2019 Open Enrollment

Employee Benefit Guide

This booklet contains information relative to your insurance (medical, dental, optical and E.A.P.) as well as all Federal and State mandated notices and optional plans offered by the Division. Please take time to read through this booklet in its entirety.

All Changes are due by December 2nd, 2018

Genesee County Drain Commissioner's Office
Division of Water & Waste Services
G-4610 Beecher Road Flint, Michigan 48532
Phone: (810) 732-7870 Fax (810) 732-7870
www.gcdcwws.com

GENESEE COUNTY DRAIN COMMISSIONER'S OFFICE

DIVISON OF WATER & WASTE SERVICES

G-4610 BEECHER RD – FLINT, MI – 48532 PHONE (810) 732-7870 FAX (810) 732-9773

JEFFREY WRIGHT - COMMISSIONER

Dear Employee,

The Division is pleased to provide you with your 2019 Open Enrollment Booklet which contains important information about your benefits for 2019.

Open Enrollment begins today and will run through December 2nd, 2018. Please allow this to be your annual opportunity to:

- Make changes to your plan
- Verify that your life insurance beneficiaries are correct
- Enroll in or change any of the optional plans offered by the Division (LifeLock, FSA (via AFLAC/Maestro Health) or AFLAC).

This booklet contains important information about your benefits including:

- Federal Notices
- Glossary of Health Coverage and Medical Terms
- Marketplace Coverage Options
- COBRA Rights
- Medical plan summary of benefits
- Vision and Dental plan summary of benefits (plan effective after probationary period)
- Employee Assistance Program (EAP) information
- Flexible Spending Account (FSA) information (plan is eligible after probationary period)
- AFLAC information (plan is eligible after probationary period)
- LifeLock (identity theft protection) information (plan is eligible after probationary period)
- Medicare Information

The Division continually strives to provide employees a strong benefit package with access to some of the best optional plans available.

Please take time to read through this entire booklet before you elect to make any changes. All changes or new enrollments must be made by December 2nd, 2018. Should you have any questions please to not hesitate to contact Christine Kleiber or myself at (810) 732-7870 or sholder@gcdcwws.com or csimms@gcdcwws.com.

Respectfully,

Shannon M. Holder - Division HR Manager

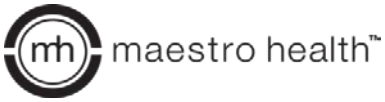
Contact and Link Information:

Division provided Medical, Dental and Vision insurance carrier - www.bcbsm.com

Division provided Life Insurance, Short & Long Term Disability and EAP - www.symetra.com. For EAP www.guidanceresources.com

OPTIONAL BENEFITS

OPTIONAL Insurance Coverage not provided by the Division. Agent Joshua Biggs (810) 624-9314 or joshua_biggs@us.aflac.com



OPTIONAL Flexible Spending Accounts (FSA) are also offered by AFLAC (via Maestro Health).

OPTIONAL Identity Theft Insurnace. For more information contact HR.

OPTIONAL Deferred Compensation Plan (457). Agent Ken Kelbel (810) 730-6659 or kelbelk@nationwide.com

OPTIONAL Deferred Compensation Plan (457). Agent Barry Jones (810) 654-9206 or barry.jones@axa-advisors.com

If you have questions on any of the above listed plans please contact HR

LIFE AND STATUS CHANGES

As your life changes so may your benefits. Changes <u>must</u> be reported to the Human Resources Department and include but are not limited to: address changes, marriage, legal separation, divorce, birth or adoption of a child. By promptly reporting changes the transition is made much simpler.

TYPES OF CHANGES YOU MUST REPORT AND WHAT FORMS ARE NEEDED:

If you **MOVE** or **CHANGE YOUR PHONE NUMBER:**

* Fill out the change of address form
* If you move into our out of a City that charges local taxes, you must notify us to either

If you **MARRY:** ***<u>YOU HAVE 30 DAYS FROM THE DATE OF MARRIAGE TO ENROLL YOUR SPOUSE</u>*** **.**

If you miss this deadline you will have to wait until open enrollment for a January 1st effective date.

* Insurance Enrollment/Change Form
* A copy of your Marriage Certificate
* Life Insurance change of beneficiary form
* Retirement Change of Nomination of Beneficiary Form

If you **DIVORCE or get a DECREE OF LEGAL SEPARATION: <u>YOU MUST NOTIFY HUMAN RESOURCES WITHIN 30 DAYS FROM THE DATE OF DIVORCE/SEPARATION</u>**

* Insurance Enrollment/Change Form
* A copy of the Divorce/Legal Separation Decree
* Life Insurance change of beneficiary form
* Retirement Change of Nomination of Beneficiary Form

If you have a **NEW CHILD in the home:**

<u>YOU ONLY HAVE 30 DAYS FROM THE DATE OF BIRTH OR ADOPTION TO ENROLL YOUR CHILD</u>

If you miss this deadline you will have to wait until open enrollment for a January 1st effective date.

* Insurance Enrollment/Change Form
* Birth Certificate and SS Card. For Adoption Court papers are required.
* BE SURE to complete all information including SSN and DOB where appropriate

Health Plan
Important Notices

Women's Health and Cancer Rights Act Enrollment Notice
On October 21, 1998 Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain re-constructive services. These services include reconstruction of the breast upon which the mastectomy has been performed, surgery/reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

Genetic Information Non-Discrimination Act Of 2008
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Disclosure Of Grandfathered Status
This group health plan believes the following plan(s), retiree divisions 0002, 0003, 0004, 0005, 0006, and 0007 are a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (810) 732-7870. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Newborns' and Mothers' Health Protection Act (Newborns' Act)
Under federal law, group health plans offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier, set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceed 48 hours (or 96 hours).

Michelle's Law
Michelle's Law is an act that requires health plans to allow college students who take a leave of absence or reduce their class load because of illness to retain their dependent status under their parents' health plan for up to one year. Students' eligibility for dependent coverage will continue for one year (unless the student would otherwise lose eligibility within the year). To qualify for protection under Michelle's Law, the following requirements must be met: the student must be enrolled as a full-time student immediately before the leave of absence or scheduled reduction, the student must have written certification from a treating physician that the leave of absence or reduced schedule is necessary due to a severe illness or injury, and the leave or reduced schedule must have triggered the loss of student status under the health plan. If the plan sponsor changes group health plans during a medically necessary leave and the new health plan offers coverage of dependent children, the new plan will be subject to the same rules.

Tell Us When You're Medicare Eligible
Please notify Human Resources within 30 days of you or your dependents becoming eligible for Medicare. As your employer, we are required by Federal Law to inform each carrier of an employee and/or dependent's Medicare status. Federal law determines whether Medicare or the health plan pays primary. Medicare eligibles must also contact Medicare directly to notify them that they have employer group sponsored health care coverage, Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian to update or change Medicare records.

NONDISCRIMINATION NOTICE - It's important we treat you fairly.
Our goal is to treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We do not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card. If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact your plan administrator. You can also contact the U.S. Department of Health and Human Services, Office for Civil Rights at:

U.S. Department of Health and Human Services, Office for Civil Rights at:
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F,
HHH Building Washington, DC 20201
Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Human Resources Department
Address	Genesee County Drain Commissioner's Office Division of Water and Waste Services
	G-4610 Beecher Road
City, State	Flint, MI 48532
Telephone	(810) 732-7870
E-mail	hr@gcdcwws.com

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period.

HIPAA Basics

Your right to privacy

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information.

In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed;
- Require that individuals be told how their health information will be used and disclosed;
- Provide individuals with a right to access, amend or copy their medical records;
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications; and
- Impose fines where the requirements contained within the regulations are not met.

Restrictions on Use & Disclosure

The rules allow health care providers, health plans, and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information for purposes of treatment, payment, or health care operations.

For example, your health care provider may submit your health information to a health insurance company in order to seek payment for the treatment provided to you. Your primary care physician can share your health information with a specialist that he or she recommends you consult. In these cases, your written permission to disclose your health information is not required.

In general, any use or disclosure not considered treatment, payment, or a health care operation requires your written authorization, unless an exception applies. For example, your physician may not share your health information with your employer or a life insurance carrier without your written permission.

However, disclosure of health information is permitted for certain purposes specifically listed in the HIPAA Privacy Rules, such as national security, law enforcement and public health issues. If you authorize release of your health information to a third party, the information released may no longer be protected by HIPAA.

Notice of Privacy Practices

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed.

For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgement indicating that you received the Notice of Privacy Practices.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated.

Right to Access, Amend, or Copy

You have a right to view and copy your medical records. You may be charged a fee for the cost of reproduction. If you believe that information within your medical records is incorrect or if important information is missing, you have a right to request that your medical records be amended.

Right to an Accounting of Disclosure

You also have a right to a list of uses and disclosures made of your medical records where the use or disclosure was not for purposes of treatment, payment, health care operations, or pursuant to your written authorization.

Right to Request Restrictions

You may request in writing that a health care provider or health plan not use or disclose information for treatment, payment, or other administrative purposes unless specifically authorized by you, when required by law, or in emergency circumstances. Health care providers and health plans must consider your request, but are not legally obligated to agree to those restrictions.

Confidential Communications

You have a right to receive confidential communications containing your health information. Health care providers and health plans are required to accommodate your reasonable requests. For example, you may ask that a physician contact you at your place of employment or send communications regarding treatment to an alternate address.

Violations of Privacy Rights

If you believe that your privacy rights have been violated, you may contact the Privacy Officer for the organization that you feel has violated your right to privacy. The name of the Privacy Officer should be included in the Notice of Privacy Practices provided to you by that organization.

If the Privacy Officer does not adequately resolve your concerns, you may contact the Department of Health and Human Services — Office of Civil Rights (OCR). OCR is responsible for enforcing the HIPAA Privacy Rules. Its Web site contains instructions on how to file a complaint www.hhs.gov/ocr/privacy/hipaa/complaints and a complaint form www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf

Penalties for Noncompliance

The HIPAA Privacy Rules do not provide individuals with a private right to sue, although methodologies for allowing a portion of civil penalties to be paid to affected individuals must be established by February 17, 2012.

Currently, health care providers, health plans, and health care clearinghouses that do not comply with the HIPAA Privacy Rules may be subject to civil money penalties ranging from $100 to $50,000 per violation, with maximum penalties ranging from $25,000 per year to $1.5 million per year.

Criminal violations of the HIPAA Privacy Rules may also be referred to the Department of Justice for enforcement. Criminal penalties for such violations include:

- $50,000 and/or up to one year in prison for knowingly obtaining or disclosing protected health information not permitted by law;
- $100,000 and/or up to five years in prison for obtaining or disclosing protected health information under false pretenses; and
- $250,000 and/or up to ten years in prison for obtaining protected health information with an intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.

State Attorneys General (AG) may also bring suit against Covered Entities to enjoin further violations and obtain damages on behalf of residents of their states, if HHS has not already taken action. The AG may seek damages of up to $100 per violation, with a maximum of $25,000 per year for identical violations.

HIPAA Privacy Resources

- Office of Civil Rights (HHS)

www.hhs.gov/ocr/

Health Privacy Project

www.healthprivacy.org

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT GUIDELINE NOTICE

Insurance Agencies, Doctors, Hospitals, Employer Sponsored Health Plans and others are required to obtain authorization or consent before disclosing any Protected Health Information (PHI) to other parties. This rule helps ensure that medical and other protected health information, whether spoken, written or in electronic form, is kept confidential. the Genesee County Drain Commissioner's Office Division of Water and Waste Services Group Benefit Plan is committed to maintaining the privacy and security of our employees (and family members) protected health information in accordance with HIPAA and other applicable law.

As a result, employees requesting assistance with medical/health related matters or updating medical information records for themselves or family members are to make their request to the Medical Privacy Officer or other designated representatives. The Employee will be required to sign a release form authorizing the Genesee County Drain Commissioner's Office Division of Water and Waste Services Group Benefit Plan Medical Privacy Officer or designated representative to assist, perhaps become knowledgeable of protected health information and to disclose medical/health information to others as deemed appropriate in accordance with HIPAA regulations.

If you have questions regarding your rights under the Health Insurance Portability and Accountability Act Privacy Standard please contact the Human Resources Department, at G4610 Beecher Rd., Flint, MI 48532 or 810.732.7870 or hr@gcdcwws.com.

Notice of Privacy Practices

Please review this notice carefully, as it describes how one or more of the health plans of The Genesee County Drain Commissioner's Office Division of Water and Waste Services. (collectively the "Plan") and any third party assisting in the administration of claims may use and disclose your health information, and how you can access this information. This notice is being provided to you pursuant to the federal law known as HIPAA and an amendment to that law known as HITECH and is effective November 1, 2014. If you have any questions about this notice, please contact the Human Resources Department, at G4610 Beecher Rd., Flint, MI 48532 or 810.732.7870 or HR@gcdcwws.com. The Plan has been amended to comply with the requirements described in this notice.

The Plan's Pledge Regarding Health Information. The Plan is committed to protecting your personal health information. The Plan is required by law to protect medical information about you. This notice applies to medical records and information the Plan maintains concerning the Plan. Your personal doctor or health care provider may have different policies or notices regarding the use and disclosure of your health information created in his or her facility. This notice will describe how the Plan may use and disclose health information (known as "protected health information" under federal law) about you, as well as the Plan's obligations and your rights regarding this use and disclosure.

