused by any of the following:

- Suicide or intentional self-inflicted injury while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning with the exception of infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury sustained while in the military service for any country or government
- Injury which occurs when the insured commits or attempts to commit a felony
- Use of any drug, narcotic or hallucinogenic agent, 1) unless prescribed by a doctor, 2) which is illegal, or 3) not taken as directed by a doctor or the manufacturer.
- The insured's intoxicated. Intoxication means the insured's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

WHEN COVERAGE ENDS

AD&D Insurance will end on the earliest of the following:

- The date your Life insurance ends.
- The date your Waiver of Premium begins.
- The date AD&D Insurance terminates under the group policy.
- The date the last period ends for which a premium was paid for your AD&D Insurance.
- The date your employer's coverage under the group policy for AD&D Insurance terminates.
- The date your employment terminates.

PORTABILITY

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage. Please contact your Human Resources Department for additional information. This is subject to state variations.

Basic Employee Term Life Insurance

All Eligible Full Time Employees (working 40 hours per week) 2 times annual salary- Maximum \$500,000 (no cost to you)

Commissioners \$25,000 (Additional Term Life spouse coverage does not apply)

Bailiffs \$20,000

All Part-time Employees \$10,000 coverage (no cost to you)

Basic Dependent Term Life Insurance \$.84 (Bi-weekly deduction) (includes Spouse & Children) \$5,000 coverage

Additional Employee & Dependent Term Life Insurance

• **Employee** coverage: \$10,000-\$300,000 (in \$10,000 increments)* ***Coverage amounts over \$50,000 (for newly hired employees) will be subject to medical underwriting**

• **Spouse** coverage: \$10,000-\$150,000 (in \$10,000 increments)* ***Coverage amounts over \$10,000 (for newly hired employees) will be subject to medical underwriting.**

****Spousal coverage is based on the age of the Employee, not the spouse****

• **Child(ren)** coverage amounts: (Cost is based on 26 pay periods)
\$2,000 (\$.19)
\$5,000 (\$.46)
\$10,000 (\$.92)

The cost applies to as many children as you need to cover, not per child.

NOTE:

Moore County has developed this document to provide you with information about the Optional coverage you may select through Voya Financial. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please refer to your Certificate and plan summary or check with your Human Resources Department. The Certificate and plan summary are the governing documents for your plan.

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Voya Financial.

Additional Employee & Spouse Term Life Rates (Based on Bi-Weekly rates, 26 pay periods)

