Provided by:

EMPLOYEE BENEFITS HANDBOOK

July 1, 2024 - June 30, 2025

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

DISCLAIMER

This guide is a brief summary of benefits offered to your group and does not constitute a policy.

Your employer may amend the benefits program at any time. Your Summary Plan Description (SPD) will contain the actual detailed provisions of your benefits. The SPD will be available at mymarkiii.com.

If there are any discrepancies between the information in this guide and the SPD, the language in the SPD will always prevail.

Important Points

- ✓ Your plan year runs from July 1, 2024 to June 30, 2025. This means your benefit elections will take effect July 1, 2024 unless otherwise noted.
- ✓ If you wish to add or make changes to your benefit elections, you have the option of self-enrolling or speaking with a trusted Mark III Benefits Counselor during your scheduled open enrollment.
- ✓ Once the enrollment period is over, you will not be able to make changes unless you experience a qualifying life event as outlined by the IRS.
- ✓ **REMINDER!** Employees must re-enroll in their Flexible Spending Account and Dependent Care Account each year! It will not automatically renew.
- ✓ This benefits guide is equipped with mobile-friendly barcodes commonly referred to as QR Codes. Use your smartphone to scan the QR codes to view your benefit summaries.
- ✓ All policy information can be found on your employee benefits portal at https://mymarkiii.com/harnettcountync.

Qualifying Life Events

Open Enrollment selections are generally locked for the plan year, but certain exceptions called Qualifying Life Events (QLEs) can grant you a special enrollment period in which to make midyear changes. You are permitted to change benefit elections if you have a “change in status” and you make an election change that is consistent with the “change in status.” Please contact your Group Contact for information on cancelling post-tax benefits.

Examples of QLEs

The following events will open a special ***30-day*** enrollment period from the date of the event, allowing you to make changes to your coverage. Documentations may be required.

marriage

divorce

childbirth/ adoption

death of a family member

loss of parental coverage

spouse gains or loses coverage

Welcome to Your Benefits!

Mark III Employee Benefits is here to help guide you through the benefits offered by your employer. This guide is simply a brief summary of benefits offered and does not constitute a policy.

Pre-Tax Benefit Information

A "**pre-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary before you pay any taxes on it. By choosing this option, you reduce your taxable income, therefore reducing the taxes you owe. If you choose this option, you cannot drop coverage until the next annual enrollment period or unless you have a qualifying life event (i.e. birth of a child, divorce, separation, reduction in hours, etc.). If your premiums are deducted on a pre-tax basis, any benefits received under the plan could be treated as taxable income.

- ✓ BlueCross BlueShield of NC Medical
- ✓ P&A Group Flexible Spending Accounts
- ✓ Delta Dental
- ✓ Superior Vision by MetLife
- ✓ Manhattan Life Group Cancer
- ✓ The Standard Group Accident
- ✓ The Standard Group Hospital Indemnity
- ✓ The Standard Group Critical Illness

Post-Tax Benefit Information

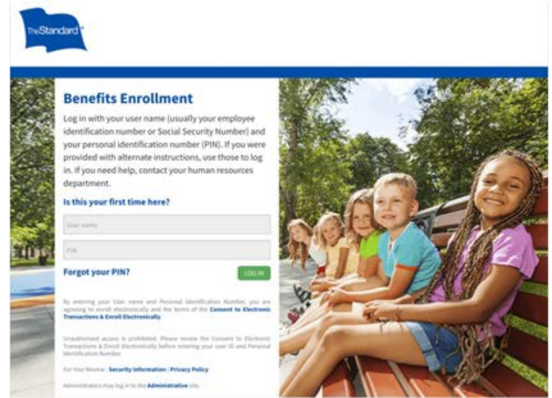
A "**post-tax basis**" means that the money you pay towards the cost of coverage comes out of your salary after you pay taxes. You **WILL NOT** be able to make any changes once the enrollment period is over unless you experience a qualified life event outlined by the IRS (i.e. birth of a child, divorce, separation, reduction in hours, etc.).

- ✓ AUL Short-Term Disability
- ✓ AUL Long-Term Disability
- ✓ Unum Basic Term Life
- ✓ Unum Voluntary Term Life
- ✓ MassMutual Whole Life

How to Enroll as a New Hire

How to Enroll Online: Step-by-Step for New Hires

Enrolling in your benefits has never been easier! Through the Selerix online platform, you can now enroll anywhere, anytime, and at your convenience.



Step 1: Login

Login Page: https://standard.benselect.com/harnett
Username: **SSN (no dashes or spaces)**
PIN: **Last four of SSN + Last two of birth year**
(Example: Jane Doe, 123-45-6789, 01/01/1974 | PIN: 678974)

Once logged in, you will be greeted with the **Welcome Page**. Follow the on-screen instructions to enroll in your benefits, find answers to questions, download forms, and much more!