Use and Disclosure of Health Information. The following categories describe different ways that the Plan uses and discloses protected health information. The Plan will explain and present examples for each category but will not list every possible use or disclosure. However, all of the permissible uses and disclosures fall within one of these categories:

- *For Treatment*. The Plan may use or disclose your health information to facilitate treatment or services by providers. For example, the Plan may disclose your health information to providers, including doctors, nurses, or other hospital personnel who are involved in your care.
- *For Payment*. The Plan may use and disclose your health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, or to determine benefit responsibility under the Plan. For example, the Plan may disclose your health history to your health care provider to determine whether a particular treatment is a qualifying health expense or to determine whether the Plan will reimburse the treatment. The Plan may also share your health information with a utilization review or precertification service provider, with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.
- *For Health Care Operations*. The Plan may use and disclose your health information in order to operate the Plan. For example, the Plan may use health information in connection with the following: (1) quality assessment and improvement; (2) underwriting, premium rating, and Plan coverage; (3) stop-loss (or excess-loss) claim submission; (4) medical review, legal services, audit services, and fraud and abuse detection programs; (5) business planning and development, such as cost management; and (6) business management and general Plan administration.
- *To Business Associates and Subcontractors*. The Plan may contract with individuals and entities known as business associates to perform various functions or provide certain services. In order to perform these functions or provide these services, business associates may receive, create, maintain, use, or disclose your health information, but only after they sign an agreement with the Plan requiring them to implement appropriate safeguards regarding your health information. For example, the Plan may disclose your health information to a business associate to administer claims or to provide support services, but only after the business associate enters into a Business Associate Agreement with the Plan. Similarly, a business associate may hire a subcontractor to assist in performing functions or providing services in connection with the Plan. If a subcontractor is hired, the business associate may not disclose your health information to the subcontractor until after the subcontractor enters into a Subcontractor Agreement with the business associate.
- *As Required by Law*. The Plan will disclose your health information when required to do so by federal, state, or local law. For example, the Plan may disclose health information when required by a court order in a litigation proceeding, such as a malpractice action.

- *To Avert a Serious Threat to Health or Safety*. The Plan may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. The Plan would disclose this information only to someone able to help prevent the threat. For example, the Plan may disclose your health information in a proceeding regarding the licensure of a physician.
- *To Health Plan Sponsor*. The Plan may disclose health information to another health plan maintained by the Plan sponsor for purposes of facilitating claims payments under that plan. In addition, the Plan may disclose your health information to the Plan sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and the Plan sponsor's HIPAA privacy policies and procedures.

Special Situations. The Plan may also use and disclose your protected health information in the following special situations:

- *Organ and Tissue Donation.* The Plan may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- *Military and Veterans.* If you are a member of the armed forces, the Plan may release your health information as required by military command authorities. The Plan may also release health information about foreign military personnel to the appropriate foreign military authority.
- *Workers' Compensation*. The Plan may release health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illnesses.
- *Public Health Risks*. The Plan may disclose health information for public health activities, such as prevention or control of disease, injury, or disability; report of births and deaths; and notification of disease exposure or risk of disease contraction or proliferation.
- *Health Oversight Activities.* The Plan may disclose health information to a health oversight agency for activities authorized by law, e.g., audits, investigations, inspections, and licensure, which are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- *Law Enforcement*. The Plan may release health information if requested by a law enforcement official in the following circumstances: (1) in response to a court order, subpoena, warrant, or summons; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) to report a crime; and (4) to disclose information about the victim of a crime if (under certain limited circumstances) the Plan is unable to obtain the person's agreement.
- *Coroners and Medical Examiners.* The Plan may release health information to a coroner or medical examiner if necessary (e.g., to identify a deceased person or determine the cause of death).

Rights Regarding Health Information. You have the following rights regarding your protected health information that the Plan maintains:

- *Right to Access*. You may request access to health information containing your enrollment, payment, and other records used to make decisions about your Plan benefits, including the right to inspect the information and the right to a copy of the information. You may request that the information be sent to a third party. You must submit a request for access in writing to the Privacy Officer. The Plan may charge a fee for the costs of copying, mailing, or other supplies associated with your request. The Plan may deny your request in certain very limited circumstances, and you may request that such denial be reviewed. If the Plan maintains your health information electronically in a designated record set, the Plan will provide you with access to the information in the electronic form and format you request if readily producible or, if not, in a readable electronic form and format as agreed to by the Plan and you.
- *Right to Amend*. If you feel that the Plan's records of your health information are incorrect or incomplete, you may request an amendment to the information for as long as the information is kept by or for the Plan. You must submit a request for amendment in writing to the Privacy Officer. Your written request must include a supporting reason; otherwise the Plan may deny your request for an amendment. In addition, the Plan may deny your request to amend information that is not part of the health information kept by or for the Plan, was not created by the Plan (unless the person or entity that

created the information is no longer available to make the amendment), is not part of the information that you would be permitted to inspect and copy, or is accurate and complete.

- *Right to an Accounting of Disclosures*. You may request an accounting of your health information disclosures except disclosures for treatment, payment, health care operations; disclosures to you about your own health information; disclosures pursuant to an individual authorization; or other disclosures as set forth in the Plan sponsor's HIPAA privacy policies and procedures. You must submit a request for accounting in writing to the Privacy Officer. Your request must state a time period for the accounting not longer than six years and indicate your preferred form (e.g., paper or electronic). The Plan will provide for free the first accounting you request within a 12-month period, but the Plan may charge you for the costs of providing additional lists (the Plan will notify you prior to provision and you may cancel your request). Effective at the time prescribed by federal regulations, you may also request an accounting of uses and disclosures of your health information maintained as an electronic health record if the Plan maintains such records.

- *Right to Request Restrictions*. You may request a restriction or limitation on your health information that the Plan uses or discloses for treatment, payment, or health care operations or that the Plan discloses to someone involved in your care or the payment for your care (e.g., a family member or friend). For example, you could ask that the Plan not use or disclose information about a surgery you had. You must submit a request for restriction in writing to the Privacy Officer. Your request must describe what information you want to limit; whether you want to limit the Plan's use, disclosure, or both; and to whom you want the limits to apply (e.g., your spouse). The Plan is not required to agree to your request.

- *Right to Request Confidential Communications*. You may request that the Plan communicate with you about health matters in a certain way or at a certain location (e.g., only by mail or at work), and the Plan will accommodate all reasonable requests. You must submit a request for confidential communications in writing to the Privacy Officer. Your written request must specify how or where you wish to be contacted. You do not need to state the reason for your request.

- *Right to a Paper Copy of this Notice*. If you received this notice electronically, you may receive a paper copy at any time by contacting the Privacy Officer.

Genetic Information. If the Plan uses or discloses protected health information for Plan underwriting purposes, the Plan will not (except in the case of any long-term care benefits) use or disclose health information that is your genetic information for such purposes.

Breach Notification Requirements. In the event unsecured protected health information about you is "breached," the Plan will notify you of the situation unless the Plan determines the probability is low that the health information has been compromised. The Plan will also inform HHS of the breach and take any other steps required by law.

Changes to this Notice. The Plan reserves the right to revise or change this notice, which may be effective for your protected health information the Plan already possesses as well as any information the Plan receives in the future. The Plan will notify you if this notice changes.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan by contacting the Privacy Officer in writing. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information. The Plan will use and disclose protected health information not covered by this notice or applicable laws only with your written permission. If you permit the Plan to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization. However, the Plan is unable to retract any disclosures it has already made with your permission.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Glossary of Health Coverage and Medical Terms

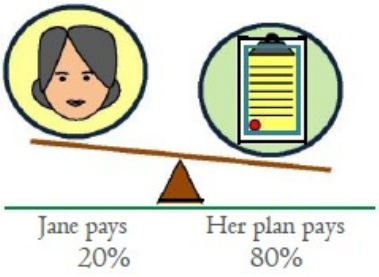
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may *not* balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

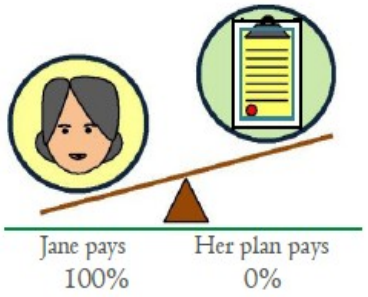


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

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

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

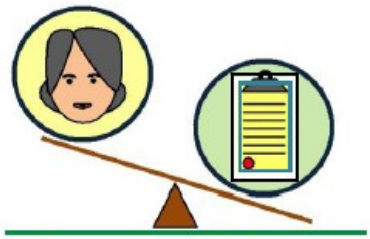
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non -physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

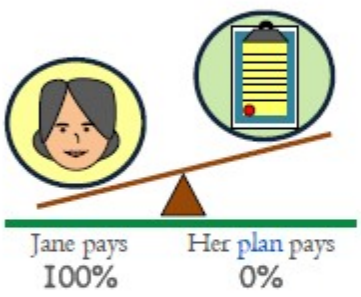
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

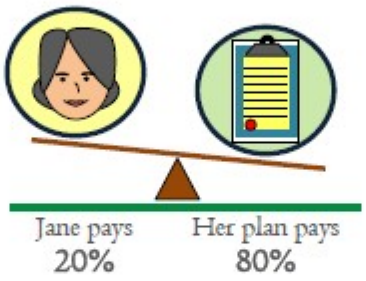


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

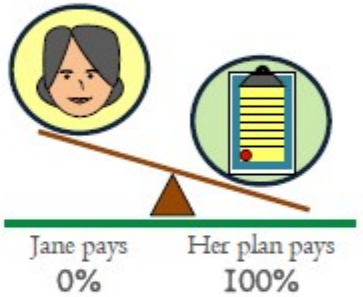


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Genesee County Drain Commissioner's Office Division of Water and Waste Services	81-0919189
5. Employer address	**6. Employer phone number**
G-4610 Beecher Rd.	810.732.7870

7. City	8. State	9. ZIP code
Flint	MI	48532

10. Who can we contact about employee health coverage at this job?	
HR Department	
11. Phone number (if different from above)	**12. Email address**
	hr@gcdcwws.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ⊡ Some employees. Eligible employees are:

  Full-time employees who work 30 hours or more who have worked more than 60 but less than 90 days.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Legally married spouses and children through the end of the year they turn age 26.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $0.00_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☑ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Genesee County Drain Commissioner's Office Division of Water & Waste Services and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the Human Resources Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Genesee County Drain Commissioner's Office Division of Water & Waste
Human Resources
G-4610 Beecher Rd
Flint MI 48532
Ph: (810) 732.7870

Hourly, Salary, Exempt & Union Employee

Medical Plan

Div-0000 (Union)

Div-0014 (Hourly, Salary, Exempt)

Div-0000 and Div-0014 are identical

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$0	$250 Individual/ $500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$2,250 Individual/ $4,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit; deductible does not apply	20% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge; deductible does not apply	20% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$10 copay/prescription for retail 30-day supply; $10 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	$20 copay/prescription for retail 30-day supply; $20 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non preferred brand-name drugs	$50 copay/prescription for retail 30-day supply; $50 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	20% coinsurance	None
	Physician/surgeon fees	No Charge; deductible does not apply	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit; deductible does not apply	$75 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	No Charge; deductible does not apply	No Charge; deductible does not apply	Mileage limits apply
	Urgent care	$30 copay/visit; deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; deductible does not apply	20% coinsurance	Preauthorization may be required
	Physician/surgeon fee	No Charge; deductible does not apply	20% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	Your cost share may be different for services performed in an office setting
	Inpatient services	No Charge; deductible does not apply	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 20% coinsurance Postnatal: 20% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	No Charge; deductible does not apply	20% coinsurance	None
	Childbirth/delivery facility services	No Charge; deductible does not apply	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required.
	Rehabilitation services	No Charge; deductible does not apply	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	None
	Skilled nursing care	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge; deductible does not apply	No Charge; deductible does not apply	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: **See Addendum**

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$150**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

[illegible] 877-469-2583 TTY:711 [illegible]

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Hourly, Salary, Exempt & Union Employee

Dental & Vision Plan

Div-0008

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

GENESEE COUNTY DRAIN COMMISSIONER DIVIS
46660012
0070029660008 - 06DQV
Effective Date: 04/01/2017

Dental Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]*Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*
[2]*A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, or legal adoption, including disabled children; eligible for coverage through the end of the year in which they turn age 19.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Class I services	None (covered at 100%)
Class II services	25%
Class III services	50%
Class IV services	50%
Annual maximum for Class I, II and III services	$2,800 per member
Lifetime maximum for Class IV services	$3,500 per member

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
Dental prophylaxis (teeth cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Panoramic or full-mouth x-rays	75% of approved amount **Note:** Once every 60 months
A set (up to 4 films) of bitewing x-rays	75% of approved amount **Note:** Twice per calendar year
Fillings - permanent (adult) teeth	75% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	75% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simple extractions	75% of approved amount
Root canal treatment - permanent tooth	75% of approved amount **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	75% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	75% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	75% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	75% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months after original was delivered

Benefits	Coverage
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount **Note:** Once every 60 months per tooth

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Vision Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Eligibility

Member	Criteria
Dependent • **Dependent children:** related to you by birth, marriage, or legal adoption, including disabled children; eligible for coverage through the end of the year in which they turn age 19.	