Coverage Amounts	< 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$0.28	\$0.46	\$0.58	\$0.74	\$1.11	\$1.80	\$3.12	\$4.34	\$7.75	\$12.55
\$20,000	\$0.55	\$0.92	\$1.15	\$1.48	\$2.22	\$3.60	\$6.24	\$8.68	\$15.51	\$25.11
\$30,000	\$0.83	\$1.38	\$1.73	\$2.22	\$3.32	\$5.40	\$9.36	\$13.02	\$23.26	\$37.66
\$40,000	\$1.11	\$1.85	\$2.31	\$2.95	\$4.43	\$7.20	\$12.48	\$17.35	\$31.02	\$50.22
\$50,000	\$1.38	\$2.31	\$2.88	\$3.69	\$5.54	\$9.00	\$15.60	\$21.69	\$38.77	\$62.77
\$60,000	\$1.66	\$2.77	\$3.46	\$4.43	\$6.65	\$10.80	\$18.72	\$26.03	\$46.52	\$75.32
\$70,000	\$1.94	\$3.23	\$4.04	\$5.17	\$7.75	\$12.60	\$21.84	\$30.37	\$54.28	\$87.88
\$80,000	\$2.22	\$3.69	\$4.62	\$5.91	\$8.86	\$14.40	\$24.96	\$34.71	\$62.03	\$100.43
\$90,000	\$2.49	\$4.15	\$5.19	\$6.65	\$9.97	\$16.20	\$28.08	\$39.05	\$69.78	\$112.98
\$100,000	\$2.77	\$4.62	\$5.77	\$7.38	\$11.08	\$18.00	\$31.20	\$43.38	\$77.54	\$125.54
\$110,000	\$3.05	\$5.08	\$6.35	\$8.12	\$12.18	\$19.80	\$34.32	\$47.72	\$85.29	\$138.09
\$120,000	\$3.32	\$5.54	\$6.92	\$8.86	\$13.29	\$21.60	\$37.44	\$52.06	\$93.05	\$150.65
\$130,000	\$3.60	\$6.00	\$7.50	\$9.60	\$14.40	\$23.40	\$40.56	\$56.40	\$100.80	\$163.20
\$140,000	\$3.88	\$6.46	\$8.08	\$10.34	\$15.51	\$25.20	\$43.68	\$60.74	\$108.55	\$175.75
\$150,000	\$4.15	\$6.92	\$8.65	\$11.08	\$16.62	\$27.00	\$46.80	\$65.08	\$116.31	\$188.31
\$160,000	\$4.43	\$7.38	\$9.23	\$11.82	\$17.72	\$28.80	\$49.92	\$69.42	\$124.06	\$200.86
\$170,000	\$4.71	\$7.85	\$9.81	\$12.55	\$18.83	\$30.60	\$53.04	\$73.75	\$131.82	\$213.42
\$180,000	\$4.98	\$8.31	\$10.38	\$13.29	\$19.94	\$32.40	\$56.16	\$78.09	\$139.57	\$225.97
\$190,000	\$5.26	\$8.77	\$10.96	\$14.03	\$21.05	\$34.20	\$59.28	\$82.43	\$147.32	\$238.52
\$200,000	\$5.54	\$9.23	\$11.54	\$14.77	\$22.15	\$36.00	\$62.40	\$86.77	\$155.08	\$251.08
\$210,000	\$5.82	\$9.69	\$12.12	\$15.51	\$23.26	\$37.80	\$65.52	\$91.11	\$162.83	\$263.63
\$220,000	\$6.09	\$10.15	\$12.69	\$16.25	\$24.37	\$39.60	\$68.64	\$95.45	\$170.58	\$276.18
\$230,000	\$6.37	\$10.62	\$13.27	\$16.98	\$25.48	\$41.40	\$71.76	\$99.78	\$178.34	\$288.74
\$240,000	\$6.65	\$11.08	\$13.85	\$17.72	\$26.58	\$43.20	\$74.88	\$104.12	\$186.09	\$301.29
\$250,000	\$6.92	\$11.54	\$14.42	\$18.46	\$27.69	\$45.00	\$78.00	\$108.46	\$193.85	\$313.85
\$260,000	\$7.20	\$12.00	\$15.00	\$19.20	\$28.80	\$46.80	\$81.12	\$112.80	\$201.60	\$326.40
\$270,000	\$7.48	\$12.46	\$15.58	\$19.94	\$29.91	\$48.60	\$84.24	\$117.14	\$209.35	\$338.95
\$280,000	\$7.75	\$12.92	\$16.15	\$20.68	\$31.02	\$50.40	\$87.36	\$121.48	\$217.11	\$351.51
\$290,000	\$8.03	\$13.38	\$16.73	\$21.42	\$32.12	\$52.20	\$90.48	\$125.82	\$224.86	\$364.06
\$300,000	\$8.31	\$13.85	\$17.31	\$22.15	\$33.23	\$54.00	\$93.60	\$130.15	\$232.62	\$376.62

IMPORTANT REMINDERS:

- ***Premiums for Additional Spouse coverage must be calculated on the age of the Moore County Employee.***
- ***Commissioners are not eligible for the additional spouse coverage.***
- ***If both husband and wife work for Moore County, neither can cover each other for Term Life.***
- ***If both husband and wife work for Moore County, only one may cover dependent child(ren) for Term Life.***

Plan Administrator

Moore County Government
302 Monroe Street
Carthage, NC 28327
910.947.6362



Texas Life Whole Life - Solutions 121

Common Issue Date: August 1, 2016 (pending underwriting approval)

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

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements.² As an employee, you are eligible to apply once you have satisfied your employer's eligibility period.

Why Voluntary Coverage?

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

The SOLUTIONS Advantage

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

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

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

15M002-C 1001 CI & Waiver R1115 (exp10117) See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

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

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

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

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

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

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

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details. Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Sample Rates

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

SOLUTIONS 121

Age	Face Amount	Monthly Premium Non-Tobacco Chronic Illness, & Waiver	Monthly Premium Tobacco Chronic Illness, & Waiver	P a i d - u p Age
20	\$50,000	\$38.11	\$46.96	65
25	\$50,000	\$43.42	\$54.63	65
30	\$50,000	\$53.45	\$67.02	65
35	\$50,000	\$68.20	\$86.49	65
40	\$50,000	\$91.80	\$115.40	65
45	\$50,000	\$125.43	\$162.01	65

SOLUTIONS REVIEW

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

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

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

³ Facts About Life, LIMRA International (2011)