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $50 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. • Progressive Lenses - Covered when rendered by a VSP network doctor	$7.50 copay most lenses (one copay applies to **both** lenses and frames) $50 copay for progressive lenses (one copay applies to **both** lenses	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	100% of the allowable amount for contact lens suitablilty exams $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	100% of the allowable amount for contact lens suitablilty exams $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 **consecutive** months	

Symetra provided

Employee Assistance Program (EAP)

via ComPsych

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

SYMETRA
RETIREMENT | BENEFITS | LIFE

Employee Assistance Program

Helping you cope with the present and plan for the future

It's tough dealing with new challenges—finding child or elder care, bankruptcy, substance abuse—especially on your own. The stress alone can affect your work, health and family.

In times like these it's helpful to have someone in your corner to listen, offer advice and point you in the right direction for additional help. That's what you get from DisabilityGuidance℠—an Employee Assistance Program that offers confidential counseling when you need it most.

Your Employee Assistance Program

We're available 24/7 to assist you.

Call: **1-888-327-9573**
TDD: **1-800-697-0353**
Online: **guidanceresources.com**
Web ID: **SYMETRA**

Program Highlights

Up to five[1] face-to-face, confidential sessions with a counselor, financial planner or attorney are available to you and your eligible family members each calendar year.[2] An additional five sessions are available if you have a covered disability claim. Sessions are per household and may be divided among the three types of professionals. These services are included in the overall premium so no additional payment is required to use the program.

Confidential Counseling

Trained counselors with a master's or doctor-level degree are just a phone call away—and completely confidential. They'll listen to your concerns and quickly refer you to appropriate resources and providers for:

- Stress, anxiety and depression
- Credit card or loan problems
- Difficulties with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Contact a certified public accountant or certified financial planner for financial advice, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support

Talk to an attorney about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Need Legal Representation?

A general guidance consultant will refer you to a qualified attorney in your area for a free 30-minute consultation. Any customary legal fees after that are reduced by 25%.

Your DisabilityGuidance℠ Employee Assistance Program

Access Anytime

Call: **1-888-327-9573**
TDD: **1-800-697-0353**
Online: **guidanceresources.com**
Web ID: **SYMETRA**

SYMETRA
RETIREMENT | BENEFITS | LIFE

Confidential support, information and resources for all of life's challenges.

continued >

Online Resources and Tools

Get trusted, professional information online about relationships, work, school, children, wellness, legal or financial issues, and more. Turn to GuidanceResources® online for:

- Timely articles, tutorials, videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Searches for child or elder care, attorneys and financial planners

First-time users, follow these simple steps:

1. Go to **www.guidanceresources.com** and click on "Register."
2. Provide your organization web ID: SYMETRA
3. Create a user name and password.

Future logins

Simply enter your user name and password, then click on the "Login" button.

If you have problems registering or logging in, send an email to memberservices@compsych.com or call 1-888-327-9573.

Planning for the Future

A will is one of the most important legal documents you can have. It ensures that you'll control who gets your property, who will be your children's guardian, and who manages your estate when you die.

EstateGuidance® makes it easy to create a simple, customized, legally binding will by offering:

- Convenient online access to will documentation tools
- Simple-to-follow instructions guiding you through the will generation process
- Online support from licensed attorneys, if needed
- The ability to make revisions at no cost

A simple will costs just $14.99; printing and mailing services are available for an additional fee. Prices may be subject to change—contact ComPsych for additional information.

[1] In California, counseling sessions are limited to three sessions in a six-month period.

[2] Once you are enrolled in a group disability income insurance policy from Symetra Life Insurance Company or First Symetra National Life Insurance Company of New York.

SYMETRA®

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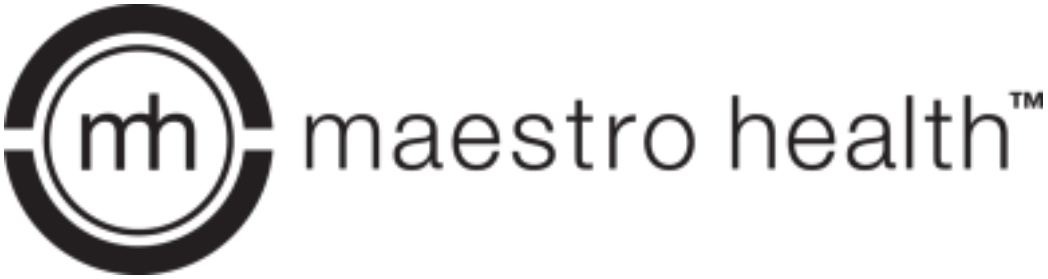
www.symetra.com
www.symetra.com/ny

Flexible Spending Account (FSA)



GENESEE COUNTY DRAIN COMMISSIONER'S OFFICE

DIVISON OF WATER & WASTE SERVICES

G-4610 BEECHER RD – FLINT, MI – 48532 PHONE (810) 732-7870 FAX (810) 732-9773

JEFFREY WRIGHT - COMMISSIONER

Dear WWS Employee:

The Division is pleased to announce that we will continue to offer both the: Health Care Flexible Spending Accounts (FSA) and Dependent Care FSA.

HOW FSAs WORK

An FSA is an employer-sponsored health care spending account that enables employees to deduct pre-tax dollars from their paychecks to pay for qualified medical expenses and dependent care. At the beginning of each plan year, employees can elect to have a certain portion of their pre-tax income contributed to fund their FSA or Dependent Care FSA. Because FSAs are employer-sponsored, an employee has access to the entire year's funds on the first day of the year (for the Health Care FSA ONLY). However, FSA funds must be used within the plan year by an employee. If funds are not used there will be a $500 carry over to the next plan year. Any unused funds are returned to the employer at the end of the year. Funds from a health care FSA can be used for qualified expenses including medical, dental and vision. For information on qualified expenses please see the information attached.

If you are interested in getting more information on the FSA please ask HR. If you any questions please feel free to contact me via email at sholder@gcdcwws.com or at (810) 732-7870.

If you enrolled last year and wish to have the FSA for next year you need to re-enroll during the open enrollment meeting.

Thank you,

Shannon M. Holder, CHRS, MBA
Human Resource Manager

maestro health™

Genesee County Water and Waste Services

A Guide To Your Flexible Spending Accounts

Save some money with Health and Dependent Care Accounts

Including a debit card, daily reimbursement processing, a secure website and the ability to access accounts and submit via our mobile app!

maestro health™

Let's learn how FSAs can

save you some money!

What is a Flexible Spending Account?

A Flexible Spending Account, or FSA, is an employee benefit that allows you to conveniently save and pay for you and your family's healthcare and dependent day care expenses. The income you choose to contribute to your FSA becomes tax-exempt, giving you extra cash to help pay for healthcare or dependent day care costs you know are coming up, as well as the inevitable unexpected. There are two accounts. The **Healthcare FSA** is used for certain qualified out-of-pocket expenses not covered by your health plan. The **Dependent Care FSA** is used for expenses paid to care for qualified dependents that allows you to work.

How much can I save?

You can save hundreds. Regardless of how much you elect to contribute, you'll decrease your taxable income and increase your spendable income. **It's a win-win.**

Federal Tax Rate	Annual FSA Contributions	Annual Tax Savings*
15%	$1,550	$365
15%	$2,600	$589
25%	$1,550	$511
25%	$2,600	$849
33%	$1,550	$635
33%	$2,600	$1,057

HOW DOES IT WORK?

It's Simple.

You'll fund your FSA by simply setting your election amount each year, based on the annual limits on the plan fact sheet included on page 1. The contribution amount you choose will be deducted evenly out of each paycheck throughout the year.

Healthcare FSAs are pre-funded. That means you'll have access to your full election amount at the very beginning of the plan year, regardless of how much you've contributed so far. It's like a tax-free, interest-free loan to help you pay for healthcare expenses. Go ahead and schedule that laser eye surgery!

What if I don't spend it all?
Not to worry. There's a 2 ½ month grace period which gives you some extra time.

Can I make changes throughout the year?
Changes to your election amount (between annual enrollments) are only permitted due to a change of status such as getting married or having a baby.

Who's covered?
An FSA covers eligible expenses for you and your dependents, even if they're not covered by your company provided health plan(s)

What's covered?
The list is way too long to include everything. To see more check out the FSA website and page 6 of this guide.

Here are some examples:

Acne Treatments**
Allergy Medicine**
Antacids**
Bandages
Chiropractic Care
Cold Medicine**
Condoms
Contact Lenses & Cleaners
Copays, Co-Insurance & Deductibles
Dental Care
Diabetic Supplies
Eyeglasses
Hearing Aids
Laser Eye Surgery
Orthodontia
Pain Relievers**
Pregnancy Tests
Prescription Drugs
Smoking Cessation Programs**
Sunscreen

**Over-the-counter (OTC) drugs and medicines (except insulin) are only eligible for reimbursement when prescribed by a physician.

SAVINGS ON-THE-GO.

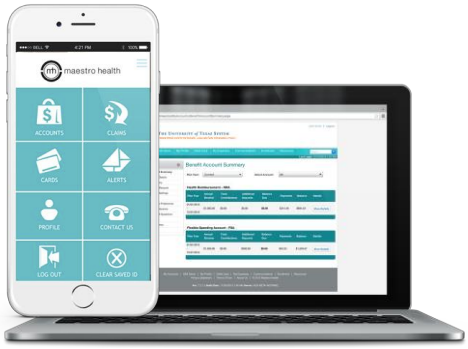
Not only does an FSA save you money, we have made it more convenient than ever. You can access and manage your account(s) anytime, anywhere. You can even file a claim in minutes using our mobile app!

Your FSA Debit Card.
After you enroll in an FSA, you'll receive a debit card that allows you to avoid out-of-pocket expenses, and much of the complicated paperwork and reimbursement delays.

Online & Mobile Access.
Our easy-to-use online portal and mobile application lets you manage your accounts all in one place.

- View and print account statements.
- File a claim by snapping a photo of the receipt.
- Check your reimbursement status.
- Access education, calculators, and helpful how-to videos.
- Get alerts and notifications.
- Contact support.

Get the App – Search for Maestro Health mSAVE in the Apple or Android App Stores



Got Questions? No Problem.
Contact us today.
1-888-488-5054
msave.maestrohealth.com

2018 Eligible and Ineligible Items

Find more details on the FSA website or the IRS by searching for publications 502 and 503.

ELIGIBLE HEALTH CARE EXPENSES

- Allergy tests and shots
- Acupuncture
- Alcohol and drug abuse treatment
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical condition
- Birth control pills & devices prescribed by a doctor
- Birth prevention surgery
- Braille materials (books and magazines)
- Childbirth classes for mother-to-be
- Chiropractic services
- Christian Science practitioner's fees
- Co-payments
- Deductibles on your or your spouse's group plan
- Dental treatment
- Guide dog
- Hospital/Health Clinic costs not covered by group health plan
- Infertility and treatment of impotence
- Insulin
- Laboratory fees
- Lead-based paint removal
- Learning Disability
- Lifetime care fees
- Lodging & meals at medical facilities
- Medical aids/equipment
- Massage therapy (medically necessary)
- Mattresses for treatment of arthritis
- Medical information plan fees
- Nurses' fees
- Obstetrical expenses
- Orthodontic services, if medically necessary
- Orthopedic equipment
- Osteopaths' fees
- Oxygen
- Physician's fees not covered by medical plan
- Podiatrists fees, if medically necessary
- Prescription drugs (excluding controlled substances)
- Psychiatric care and fees
- Radial Keratotamy and LASIK
- Ramps required by medical condition
- Routine physical examination
- Smoking programs prescribed by a doctor to treat other medical conditions
- Seeing eye dog and its upkeep
- Spa or resort medical expenses prescribed by a physician
- Telephone costs to purchase and repair special telephone equipment for hearing impaired
- Therapeutic care for substance abuse (drug or alcohol)
- Therapy fees for medical treatment
- Transportation expenses to obtain medical services
- Vision care (exams, glass, contacts)
- Weight loss program prescribed by a physician for specific health problems
- Over-the-Counter **medicines** (will require a Prescription from your doctor effective 01/01/11 and a receipt):
  - Acne treatment
  - Allergy medicine
  - Antacids
  - Anti-diarrhea medicine
  - Ben-Gay, Tiger Balm, and similar products for muscle pain or joint pain
  - Bug bite medication
  - Cold medicine
  - Cough drops, throat lozenges, sinus medications, nasal sinus sprays
  - Eye drops (such as Visine)
  - First aid cream, Bactine, special diaper rash ointments, calamine lotion
  - Laxatives such as Ex-Lax
  - Menstrual cycle products for pain and cramp relief
  - Motion sickness pills
  - Nasal sinus sprays and nasal strips
  - Nicotine gum or patches for stopping Smoking
  - Pain reliever
  - Pedialyte for child's dehydration
  - Pre-natal vitamins
  - Rubbing alcohol
  - Sleeping aids
  - Suppositories/ creams for hemorrhoids
  - Wart remover treatments
- Over-the-Counter items will require a receipt:
  - Band-Aids, bandages, liquid adhesive, Gauze pads, first aid kits
  - Carpal tunnel wrist supports
  - Cold/hot packs
  - Condoms and spermicidal foam
  - Contact lens cleaning solution
  - Glucosamine supplements
  - Incontinence supplies
  - Pregnancy test kits
  - Reading glasses
  - Special ointment or cream for sunburns (not regular skin moisturizers)
  - Sunscreen
  - Take-home screening test kits
  - Thermometers
- OTC Items requiring a medical practitioner's diagnosis and prescription:
  - Dietary supplements or herbal Medicines
  - Fiber supplements
  - Hormone therapy and treatment for Menopause
  - Medicated shampoos and soaps
  - Nasal sprays for snoring
  - Orthopedic shoes and inserts
  - Pills for lactose intolerance
  - St. John's Wort for depression
  - Topical creams to treat gingivitis
  - Weight-loss drugs to treat a specific disease (including obesity)
  - Home exercise equipment

ELIGIBLE DEPENDENT CARE EXPENSES

(when expenses are necessary due to employment of parent(s)).

- After school care expenses
- Baby sitters' fee
- Day care center fees Federal and state employment taxes you pay for an individual you pay to provide dependent care
- Pre-school tuition
- Wages of individuals who provide care inside or outside your home

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INELIGIBLE HEALTH CARE EXPENSES

- Contact lens replacement insurance premiums
- Cosmetic services/ surgery
- Dancing lessons, swimming lessons, even if recommend by physician
- Diaper service
- Fitness programs for general health
- Health insurance premiums
- Illegal operations or treatments
- Life insurance premiums
- Long-term care insurance premiums
- Medicare tax for Part A
- Medicare premiums for Part B
- Marriage counseling
- Maternity clothes
- Nursing home expenses that are custodial in nature
- Over-the-Counter (i.e. Chapstick, cosmetics, daily vitamins, dandruff shampoos, deodorant, face cream, hair color, hand lotions, moisturizers, razors and other shaving supplies, soaps, toothbrushes & toothpaste)

INELIGIBLE DEPENDENT CARE EXPENSES

- Claims submitted without the care givers' Federal tax ID and/or social security number
- Nursing home expenses
- "Sleep away" camp expenses, i.e., camp expenses other than day camp in lieu of the child's regular day care
- Specialty camps, e.g., tennis camps and basketball camps
- Wages for a care giver who is your spouse or dependent under the age of 19.

2018 Worksheet and Expense Guide

for estimating your health expenses.

The planning worksheet below can help you estimate your eligible healthcare expenses that may not be covered under your company's group insurance plans. Remember, all eligible healthcare expenses for you, your spouse and your eligible dependents are reimbursable from your Healthcare FSA.

Many members or their family members take prescriptions every month and each member will go to the doctor at least once a year. Some members may need glasses. Please look at the list below and enter amounts for services that you know your family members will need in the plan year. Your employer will divide the total above by each paycheck that you will receive during the plan year. The total amount will be loaded on a debit card and available to you at the beginning of the FSA plan year.

Medical Expenses	***Estimated Plan Year Expenses***	***Vision Expenses***	***Estimated Plan Year Expenses***
Copays	$_____	Contact lens supplies	$_____
Deductibles	$_____	Copays	$_____
Lab fees	$_____	Deductibles	$_____
Physical exams	$_____	Eye examinations	$_____
Physician fees	$_____	Prescription contact lenses	$_____
Prescription drug expenses	$_____	Prescription eyeglasses or sunglasses	$_____
Dental Expenses		***Other Expenses***	
Copays	$_____	Acupuncture or chiropractic	$_____
Deductibles	$_____	Hearing aids	$_____
Dentures	$_____	Immunization fees	$_____
Examinations	$_____	Psychiatrist, psychologist, counseling*	$_____
Orthodontia	$_____	Other eligible expenses	$_____
Restorative work (crowns, caps, bridges)	$_____		
Teeth cleaning	$_____		
Other dental expenses	$_____		
TOTAL COLUMN 1	$_____	TOTAL COLUMN 2	$_____

TOTAL COLUMN 1 $_____ + TOTAL COLUMN 2 $_____ = TOTAL ESTIMATED EXPENSES $_____

FREQUENTLY ASKED QUESTIONS

What is the Section 125 Flexible Spending Account (FSA) Plan?

The Section 125 Flexible Spending Account (FSA) Plan is an IRS approved tax savings plan. It enables employees to use before tax dollars for reimbursement of items previously purchased with after-tax dollars. This results in an increase in your spendable income.

When and How Do I Enroll?

There is an open enrollment period for the Flexible Spending Account each year. During the enrollment period you can elect to enroll, change your contribution amount, or drop your coverage under the plan. Your employer will communicate when your open enrollment period begins and ends.

How do I determine how much to allocate for the Flexible Spending Accounts?

Be Conservative! Only consider known expenses. Do not allow for things that might happen. For dependent care, do not forget to allow for vacations or time you will not be paying the dependent care provider.

What expenses are eligible?

Unreimbursed Medical Expenses - Medical costs include medical, dental, vision and hearing expenses that are not paid by insurance and are "out of pocket" expenses. (Examples: deductibles, co-payments, co-insurance, and some items not considered to be eligible charges.).

Dependent/Child Care Expenses – Expenses include most costs incurred for the care of a dependent so that you and your spouse can be employed or attend school. The dependent must be under 13 years old or physically or mentally incapable of caring for himself or herself. The maximum annual allowed for Dependent/Child Care Expenses is $5,000 ($2,500 if married filing separate returns) and may not exceed the lower of either your spouse's or your earned income.

Are there any medical expenses which are not eligible?

Yes. For example, cosmetic surgery for purely cosmetic reasons is not covered by the FSA plan. Please note that as of January 1, 2011, federal regulations exclude FSA coverage for over the counter (OTC) medication unless you have a prescription from your provider.

Are my spouse's health plan premiums eligible expenses?

No, another employer's health plan premiums are not eligible expenses. **Your costs to participate in the health plans (medical and dental) are already being deducted in a pre-tax basis.** Therefore, the premiums for your participation **cannot** be included in the new Health Care Flexible Spending Account Plan.

What if I don't spend my entire annual election?

The IRS has a "use it or lose it rule". Claims must be incurred during your eligibility dates for the Plan. You will forfeit any money that you have not incurred eligible expenses for and filed for reimbursement by the end of the runout period.

FREQUENTLY ASKED QUESTIONS

Can I Make a Change to My FSA?

Participation in the Flexible Spending Account is a binding election for the plan year unless you experience a qualified Change in Status. Your employer or the FSA Service Center can provide you with information on what constitutes a qualified Change in Status and the allowable plan changes as a result of that event. In order to process the change, notice must be provided, in writing, within 30 days of the event. All contribution adjustments must generally be prospective from the Change in Status event or the reporting date, whichever is later.

A Change in Status is considered a new election, so a change will constitute the end of your prior election and the beginning of a new election. Expenses incurred during the period prior to the change are subject to the initial election amount. Expenses incurred after the election change are subject to the new election amount.

Your plan participation rights may be different if the change is the result of a qualifying leave under the Family and Medical Leave Act (FMLA). Contact your employer or the FSA Service Center with questions regarding Change in Status options for FMLA.

What Happens if I Terminate from the Plan?

Your Flexible Spending Account coverage terminates if you terminate employment or cease to participate in the plan. When termination occurs, you may only submit expenses incurred prior to the date you lose coverage under the plan.

Do I Have COBRA Rights?

Some employers are required by law to provide benefit continuation coverage under COBRA. The Health Care FSA may qualify under this program. Check with your employer to determine your COBRA eligibility. COBRA participation will require that you continue at your current contribution level. The advantage is that you will be able to continue to submit expenses incurred after your termination date. The difference is that you will be paying after-tax dollars plus administration fees.

The Dependent Care FSA does not qualify for COBRA. Therefore, any funds remaining in the account after termination are forfeited.

Who is an eligible day care provider?

The person who provides the day care must not be your spouse or a person whom you claim as a dependent. The provider does not have to be licensed. However, you are responsible for providing the name and identification number of the day care provider to the IRS on your tax return and on the claim form.

FREQUENTLY ASKED QUESTIONS

How do I send in receipts?

Unreimbursed Medical Receipts – Submit receipts along with a signed claim form or upload through the web or mobile app. The receipts must show the date of service, the type of service, and the amount of the service. If the expense is covered by your insurance company(s), please submit the receipt to the insurance company first. You may then forward a copy of the Explanation of Benefits from the insurance company along with the signed claim form. Cancelled checks are not eligible as receipts for unreimbursed medical expenses.

Dependent Care Receipts – Submit receipts along with a signed claim form or upload through the web or mobile app. Provide copies of statements or receipts which show the day care providers name, the date of service, tax Id number and the amount of the service to Maestro Health along with a completed claim form. Cancelled checks are not eligible as receipts for unreimbursed medical expenses.

How Long Do I Have to Submit my Request for Reimbursement?

You have until the end of the run-out period to submit your expenses. The run-out period is the timeframe allowed at the end of the plan year or the end of your participation in the plan to submit receipts for services incurred during the plan year. This is not a period when you are able to continue to incur expenses but rather, it allows you time to gather and submit expenses before forfeitures are applied.

AFLAC

Aflac

Group Accident Advantage Plus

INSURANCE – HIGH NONOCCUPATIONAL WITH WELLNESS PLAN

Home or on the road —
accidents can happen.

We're here to help.

Aflac®

We've got you under our wing.®

AFLAC GROUP ACCIDENT ADVANTAGE PLUS INSURANCE

GROUP ACCIDENTAL INJURY INSURANCE – HIGH NONOCCUPATIONAL WITH WELLNESS PLAN

Policy Series CAI7800

AC^G

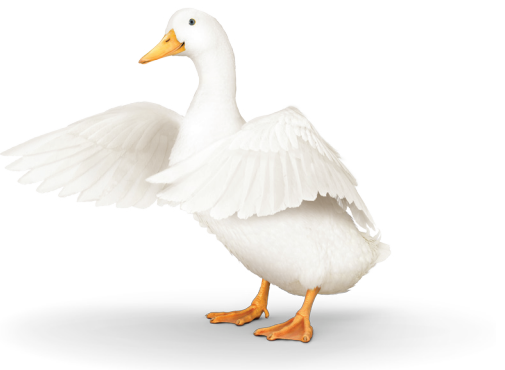
Introducing added protection for life's unexpected moments.

If you're like most people, you don't budget for life's unexpected moments. But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

That's the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.



Understanding the facts can help you decide if the Aflac group Accident Advantage Plus plan makes sense for you.

FACT NO. 1

80.1 MILLION

PEOPLE SOUGHT MEDICAL ATTENTION FOR AN INJURY.[1]

FACT NO. 2

40.2 MILLION

VISITS TO HOSPITAL EMERGENCY DEPARTMENTS IN 2011 WERE DUE TO INJURIES.[2]

[1] All Injuries, 2014, Centers for Disease Control and Prevention.
[2] Health, United States, 2014, Centers for Disease Control and Prevention.

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

Here's why the Aflac group Accident Advantage Plus plan may be right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our group Accident Advantage Plus plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. The group Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

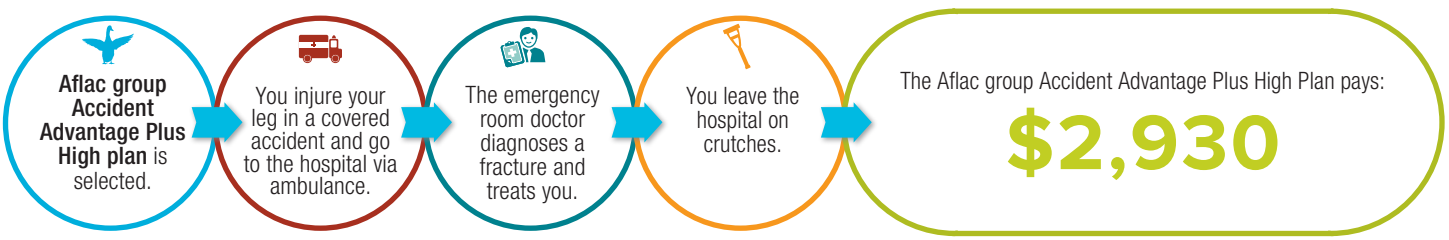
The Aflac group Accident Advantage Plus plan benefits:

- A Wellness Benefit for covered preventive screenings
- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

How it works



Amount payable was generated based on benefit amounts for: Closed-Reduction Leg Fracture ($2,400), Emergency Room Treatment ($200), one Follow-Up Treatment ($30), Ambulance ($200) and Appliance ($100)

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

HOSPITAL BENEFITS	EMPLOYEE	SPOUSE	CHILD
HOSPITAL ADMISSION We will pay the amount shown, when because of a covered accident, you are injured, require hospital confinement, and are confined to a hospital for at least 24 hours within 6 months after the accident date. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$1,000	$1,000	$1,000
HOSPITAL CONFINEMENT (per day) We will pay the amount shown when, because of a covered accident, you are injured and those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date. The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$200	$200	$200
HOSPITAL INTENSIVE CARE (per day) We will pay the amount shown when, because of a covered accident, you are injured, and those injuries cause confinement to a hospital intensive care unit. This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.	$400	$400	$400
MEDICAL FEES (for each accident) We will pay up to the amount shown for X-rays and doctor services when, because of a covered accident, you are injured and those injuries cause you to receive initial treatment from a doctor within 72 hours after the accident. If you do not exhaust the maximum benefit paid during the initial treatment, we will pay the remainder of this benefit for treatment received due to injuries from a covered accident and for each covered accident up to one year after the accident date.	$125	$125	$75
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days) Quadriplegia Paraplegia *Paralysis* means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, you are injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the accident. The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.	 $10,000 $5,000	 $10,000 $5,000	 $10,000 $5,000

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ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)	EMPLOYEE	SPOUSE	CHILD
ACCIDENTAL-DEATH	$50,000	$25,000	$5,000
ACCIDENTAL COMMON-CARRIER DEATH (plane, train, boat, or ship)	$100,000	$50,000	$15,000
SINGLE DISMEMBERMENT	$12,500	$5,000	$2,500
DOUBLE DISMEMBERMENT	$25,000	$10,000	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	$1,250	$500	$250
PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)	$100	$100	$100

If the Accidental Common-Carrier Death Benefit is paid, we will pay the Accidental-Death Benefit.