If you have any questions regarding your Texas Life policy, please call 800.283.9233, prompt 2

TEXASLIFE INSURANCE
COMPANY

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

15M002-C 1001 CI & Waiver R1115 (exp0117) See the SOLUTIONS brochure for complete details. Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Continuation of Benefits If You Leave Employment

AFLAC GROUP CRITICAL ILLNESS AND ACCIDENT

When you leave employment, you may continue your Critical Illness and Accident plans by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. **You may contact Aflac at 1.800.433.3036.**

ALLSTATE BENEFITS GROUP CANCER

When you leave employment you may continue your cancer coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Allstate Benefits Group Division at 1.800.521.3535.**

AUL SHORT & LONG TERM DISABILITY

Once you are on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 31 days from your date of termination to apply for portability. Please see the Mark III website for the portability form; **www.markiiibrokerage.com/moorecountync.**

COMMUNITY EYE CARE VISION

Under the Community Eye Care plan, you may continue the Vision coverage once you leave employment by calling Community Eye Care and have the deduction set up to be bank drafted or paid by Visa and or Mastercard. The premium will remain the same even though you have ceased employment. You may set up direct bill or credit card payments by contacting **Community Eye Care at 1.888.254.4290.**

FIRSTCAROLINACARE HEALTH

If you need to make changes or have questions about the Health plan, **contact Dawn Spivey at 910. 947.6362.**

TEXAS LIFE WHOLE LIFE~ SOLUTIONS 121

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Texas Life at 1.800.283.9233, prompt #2.**

VOYA FINANCIAL (RELIASTAR) TERM LIFE

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

- You must apply for coverage within 31 days from the date your life coverage terminates.

•You must be ACTIVELY at work prior to employment termination.

•You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information and rates for porting coverage, please contact your Human Resources Department at 910.947.6362. You must send in the portability documents that you will receive within 31 days of your termination date.

WAGeworks FLEXIBLE SPENDING ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Spending Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting one of the COBRA options. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **your Benefits Department at 1.910.947.6362.**

FOR RETIREES

METLIFE DENTAL & SUPERIOR VISION INSURANCE PLANS FOR RETIREES OF STATE OR LOCAL GOVERNMENT OFFERED THROUGH NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES' ASSOCIATION, INC.

With over 54,000 members, the North Carolina Retired Governmental Employees' Association is the largest single group representing retirees before the N.C. General Assembly, the Retirement Systems Boards of Trustees, and the State Health Plan trustees. For retirees or future retirees of state or local governments in North Carolina (including teachers, legislators, National Guard, and judicial), NCRGEA is your voice for sustaining and increasing your benefits after retirement.

Additionally, there are many benefits included with membership at no additional cost (\$10,000 AD&D Insurance, bimonthly newsletter, weekly electronic legislative updates while the General Assembly is in session, a toll-free number to call for information and assistance, hearing assistance and vision care discount programs, and free district meetings).

The Association also offers optional MetLife Dental Insurance and Superior Vision Insurance plans for our members. Those premiums are conveniently deducted from your retirement benefit check monthly. **Please contact us at NCRGEA, PO Box 10561, Raleigh, NC 27605, 1.800.356.1190, www.info@ncrgea.com or go to our website, www.ncrgea.com for further information.**

Phone Directory

- Aflac Critical Illness & Accident- 1.800.433.3036
- Allstate Benefits Group Cancer - 1.800.521.3535
- AUL Short & Long Term Disability - 1.800.553.5318
- Community Eye Care - 1.888.254.4290
- FirstCarolinaCare Health -
 - **Claim Status/Register for Online Access- 1.800.811.3298**
 - **Precertification Inquiry- 1.800.574.8556**
 - **Pharmacy Benefits - 1.800.788.2949**
 - **Pharmacy Mail Order- 1.800.552.6694**
- Mark III Brokerage, Inc. - 1.800.532.1044
- Moore County Government - 1.910.947.6362
- Voya Financial (ReliaStar) Term Life - 1.910.947.6362
- Texas Life Whole Life - 1.800.283.9233 prompt #2
- WageWorks Health & Dependent Care Accounts - 1.877.924.3967

AFLAC POLICIES *(older than 3 years)*

When you leave employment, you may continue your Aflac policies by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. You may **contact Aflac at 1.800.992.3522**.



View Benefit Information & Download Forms at:
www.markiiibrokerage.com/moorecountync

or scan:



Mark III

Employee Benefits

211 Greenwich Road

Charlotte, NC 28211

(800) 532-1044 x209

(704) 365-4280 x209