Accidental-Death Benefit

We will pay the amount shown if, because of a covered accident, you are injured, and the injury causes you to die within 90 days after the accident.

Accidental Common-Carrier Death Benefit

We will pay the amount shown if you are a fare-paying passenger on a common carrier, as defined below, are injured in a covered accident, and die within 90 days after the covered accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

Dismemberment Benefit

We will pay the appropriate amount shown if, because of a covered accident, you are injured and lose a hand, a foot, or sight within 90 days after the accident as a result of the injury. If you lose one hand, one foot, or the sight of one eye in a covered accident, we will pay the single dismemberment benefit shown. If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double dismemberment benefit shown. If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

If the Dismemberment Benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

MAJOR INJURIES (diagnosis and treatment within 90 days)	EMPLOYEE/ SPOUSE/CHILDREN
FRACTURES (closed reduction)	
Hip/Thigh	$4,000
Vertebrae (except processes)	$3,600
Pelvis	$3,200
Skull (depressed)	$3,000
Leg	$2,400
Forearm/Hand/Wrist	$2,000
Foot/Ankle/Kneecap	$2,000
Shoulder Blade/Collar Bone	$1,600
Lower Jaw (mandible)	$1,600
Skull (simple)	$1,400
Upper Arm/Upper Jaw	$1,400
Facial Bones (except teeth)	$1,200
Vertebral Processes	$800
Coccyx/Rib/Finger/Toe	$320

Fracture* is a break in the bone that can be seen by X-ray. If a bone is fractured in a covered accident, we will pay the appropriate benefit shown.

Multiple fractures* means having more than one fracture requiring open or closed reduction. If these fractures occur in any one covered accident, we will pay the appropriate benefits shown for each fracture, but no more than double the amount for the bone fractured that has the highest benefit amount.

Chip fracture* means a piece of bone that is completely broken off near a joint. If a doctor diagnoses a chip fracture, we will pay 25% of the appropriate benefit shown.

**If a fracture requires open reduction, we will pay double the amount shown.*

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MAJOR INJURIES – *continued*	EMPLOYEE/ SPOUSE/CHILDREN
DISLOCATIONS (closed reduction)	
Hip	$3,000
Knee (not kneecap)	$1,950
Shoulder	$1,500
Foot/Ankle	$1,200
Hand	$1,050
Lower Jaw	$900
Wrist	$750
Elbow	$600
Finger/Toe	$240

Dislocation* means a completely separated joint. If a doctor diagnoses and treats the dislocation within 90 days after the covered accident, we will pay the amount shown. If the dislocation requires open reduction, we will pay 200% of the appropriate amount shown.

Multiple Dislocations* means having more than one dislocation requiring either open or closed reduction. For each dislocation, we will pay the amounts shown. We will not pay more than 200% of the benefit amount for the dislocated joint that has the highest benefit amount.

Partial dislocation* means the joint is not completely separated. If a doctor diagnoses and treats the partial dislocation, we will pay 25% of the amount shown for the affected joint.

** If a dislocation requires open reduction, we will pay double the amount shown.*

SPECIFIC INJURIES	EMPLOYEE/ SPOUSE/CHILDREN
RUPTURED DISC (treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
TENDONS/LIGAMENTS (treatment within 60 days; surgical repair within 90 days)	
If you tear, sever, or rupture a tendon or ligament in a covered accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for tendons and ligaments repaired.	$600 (Multiple) $400 (Single)
TORN KNEE CARTILAGE (treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
EYE INJURIES	
Treatment and surgical repair within 90 days	$250
Removal of foreign body nonsurgically, with or without anesthesia	$50

SPECIFIC INJURIES	EMPLOYEE/ SPOUSE/CHILDREN
CONCUSSION A *concussion or mild traumatic brain injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head.	$200
COMA *Coma* means a state of profound unconsciousness caused by a covered accident. If you are in a coma lasting 30 days or more as the result of a covered accident, we will pay the benefit shown.	$10,000
EMERGENCY DENTAL WORK (per accident; injury to sound, natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50
BURNS (treatment within 72 hours and based on percentage of body surface burned)	
Second-Degree Burns	
Less than 10%	$100
At least 10%, but less than 25%	$200
At least 25%, but less than 35%	$500
35% or more	$1,000
Third-Degree Burns	
Less than 10%	$1,000
At least 10%, but less than 25%	$5,000
At least 25%, but less than 35%	$10,000
35% or more	$20,000
First-degree burns are not covered.	
LACERATIONS (treatment and repair within 72 hours)	
Under 2" long	$50
2" to 6" long	$200
Over 6" long	$400
Lacerations not requiring stitches	$25
Multiple Lacerations: We will pay for the largest single laceration requiring stitches.	

Benefits Overview

ADDITIONAL BENEFITS	EMPLOYEE/ SPOUSE/CHILDREN
EMERGENCY ROOM TREATMENT We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room and receive initial treatment within 72 hours after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident. We will not pay the Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.	$200
EMERGENCY ROOM OBSERVATION We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room, are held in a hospital for observation for at least 24 hours, and receive initial treatment within 72 hours after the accident. This benefit is payable only once per 24-hour period and only once per covered accident. This benefit is payable in addition to Emergency Room Treatment Benefit.	$100
MAJOR DIAGNOSTIC TESTING We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG). These exams must be performed in a hospital or a doctor's office. This benefit is limited to one payment per covered accident.	$200
POST TRAUMATIC STRESS DISORDER DIAGNOSIS *Post-traumatic Stress Disorder (PTSD)* is a mental health condition triggered by a covered accident. We will pay the amount shown if you are diagnosed with post-traumatic stress disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist. This benefit is payable only once per covered accident.	$200
AMBULANCE/ AIR AMBULANCE If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.	$200 ambulance $1,000 air ambulance
BLOOD/PLASMA If you are injured, and receive blood or plasma within 90 days after the covered accident, we will pay the benefit shown.	$100
APPLIANCES If a doctor advises you to use a medical appliance, we will pay the benefit shown. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.	$100

The plan has limitations and exclusions that may affect benefits payable.
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ADDITIONAL BENEFITS	EMPLOYEE/ SPOUSE/CHILDREN
INTERNAL INJURIES (resulting in open abdominal or thoracic surgery) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$1,000
ACCIDENT FOLLOW-UP TREATMENT We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. You must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.	$30
EXPLORATORY SURGERY WITHOUT REPAIR (i.e., arthroscopy) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.	$250
WELLNESS BENEFIT (per 12-month period) After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable (for each covered person) for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.	$50
PROSTHESIS We will pay this benefit if you require the use of a prosthetic device due to injuries received in a covered accident. We will pay this benefit for **each** prosthetic device you use. Hearing aids, wigs, dental aids, and false teeth are not covered.	$500
PHYSICAL THERAPY We will pay this benefit for up to six doctor-prescribed physical therapy treatments per covered accident. You must have received initial treatment within 72 hours of the covered accident. The physical therapy treatment must begin within 30 days after the covered accident or discharge from the hospital and must take place within six months of the covered accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$30
TRANSPORTATION We will pay this benefit if a doctor-recommended hospital treatment or diagnostic study is not available in your resident city. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.	$300 (train/plane) $150 (bus)
FAMILY LODGING BENEFIT (per night) We will pay this benefit for each night's lodging, up to 30 days, for an adult immediate family member's lodging if you are required to travel more than 100 miles from your resident home due to confinement in a hospital for treatment of an injury from a covered accident. This benefit is only payable while you remain confined to the hospital, and treatment must be prescribed by your local doctor.	$100
REHABILITATION UNIT BENEFIT (per 12-month period) We will pay the amount shown for injuries received in a covered accident if you are admitted for a hospital confinement, are transferred to a bed in a rehabilitation unit of a hospital, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.	$75

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ACCIDENT ADVANTAGE PLUS INSURANCE

LIMITATIONS AND EXCLUSIONS
WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW

LIMITATIONS AND EXCLUSIONS

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

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

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semi-professional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
- An injury arising from any employment.
- An injury or sickness covered by Worker's Compensation.

TERMS YOU NEED TO KNOW

Accidental injury or injuries means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *covered accident*.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse must furnish proof of this incapacity and dependency to the company within 31 days following the child's 26th birthday.

Newborn dependent children will be covered from the moment of live birth, if the birth occurs while the plan is in force.

Dismemberment means: loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Employee means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

Family member includes your spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

This includes step-family members and family-members-in-law.

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; and maintains permanent medical history records.

A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Rehabilitation Unit is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

You and **Your** refer to an employee as defined in the plan.

We refers to Continental American Insurance Company.

Spouse means your legal wife or husband. Coverage may only be issued to your spouse if your spouse is over 18.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

EFFECTIVE DATE

The effective date for you, the employee, is as follows: (1) Your insurance will be effective on the date shown on the certificate schedule, provided you are then actively at work. (2) If you are not actively at work on the date coverage would otherwise become effective, the effective date of your coverage will be the date on which you are first thereafter actively at work.

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 the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary 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.

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

Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains is written only in English; the certificate prevails if interpretation of this material varies.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

This brochure is subject to the terms, conditions, and limitations of Policy Series CAI7800.

Group Accident

GMO Accounts - Monthly (12pp/yr)

Coverage	Rates
Employee	$14.09
Employee & Dependent Spouse	$23.36
Employee & Dependent Child(ren)	$31.95
Family	$41.22

Initial Accident Treatment Category High

Hospitalization Category High

After Care Category High

Life-Changing Events Category High

Included Riders:

Accidental Death
Organized Athletic Activity

Provisions:

Non-occupational (off job) protection
Rate Guarantee: 2 Years
Portability: Standard

Group Attributes:

Situs State: MI
Group Size: 750

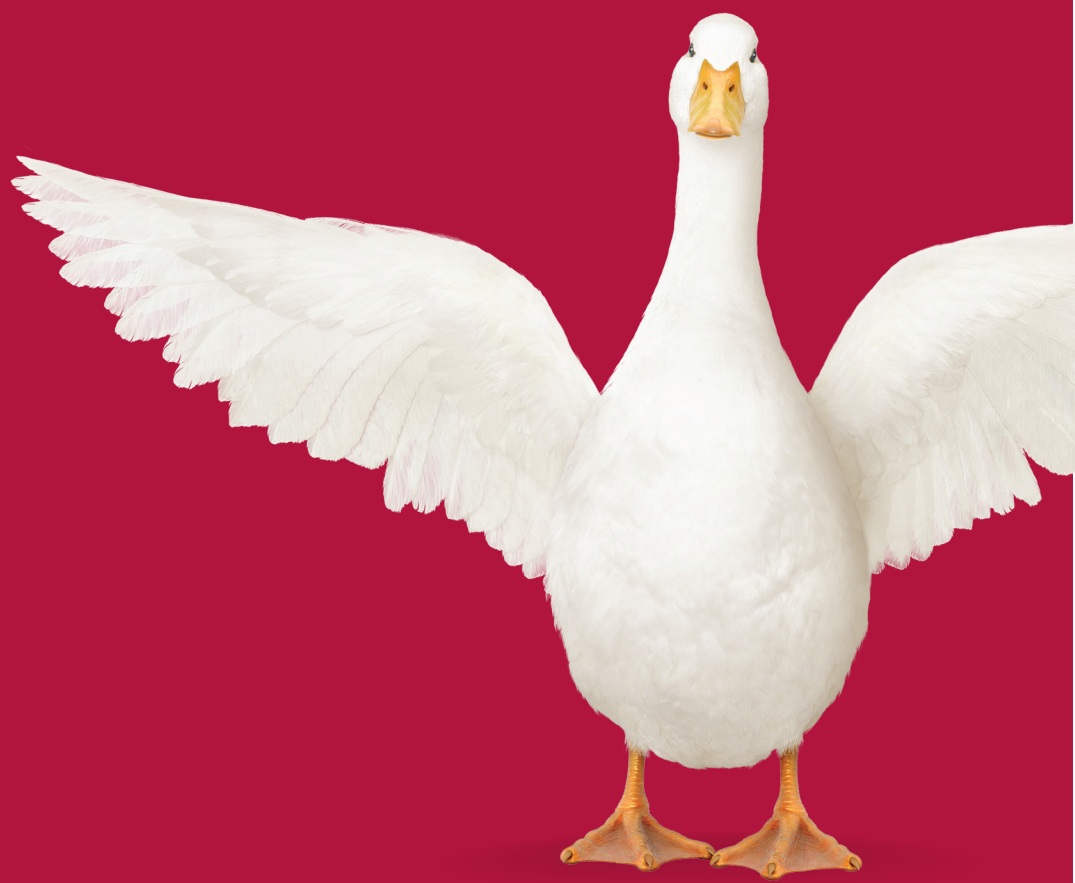
Please note: Premiums shown are accurate as of publication. They are subject to change.

Aflac

Group Critical Illness Advantage

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

We help take care of your expenses while you take care of yourself.



The plan does not contain comprehensive adult wellness benefits as defined by law.

Aflac®

We've got you under our wing.®

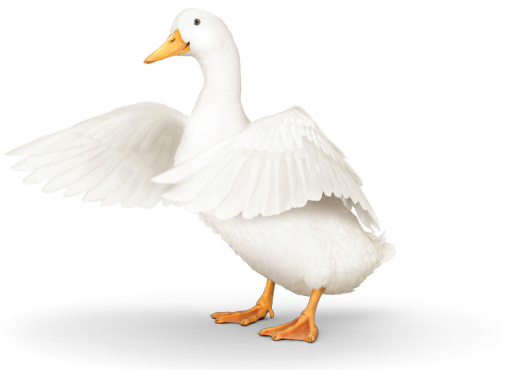
AFLAC GROUP CRITICAL ILLNESS ADVANTAGE

Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who's been diagnosed with a critical illness. You can't help notice the difference in the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness plan.



It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Understanding the facts can help you decide if the Aflac Group Critical Illness plan makes sense for you.

FACT NO. 1

ESTIMATED **83.6** MILLION

AMERICAN ADULTS–GREATER THAN 1 IN 3–HAVE ONE OR MORE TYPES OF CARDIOVASCULAR DISEASE (CVD).[1]

FACT NO. 2

CORONARY HEART DISEASE COST THE UNITED STATES **$108.9** BILLION

THIS TOTAL INCLUDES THE COST OF HEALTH CARE SERVICES, MEDICATIONS AND LOST PRODUCTIVITY. [2]

[1] American Heart Association/American Stroke Association 2013 Statistical Fact Sheet
[2] Centers for Disease Control and Prevention Heart Disease Fact Sheet 2015

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

Here's why the Aflac Group Critical Illness plan may be right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

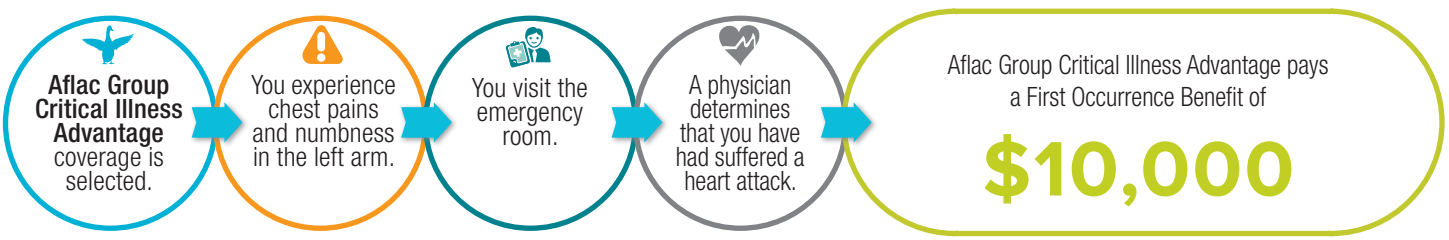
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

How it works



Amount payable based on $10,000 First Occurrence Benefit.

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

CHILD COVERAGE AT NO ADDITIONAL COST
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

WAIVER OF PREMIUM

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT (Employee and Spouse only)

We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

- Blood test for triglycerides
- 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
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

HEART EVENT RIDER SUMMARY PAGE

CI G

WHAT WE WILL PAY

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1- Specified Surgeries of the Heart	
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Coronary Artery Bypass Surgery	75%*
Category 2- Invasive Procedures and Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above when caused by a defined underlying disease, treatment is recommended by a doctor, and is not excluded by name or specific description. Benefits from each category are payable once per calendar year, per insured. If multiple procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

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WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to this rider unless amended by the rider.

COVERED HEART PROCEDURE is one of the Category I or Category II procedures defined below:

CATEGORY I – SPECIFIED SURGERIES OF THE HEART

Specified Surgeries of the Heart (Open Heart Surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **Coronary Artery Bypass Surgery** (also **Coronary Artery Bypass Graft Surgery** or **Bypass Surgery)** is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.
  - **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart lung machine.
  - **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries. A blood vessel is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under the rider.
- **Mitral Valve Replacement** or **Repair** is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement** or **Repair** is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

CATEGORY II – INVASIVE PROCEDURES AND TECHNIQUES OF THE HEART

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **AngioJet Clot Busting** clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.
- **Balloon Angioplasty (**or **Balloon Valvuloplasty)** opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.
- **Laser Angioplasty** uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization**) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal**) **Cardioverter Defibrillator (AICD**) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemaker Placement** refers to the initial placement/ implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Valvular Heart Disease is a disease characterized by damage to or a defect in one of the four heart valves.

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

This insert is subject to the terms, conditions, and limitations of Form Number C21304. In Arkansas, C21304AR. In Pennsylvania, C21304PA. In Texas, C21304TX.

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CRITICAL ILLNESS ADVANTAGE INSURANCE

LIMITATIONS AND EXCLUSIONS, TERMS YOU NEED TO KNOW, AND NOTICES

LIMITATIONS AND EXCLUSIONS

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
  - In Alaska: injuring or attempting to injure oneself intentionally
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
  - In Missouri: committing or attempting to commit suicide, while sane
  - In Illinois and Minnesota: this exclusion does not apply
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job:
  - In Arizona: participating in or attempting to commit a felony, or being engaged in an illegal occupation;
  - In Florida: participating or attempting to participate in an illegal activity, or working at an illegal occupation;
  - In Illinois and Pennsylvania: Illegal Occupation - committing or attempting to commit a felony or being engaged in an illegal occupation;
  - In Michigan: Illegal Occupation – the commission of or attempt to commit a felony, or being engaged in an illegal occupation;
  - In Nebraska: being engaged in an illegal occupation, or commission of or attempting to commit a felony;
  - In Ohio: committing or attempting to commit a felony, or working at an illegal job
- **Participation in Aggressive Conflict:**
  - War (declared or undeclared) or military conflicts;
    - -In Florida: War does not include acts of terrorism
    - -In Oklahoma: War, or act of war, declared or undeclared when serving in the military service or an auxiliary unit thereto
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs
  - In Arizona: Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician
  - In Michigan, Nevada, and South Dakota: this exclusion does not apply

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by:

- The uncontrolled growth and spread of malignant cells, and
- The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as

- Clark's Level I or II,
- Breslow depth less than 0.77mm, or
- Stage 1A melanomas under TNM Staging

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of the plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, non-invasive cancer, or skin cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist and conform to the American Board of Pathology standards.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
   - A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the diagnosis, and
   - A doctor is treating you for cancer or carcinoma in situ

Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Civil Union: In Washington DC, Civil Union is defined as a relationship similar to marriage that is recognized by law. In Illinois, a Civil Union is defined as a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, (In Delaware, Illinois, Nevada, Oregon, or Washington DC - or a person who is in a legally recognized domestic partnership, civil union, or similar relationship with you), who is listed on your application. Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly dependent) on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days (in Indiana, 120 days) following the dependent child's 26th birthday.

- In South Dakota, this limit will not apply to any child who is incapable of self-sustaining employment and is chiefly dependent upon the insured for support and maintenance.
- In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal

income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

- In New Mexico, coverage may be provided for the children of custodial and non-custodial parents.
- In Illinois, coverage of an unmarried dependent child who is under age 30 and who served in the military will not terminate if he/she is an Illinois resident, served as a member of the active or reserve components of any United States Armed Forces branch, and has received a release or discharge (other than a dishonorable discharge). To be eligible for coverage, the eligible dependent must submit to us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.
- In Louisiana, dependent children must be unmarried and may also include grandchildren who are in the legal custody of and residing with a grandparent. Regarding the Age 26 limit exception - we will not require proof of incapacity and dependency more frequently than annually after the two-year period following the child's attainment of the limiting age.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.
- In Montana, for purposes of treatment, you have full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, licensed social worker, psychologist, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse.
- In New Mexico, a doctor is also a practitioner of the healing arts.

A doctor does not include you or any of your family members.

- In South Dakota, a doctor who is your family member may treat you if that doctor is the only doctor in the area and acts within the scope of his or her practice.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-family members and family-members-in-law.

Domestic Partner:

- In Washington DC, Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state or local domestic partner registry with you.
- In Nevada, Domestic Partner is defined as a person who is party to a valid domestic partnership, has not terminated that domestic partnership, and meets the requisites for a valid domestic partnership. In order to enter into a valid domestic partnership, it is necessary that the two persons register with the state of Nevada when it is established, by having previously furnished proof to the state of Nevada, that both persons have a common residence, neither person is married or a member of another domestic partnership, the two persons are not related by blood in a way that would prevent them from being married to each other in the state of Nevada, both persons are at least 18 years of age, and both persons are competent to consent to the domestic partnership.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis
- Cardiomyopathy

- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Pathologist is a doctor who is licensed:

- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.
  - In Ohio, Unable to Work is defined as the inability to perform duties of any gainful occupation for which you are reasonably fitted by training, experience, and accomplishment.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

In Montana, Consultation is not considered treatment or medical treatment.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

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

Continental American Insurance Company 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 the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary 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.

In Nevada: This limited plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

In New Mexico: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a tax penalty. Please consult your tax advisor.

In Washington DC: NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

We've got you under our wing.®

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Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains is written only in English; the certificate prevails if interpretation of this material varies.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

This brochure is subject to the terms, conditions, and limitations of Policy Series C21000. In Arkansas, C21100AR. In Oklahoma, C21100OK. In Oregon, C21100OR . In Pennsylvania, C21100PA. In Texas, C21100TX.

Group Critical Illness Advantage

GMO Accounts - Standard - Monthly (12pp/yr) Rates

NONTOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$4.52	$7.51	$10.51	$13.50	$16.50	$19.50	$22.49	$25.49	$28.48	$31.48
30-39	$6.28	$11.04	$15.80	$20.56	$25.32	$30.08	$34.84	$39.60	$44.36	$49.12
40-49	$11.79	$22.05	$32.32	$42.58	$52.85	$63.11	$73.38	$83.65	$93.91	$104.18
50-59	$20.48	$39.45	$58.41	$77.38	$96.34	$115.31	$134.27	$153.24	$172.20	$191.17
60+	$36.69	$71.87	$107.04	$142.22	$177.39	$212.56	$247.74	$282.91	$318.08	$353.26

NONTOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$4.52	$6.01	$7.51	$9.01	$10.51	$12.01	$13.50	$15.00	$16.50
30-39	$6.28	$8.66	$11.04	$13.42	$15.80	$18.18	$20.56	$22.94	$25.32
40-49	$11.79	$16.92	$22.05	$27.18	$32.32	$37.45	$42.58	$47.72	$52.85
50-59	$20.48	$29.97	$39.45	$48.93	$58.41	$67.90	$77.38	$86.86	$96.34
60+	$36.69	$54.28	$71.87	$89.45	$107.04	$124.63	$142.22	$159.80	$177.39

TOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$6.02	$10.52	$15.02	$19.53	$24.03	$28.53	$33.03	$37.53	$42.03	$46.54
30-39	$9.71	$17.90	$26.08	$34.27	$42.46	$50.65	$58.84	$67.03	$75.21	$83.40
40-49	$19.17	$36.82	$54.46	$72.11	$89.76	$107.41	$125.05	$142.70	$160.35	$178.00
50-59	$34.50	$67.48	$100.45	$133.43	$166.41	$199.39	$232.36	$265.34	$298.32	$331.30
60+	$62.13	$122.74	$183.34	$243.95	$304.56	$365.17	$425.78	$486.39	$546.99	$607.60

TOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$6.02	$8.27	$10.52	$12.77	$15.02	$17.28	$19.53	$21.78	$24.03
30-39	$9.71	$13.80	$17.90	$21.99	$26.08	$30.18	$34.27	$38.37	$42.46
40-49	$19.17	$27.99	$36.82	$45.64	$54.46	$63.29	$72.11	$80.93	$89.76
50-59	$34.50	$50.99	$67.48	$83.96	$100.45	$116.94	$133.43	$149.92	$166.41
60+	$62.13	$92.43	$122.74	$153.04	$183.34	$213.65	$243.95	$274.26	$304.56

Base Plan:
-With Cancer Benefit
-$50 Health Screening Benefit
-$250 Skin Cancer Benefit
-Without Additional Benefits
(Loss of Sight, Speech, Hearing)
(Coma, Burns, Paralysis)

Riders:
-Heart Rider

Provisions:
-No Pre-Existing Condition Limitation
-Add'l Separation Waiting Period: 6 Months
-Re-Separation Waiting Period: 6 Months
-Standard Portability
-Rate Guarantee: 2 Years

Group Attributes:
-Situs State: AK
-Eligible Lives: 700

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

Published: Mar-17 Series C21000 CI21000-170329-075502-F3zLJ5OT-037Yj3b-39651

Product Code: CI170329-075502

Aflac

Group Hospital Indemnity

INSURANCE

Even a small trip to the hospital can have a major impact on your finances.

Here's a way to help make your visit a little more affordable.

Aflac®

We've got you under our wing.®

AFLAC GROUP HOSPITAL INDEMNITY

Policy Series C80000

HI G

The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all of your bills?

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

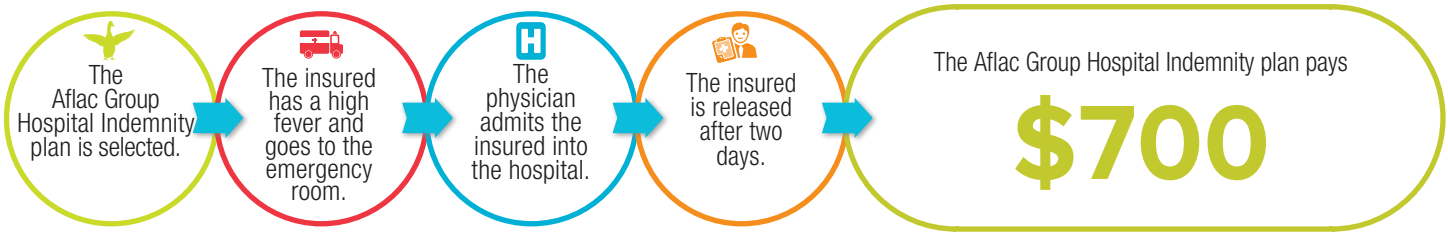
That's how the Aflac Group Hospital Indemnity plan can help.

It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

The Aflac Group Hospital Indemnity plan benefits include the following:

- **Hospital Confinement Benefit**
- **Hospital Admission Benefit**
- **Hospital Intensive Care Benefit**
- **Intermediate Intensive Care Step-Down Unit**

How it works



Amount payable was generated based on benefit amounts for: Hospital Admission ($500), and Hospital Confinement ($100 per day).

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Benefits Overview

	BENEFIT AMOUNT
HOSPITAL ADMISSION BENEFIT per first day of confinement (once per covered sickness or accident per calendar year for each insured) Payable when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.	$500
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$100
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$100
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. **This benefit is payable in addition to the Hospital Confinement Benefit.**	$50

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident.

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a family member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
  - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
  - Congenital defects in newborns.

TERMS YOU NEED TO KNOW

A Covered Accident is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage. Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Dependent Children are your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption. Newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered for 60 days also. See certificate for details. Dependent children must be younger than age 26, however this limit will not apply to any insured dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and: is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A Doctor does not include you or any of your Family Members. For the purposes of this definition, Family Member includes your spouse as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

A Hospital is not a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a rehabilitation facility; a facility for the treatment of alcoholism or drug addiction; an assisted living facility; or any facility not meeting the definition of a Hospital as defined in the certificate.

A Hospital Intensive Care Unit is not any of the following step-down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a Hospital Intensive Care Unit as defined in the certificate

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A Covered Sickness is one that is not excluded by name, specific description, or any other provision in this plan. For a benefit to be payable, loss arising from the covered sickness must occur while the applicable insured's coverage is in force.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

You May Continue Your Coverage
Your coverage may be continued with certain stipulations. See certificate for details.

Termination of Coverage
Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

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

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or your dependents 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, you should please check 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

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This brochure is subject to the terms, conditions, and limitations of Policy Series C80000.

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Policy Series C80000

HI G

TREATMENT BENEFITS

	BENEFIT AMOUNT
OUTPATIENT DOCTOR'S OFFICE VISIT (maximum of 6 visits per calendar year for each insured) We will pay the amount shown for each day that an insured visits a doctor's office. This benefit is not payable for visits to a chiropractor's office.	$25
TELEMEDICINE SERVICES (maximum of 6 per calendar year for each insured) We will pay the benefit amount shown for each day that, because of a covered accidental injury or covered sickness, an insured seeks medical advice from a doctor via telemedicine services. The telemedicine services must be provided in lieu of an outpatient doctor's office visit.	$10
CHIROPRACTOR VISIT (maximum of 4 visits per calendar year for each insured) We will pay the amount shown for each day that an insured receives services from a chiropractor for treatment of a covered accidental injury or because of a covered sickness. Visits to a chiropractor's office are not payable under the outpatient doctor's office visit benefit.	$10
MAJOR DIAGNOSTIC EXAMS (once per covered sickness or accident per calendar year) We will pay the amount shown for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams: · Computerized Tomography (CT/CAT scan) · Magnetic Resonance Imaging (MRI) · Electroencephalography (EEG)	$100
OUT OF HOSPITAL PRESCRIPTION DRUG (maximum of $100 per calendar year for each insured) We will pay the amount shown for each day an insured has a prescription filled. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the insured. This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; (d) immunization agents, biological sera, blood or blood plasma; or (e) contraceptive materials, devices or medications or infertility medication, except where required by law.	$20
HOSPITAL EMERGENCY ROOM VISIT (maximum of 5 visits per calendar year for each insured) We will pay the amount shown for each day that an insured visits a hospital emergency room due to a covered accidental injury or for treatment due to a covered sickness.	$75
EMERGENCY ROOM OBSERVATION (1 visit for each covered sickness or accident per calendar year, maximum of 5 total visits per calendar year for each insured) We will pay the amount shown for each period of observation that, because of a covered accidental injury or covered sickness, an insured: · Receives treatment in a hospital emergency room, and · Is held in a hospital for observation without being admitted as an inpatient.	$25 Minimum 4 hours $50 More than 24 hours
REHABILITATION FACILITY per day (maximum of 15 days per confinement, no more than 30 days total per calendar year for each insured) We will pay the amount shown for each day that, due to a covered accidental injury or a covered sickness, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid.	$50

Aflac®

We've got you under our wing.®

Residents of Massachusetts are not eligible for these benefits.

TERMS YOU NEED TO KNOW

Chiropractor means a person, other than the insured or the insured's family member, who

- Is licensed as a chiropractor in the state in which treatment is received, and
- While working under the scope of his license, uses manual or mechanical means to detect or correct disorders of structural imbalance, distortion, or subluxation of the musculoskeletal system and the nervous system for the purpose of removing nerve interference and related effects. The interference must result from or relate to distortion, misalignment, or subluxation of or in the vertebral column.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the treatment of alcoholism or drug addiction.

Telemedicine Service means a medical inquiry with a doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

For a complete list of limitations and exclusions please refer to the brochure.

AFLAC GROUP HOSPITAL INDEMNITY INSURANCE

Policy Series C80000

HI G

INPATIENT AND OUTPATIENT SURGICAL BENEFITS

	BENEFIT AMOUNT
INPATIENT SURGERY AND ANESTHESIA (performed in hospital or ambulatory surgical center) Payable for each day that, due to a covered accidental injury or sickness, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient.	$250
OUTPATIENT SURGERY AND ANESTHESIA (performed in hospital or ambulatory surgical center) Payable for each day that, due to a covered accidental injury or sickness, an insured has an outpatient surgical procedure performed by a doctor in a hospital on an outpatient basis or ambulatory surgical center.	$125
FACILITIES FEE FOR OUTPATIENT SURGERY (performed in hospital or ambulatory surgical center) Payable if due to a covered accidental injury or sickness: · An insured has an outpatient surgical procedure performed in an ambulatory surgical center or in a hospital on an outpatient basis, and · The insured receives an Outpatient Surgery and Anesthesia Benefit under this plan.	$50
OUTPATIENT SURGERY AND ANESTHESIA (performed in a doctor's office, urgent care facility or emergency room; maximum of 4 procedures per calendar year for each insured) Payable for each day that, due to a covered accidental injury or sickness, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office or urgent care facility.	$50

Residents of Massachusetts are not eligible for these benefits.

TERMS YOU NEED TO KNOW

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

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Aflac®

Group Hospital Indemnity

Maestro Health Standard Offer - Monthly (12 pp/yr)

Coverage	Rates
Employee	$34.00
Employee & Dependent Spouse	$64.70
Employee & Dependent Child(ren)	$55.76
Family	$86.46

Hospitalization Category:

Hospital Admission	$500
Hospital Confinement	$100
Hospital Intensive Care Unit	$100
Intermediate I.C. Step-Down Unit	$50

Treatment Category:

Hospital Emergency Room Visit	$75
ER Observation: 4 to 24 hours	$25
ER Observation: over 24 hours	$50
Outpatient Doctor's Office Visit	$25
Telemedicine Services	$10
Chiropractor Visit	$10
Rehabilitation Facility	$50
Major Diagnostic Exams	$100
Out-of-Hospital Prescription Drug	$20

Surgery Category:

Inpatient Surgery/Anes.	$250
OP Surgery/Anes.: Hospital/ASC	$125
Facilities Fee for Outpatient Surgery	$50
OP Surgery/Anes.: Doctor Office/ER	$50

Provisions:

Waiver of Pre-existing Conditions Exclusion
Waiver of Pregnancy Exclusion
Waiver of Mental and Emotional Disorders Exclusion
No Issue Age or Termination Age Limitations
Rate Guarantee: 2 years
Portability: Standard

Group Attributes:

Situs State: AK
Group Size: 100

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

Published: Sep-16 Series C80000 - AK HI80000-160923-115103-028T5CYA-5Pxv75fB-53362 **Product Code: HI160923-115103**


LifeLock®

GENESEE COUNTY DRAIN COMMISSIONER'S OFFICE

DIVISON OF WATER & WASTE SERVICES

G-4610 BEECHER RD – FLINT, MI – 48532 PHONE (810) 732-7870 FAX (810) 732-9773

JEFFREY WRIGHT - COMMISSIONER

Dear Hourly, Salaried and Exempt Employees:

The Division is pleased to announce that we are offering a new valuable benefit: best-in-class identity theft protection, provided by LifeLock. Today, your identity includes: your life, your credit, your home and your job! In our digital society identity theft is all too common.

HOW LIFELOCK WORKS

There are many types of identity theft protection services available. LifeLock monitors your identity and when activity occurs involving your information, you're alerted by email, text or a phone call. You can respond to confirm whether the activity is legitimate and a LifeLock agent will help you resolve the issue. That's just one of the many benefits.

The two LifeLock plans offered are the Benefit Elite and the Ultimate Plus (information attached). The cost for the plans are shown below, rates are bi-weekly.

Lifelock Benefit Elite	
	Rates (bi-weekly)
Employee	$3.92
Employee + Spouse	$7.84
Employee + Child(ren)	$6.86
Employee + Family	$10.78

Lifelock Ultimate Plus	
	Rates (bi-weekly)
Employee	$11.76
Employee + Spouse	$23.53
Employee + Child(ren)	$16.67
Employee + Family	$28.44

If you are interested in signing up for LifeLock or have any questions please feel free to contact me via email at sholder@gcdcwws.com or at (810) 732-7870.

Thank you,

Shannon M. Holder, CHRS, MBA
Human Resource Manager

LifeLock
BENEFIT ELITE

FACT SHEET

LifeLock Benefit Elite

LifeLock Benefit Elite protection is aimed squarely at what matters to employees — helping protect their identities and helping protect their nest eggs. While most employees have a 401 (k), many may set it and forget it — which means they could miss important cues that may indicate potential fraud. LifeLock Benefit Elite protection helps detect potential fraud and brings it to the attention of employees through alerts with the company's network via email, text or phone.[†]

Available only through employers, LifeLock Benefit Elite protection helps protect 401 (k) and other investment accounts from fraudulent withdrawals and balance transfers. LifeLock also searches over a trillion data points every day for potential threats to its members' personal identity, including suspicious uses of name, address, phone number, birth date, and Social Security number to obtain loans, credit and services, or to commit crimes.

If an employee becomes a victim of identity theft while a LifeLock member, LifeLock will spend up to $1 million to hire the necessary lawyers, accountants and investigators to help with recovery.[‡]

FEATURES INCLUDE:

LifeLock Identity Alert® System[†]
It's the foundation for all LifeLock services. We monitor for fraudulent use of your Social Security number, name, address, or date of birth in applications for credit and services. The patented system sends alerts by text, phone[††], or email.

Black Market Website Surveillance
Identity thieves sell personal information on black market websites around the world. LifeLock patrols over 10,000 criminal websites and notifies you if we find your data.

LifeLock Privacy Monitor™ Tool (Beginning 1/1/17)
Privacy Monitor helps reduce public exposure of your personal information. We scan common public people-search websites to find your personal information and help you opt-out.

Address Change Verification
Identity thieves try to divert mail to get important financial information. LifeLock lets you know of change in address requests linked to your identity.

Reduced Pre-Approved Credit Card Offers
Pre-approved credit card offers can provide important information to identity thieves. LifeLock will request your name be removed from many pre-approved credit card mailing lists.

(continued on reverse)

No one can prevent all identity theft.
[†] LifeLock does not monitor all transactions at all businesses.
[††] Phone alerts made during normal local business hours.
[‡] Stolen Funds Reimbursement and Service Guarantee benefits for State of New York members are provided under a Master Insurance Policy issued by State National Insurance Company. Benefits for all other members are provided under a Master Insurance Policy underwritten by United Specialty Insurance Company. Under the Service Guarantee LifeLock will spend up to $1 million to hire experts to help your recovery. Under the Stolen Funds Reimbursement, LifeLock will reimburse stolen funds up to $100,000 for Benefit Elite membership (up to $1 million for Benefit Elite membership effective January 1, 2017). Please see the policy for terms, conditions and exclusions at LifeLock.com/legal.

FEATURES CONTINUE:

Lost Wallet Protection
A lost wallet can mean a lost identity. Call us if your wallet is lost or stolen and we'll help cancel or replace credit cards, driver's licenses, Social Security cards, insurance cards and more.

Identity Restoration Support
If your identity is compromised, an Identity Restoration Specialist will personally handle your case and help restore your identity.

Stolen Funds Reimbursement‡
If you're ever a victim of identity theft, LifeLock will help protect your hard-earned money with dollar for dollar reimbursement for lost funds – up to **$1 million** (beginning 1/1/17). This includes everything from fraudulent bank and investment account withdrawals to tax returns filed in your name.‡

$1M $1 Million Service Guarantee‡
If you become a victim of identity theft while a LifeLock member, we'll spend up to $1 million on experts and lawyers to help your recovery.

Fictitious Identity Monitoring
We scan for names and addresses connected with your Social Security number to help protect against criminals building fictitious identities to open accounts or commit fraud.

Court Records Scanning
We check court records for matches of your name and date of birth to criminal activity. It helps protect you from being falsely linked to arrests and convictions you know nothing about.

Data Breach Notifications
Your identity is virtually everywhere. Doctors, insurance companies, employers, even your favorite retailers. We'll let you know about large-scale breaches so you can help protect your personal information.

Credit Card, Checking & Savings Account Activity Alerts† (Beginning 1/1/17)
Help protect your finances from fraud with alerts that notify you of cash withdrawals, balance transfers and large purchases.

Investment Account Activity Alerts†
Investment and retirement accounts are often the lifeline for financial growth. We'll help protect your nest egg from fraudulent cash withdrawals and balance transfers.

Live Member Support
We have live, U.S.-based, award-winning Identity Protection Agents available to answer your questions.

LifeLock
BENEFIT ELITE

No one can prevent all identity theft.
† LifeLock does not monitor all transactions at all businesses.
†† Phone alerts made during normal local business hours.
‡ Stolen Funds Reimbursement and Service Guarantee benefits for State of New York members are provided under a Master Insurance Policy issued by State National Insurance Company. Benefits for all other members are provided under a Master Insurance Policy underwritten by United Specialty Insurance Company. Under the Service Guarantee LifeLock will spend up to $1 million to hire experts to help your recovery. Under the Stolen Funds Reimbursement, LifeLock will reimburse stolen funds up to $100,000 for Benefit Elite membership (up to $1 million for Benefit Elite membership effective January 1, 2017). Please see the policy for terms, conditions and exclusions at LifeLock.com/legal.

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LifeLock ULTIMATE PLUS™

FACT SHEET

LifeLock Ultimate Plus

Your bank accounts and credit are a gold mine for identity thieves. LifeLock Ultimate Plus™ service gives you peace of mind knowing you have LifeLock's most comprehensive identity theft protection. You'll get alerts if we find new bank account applications and attempts to take over existing accounts.† You'll also enjoy the convenience of online access to annual credit reports from all three bureaus, monthly credit score tracking and priority access to live U.S.-Based Member Support.

FEATURES INCLUDE:

LifeLock Identity Alert® System†
It's the foundation for all LifeLock services. We monitor for fraudulent use of your Social Security number, name, address, or date of birth in applications for credit and services. The patented system sends alerts by text, phone††, or email.

Black Market Website Surveillance
Identity thieves sell personal information on black market websites around the world. LifeLock patrols over 10,000 criminal websites and notifies you if we find your data.

LifeLock Privacy Monitor™ Tool
Privacy Monitor helps reduce public exposure of your personal information. We scan common public people-search websites to find your personal information and help you opt-out.

Address Change Verification
Identity thieves try to divert mail to get important financial information. LifeLock lets you know of change in address requests linked to your identity.

Reduced Pre-Approved Credit Card Offers
Pre-approved credit card offers can provide important information to identity thieves. LifeLock will request your name be removed from many pre-approved credit card mailing lists.

Lost Wallet Protection
A lost wallet can mean a lost identity. Call us if your wallet is lost or stolen and we'll help cancel or replace credit cards, driver's licenses, Social Security cards, insurance cards and more.

Identity Restoration Support
If your identity is compromised, an Identity Restoration Specialist will personally handle your case and help restore your identity.

Stolen Funds Reimbursement‡
If you're ever a victim of identity theft, LifeLock will help protect your hard-earned money with dollar for dollar reimbursement for lost funds – up to **$1 million**. This includes everything from fraudulent bank and investment account withdrawals to tax returns filed in your name.‡

$1M $1 Million Service Guarantee‡
If you become a victim of identity theft while a LifeLock member, we'll spend up to $1 million on experts and lawyers to help your recovery.

(continued on reverse)

No one can prevent all identity theft.
† LifeLock does not monitor all transactions at all businesses.
†† Phone alerts made during normal local business hours.
‡ Stolen Funds Replacement and Service Guarantee benefits for State of New York members are provided under a Master Insurance Policy issued by State National Insurance Company. Benefits for all other members are provided under a Master Insurance Policy underwritten by United Specialty Insurance Company. Under the Service Guarantee LifeLock will spend up to $1 million to hire experts to help your recovery. Under the Stolen Funds Replacement, LifeLock will reimburse stolen funds up to $25,000 for Standard membership, up to $100,000 for Advantage membership and up to $1 million for Ultimate Plus membership. Please see the policy for terms, conditions and exclusions at LifeLock.com/legal.

FEATURES CONTINUE:

Fictitious Identity Monitoring
We scan for names and addresses connected with your Social Security number to help protect against criminals building fictitious identities to open accounts or commit fraud.

Court Records Scanning
We check court records for matches of your name and date of birth to criminal activity. It helps protect you from being falsely linked to arrests and convictions you know nothing about.

Data Breach Notifications
Your identity is virtually everywhere. Doctors, insurance companies, employers, even your favorite retailers. We'll let you know about large-scale breaches so you can help protect your personal information.

Credit Card, Checking & Savings Account Activity Alerts†
Help protect your finances from fraud with alerts that notify you of cash withdrawals, balance transfers and large purchases.

Checking & Savings Account Application Alerts†
Continuously searches for your personal information in new bank account applications at national banks, local banks and credit unions from coast to coast.

Bank Account Takeover Alerts†
Smart identity thieves use their computers to take over accounts or add new account holders to existing accounts. LifeLock helps protect your finances by monitoring for these changes.

Investment Account Activity Alerts†
Investment and retirement accounts are often the lifeline for financial growth. We'll help protect your nest egg from fraudulent cash withdrawals and balance transfers.

Credit Inquiry Alerts†
Lenders make credit inquiries when someone submits a credit application. We monitor for suspicious activity and you can respond if the application is fraudulent.

File-Sharing Network Searches
Music, photo and data file-sharing networks can expose your personal information. We monitor many popular networks for use of your name, Social Security number, date of birth or contact information.

Sex Offender Registry Reports
Receive notification if your name and personal information appear in a sex offender registry.

Online Annual Tri-Bureau Credit Reports & Scores
Secure online access to your annual credit reports from the three primary bureaus: Equifax, TransUnion and Experian. It's a convenient way to see details of your credit history over the past year.

Monthly Credit Score Tracking
This monthly single-bureau credit score tracker helps you identify important changes and see how your credit is trending over time.

Priority Live Member Support
Skip the wait and move to the front of the line to speak with a U.S.-based Member Services Agent available to answer your questions.

LifeLock ULTIMATE PLUS™

No one can prevent all identity theft.
† LifeLock does not monitor all transactions at all businesses.

MAS0634

Medicare

Turning 65?

What You Need to Know about Signing up for Medicare

https://www.elderlawanswers.com/turning-65-what-you-need-to-know-about-signing-up-for-medicare--8968

The information below is important for you to know; perhaps not while you are still employed with the Division but after you retire. The information below assumes you will retire from the Division with BCBS benefits.

You become eligible for Medicare at age 65, and delaying your enrollment can result in penalties, so it is important to act right away. There are a number of different options to consider when signing up for Medicare. Medicare consists of four major programs: Part A covers hospital stays, Part B covers physician fees, Part C permits Medicare beneficiaries to receive their medical care from among a number of delivery options, and Part D covers prescription medications. In addition, Medigap policies offer additional coverage to individuals enrolled in Parts A and B.

Medicare enrollment begins three months before your 65th birthday and continues for 7 months. If you are currently receiving Social Security benefits, you don't need to do anything. You will be automatically enrolled in Medicare Parts A and B effective the month you turn 65. If you do not receive Social Security benefits, then you will need to sign up for Medicare by calling the Social Security Administration at 800-772-1213 or online at www.socialsecurity.gov/medicareonly/. It is best to do it as early as possible so your coverage begins as soon as you turn 65.

After you retire and turn 65 you must be enrolled in Medicare Parts A and B. Part A is free in most cases while Part B is not. Once you receive your Medicare A&B card you will need to provide a copy of it to HR. Medicare will then become your primary form of insurance and the BCBS coverage you had while employed with the Division (if applicable) will become secondary. The BCBS insurance will also cover your prescription drugs. You DO NOT need to enroll in Medicare Part C, Part D or Medigap.

If you are still working and have an employer or union group health insurance plan, it is possible you do not need to sign up for Medicare Part B right away. You will need to find out from your employer whether the employer's plan is the primary insurer.

For active employees who are currently enrolled in Division provided BCBS insurance: you do not need to enroll in Medicare Part A when you are eligible but you should. Because Medicare Part A is free for most people, it pays to enroll in it as soon as you're eligible, even if you have existing coverage. If you elect to enroll please notify HR. Your BCBS through the Division will remain your primary insurance but Medicare will become secondary. Because you are still working you will NOT need to enroll in Part B until you retire.

If Medicare, rather than the employer's plan, is the primary insurer, then you will still need to sign up for Part B. Even if you aren't going to sign up for Part B, you should still enroll in Medicare Part A, which may help pay some of the costs not covered by your group health plan.

Please note that you will pay a premium each month for Part B. If you get Social Security your Part B premium will be automatically deducted from your benefit payment. If you don't get this benefit payment, you'll get a bill. Most people will pay the standard premium amount. The standard Part B premium amount in 2017 is $134 (or higher depending on your income). However, most people who get Social Security benefits pay less than this amount. This is because the Part B premium increased more than the cost-of-living increase for 2017 Social Security benefits. If you pay your Part B premium through your monthly Social Security benefit, you'll pay less ($109 on average). Social Security will tell you the exact amount you'll pay for Part B.

If you don't have an employer or union group health insurance plan, or that plan is secondary to Medicare, it is extremely important to sign up for Medicare Part B during your initial enrollment period. Note that COBRA coverage does not count as a health insurance plan for Medicare purposes. Neither does retiree coverage or VA benefits. Just because you have some type of health insurance doesn't mean you don't have to sign up for Medicare Part B. If you do not sign up for Part B right away, then you will be subject to a penalty. Your Medicare Part B premium may go up 10 percent for each 12-month period that you could have had Medicare Part B, but did not take it. In addition, you will have to wait for the general enrollment period to enroll. The general enrollment period usually runs between January 1 and March 31 of each year.

With all the deductibles, copayments and coverage exclusions, Medicare pays for only about half of your medical costs. Much of the balance not covered by Medicare can be covered by purchasing a so-called "Medigap" insurance policy from a private insurer. You can search online for a Medigap policy in your area at www.medicare.gov/find-a-plan/questions/medigap-home.aspx.

You do not need to purchase Medigap insurance. Your BCBS insurance is your secondary insurance provider after Medicare and should cover what Medicare does not (within the limits of the specific BCBS plan you are on).

Medicare also offers Medicare Part C (also called Medicare Advantage). You must be enrolled in Medicare Parts A and B to join a Medicare Advantage plan, the name for private health plans that operate under the Medicare program. If you join a Medicare Advantage Plan, the plan will provide all of your Part A and Part B coverage, and it may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most such plans include Medicare prescription drug coverage.

You do not need to purchase Part C or Medicare Advantage insurance. Your BCBS insurance is your secondary insurance provider after Medicare and should cover what Medicare does not (within the limits of the specific BCBS plan you are on).

Finally, Medicare offers prescription drug coverage under Medicare Part D. If you are not going to sign up for a Medicare Advantage plan with prescription drug coverage, then you will want to enroll in a prescription drug plan at the same time you sign up for Parts A and B. For every month you delay enrollment past the initial enrollment period, your Medicare Part D premium will increase at least 1 percent. You are exempt from these penalties if you did not enroll because you had drug coverage from a private insurer, such as through a retirement plan, at least as good as Medicare's. This is called "creditable coverage." Your insurer should let you know if their coverage will be considered creditable. Visit the Medicare Web site at https://www.medicare.gov/find-a-plan/questions/home.aspx to find a drug plan in your area. After you've signed up for Medicare Part B, you can schedule a free "Welcome to Medicare" exam with your doctor.

You do not need to purchase Part D insurance. Your BCBS insurance is your secondary insurance provider after Medicare, is "credible coverage", and covers prescription drugs (within the limits of the specific BCBS plan you are on).

If you have any questions please contact the Division HR Department at (810) 732-7870.