**Please note: Be sure to remember your password for future changes/enrollments.*

Step 2: Add Dependents

Click on the **+** icon on the far-right hand side. This will bring up the screen to add additional dependents. To edit a dependent, simply click on their name in the list. Click **Save** once complete.

**You will need to add dependents prior to enrolling in coverage.*

No Dependent Information Available

Name	SSN	DOB	Sex	Relation	Uploads	+
No items found.						

Step 3: Elect Benefits

Follow the on-screen selections to elect or decline your benefit options.

**Please note, the system will display per pay period amounts and show you the coverages available to you.*

M3 MEDICAL HDHP (Current)	M3 MEDICAL PPO	DECLINE COVERAGE
Your Cost: Per Pay Period	Your Cost: Per Pay Period	You should only decline coverage if you are covered elsewhere. Declining coverage may require you to answer questions about your reasons for declining.
Employee Only: $0.00	Employee Only: $92.31	
Employee + Spouse: $92.31	Employee + Spouse: $276.92	
Employee + Children: $46.15	Employee + Children: $184.62	
Employee+Family: $138.46	Employee+Family: $369.23	
Covered People: TEST TEST	Covered People: TEST TEST	Your Cost: $0.00
Enroll	Enroll	Decline

Step 4: Sign & Submit!

Finalize your benefit selections by signing the benefit summary at the very end of enrollment. You will utilize your PIN to electronically sign the benefits elected. Click **Sign Form** once you have entered your PIN.

PIN: [ ] Sign Form

You are completely enrolled when you see: Congratulations! Your enrollment is now complete!

HEALTHY LIVING

Core Benefit options to keep you and your family healthy.

Health, Dental & Vision Monthly Costs

Health Plan

Rates	Total Cost	Employee Cost
Employee Only	$962.00	$0.00
Employee + Spouse	$1,276.03	$339.96
Employee + Child(ren)	$1,301.96	$314.03
Employee + Family	$1,671.54	$709.54

Dental Plan

Rates	Total Cost	Employee Cost
Employee Only	$32.00	$0.00
Employee + Spouse	$62.46	$30.46
Employee + Child(ren)	$66.04	$34.04
Employee + Family	$117.44	$85.44

Vision Plan

Rates	Total Cost	Employee Cost
Employee Only	$6.46	$6.46
Employee + Spouse	$12.28	$12.28
Employee + Child(ren)	$12.93	$12.93
Employee + Family	$19.00	$19.00

Employee Cost indicated above is pre-tax payroll deduction.

Medical Plan Summary

BlueCross BlueShield of NC Benefit Summary

Benefit	In-Network	Out-of-Network
Deductible	$2,000 Individual | $4,000 Family	$4,000 Individual | $8,000 Family
Out-of-Pocket Limit	$6,600 Individual | $13,200 Family	$13,200 Individual | $26,400 Family
Primary Care Visit	$25 Copayment	50% Coinsurance
Specialist Visit	$50 Copayment	50% Coinsurance
Preventative Care/Screenings	No Charge	50% Coinsurance
Diagnostic Text (X-Ray, Blood Work)	70% Coinsurance	50% Coinsurance
Imaging (CT/PET scans, MRIs)	70% Coinsurance	50% Coinsurance
Facility Fee	70% Coinsurance	50% Coinsurance
Physician/Surgeon Fees	70% Coinsurance	50% Coinsurance
Emergency Room Visit*	$500	$500
Ambulance	70% Coinsurance	70% Coinsurance
Urgent Care Centers	$50	$50

Drug Tier	In-Network	Out-of-Network
Tier 1	$10 Copayment	$10 Copayment
Tier 2	$10 Copayment	$10 Copayment
Tier 3	50% Coinsurance	50% Coinsurance
Tier 4	50% Coinsurance	50% Coinsurance

There is a $100 per prescription maximum for each 30-day supply of Tier 2, 3, 4 drugs. Any Out-of-Network charges over the allowed amount are not included in this maximum. You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy.

**If admitted from the ER, any applicable ER member responsibility does not apply; Instead, Inpatient Hospital benefits apply. If held for observation, Outpatient benefits apply. See "Inpatient Hospital Services" and Outpatient Services". Out-of-Network Emergency Room services are payable at the In-Network level and applied to the In-Network Out-of-Pocket Limit regardless of where they are obtained.*

Summary of Benefits & Coverage (SBC) Documents

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. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit www.bluecrossnc.com.

Visit: mymarkiii.com/harnettcountync/policy-information/ to view the SBC documents or scan the QR Code for quick access to view your SBCs online.

This document is a highlight of plan benefits provided by BlueCross BlueShield of NC as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For a complete list of covered procedures, please see your benefits administrator.

HealthMapRx™

Diabetes Care Management

You may be eligible to participate in a free health benefit sponsored by Harnett County called HealthMapRx. This program is voluntary and made available to employees, retirees, and dependents who are currently covered under the health insurance plan. HealthMapRx is a confidential program and Harnett County will **NOT** have access to your personal health information.

How Does It Work?

This program is designed to help individuals manage their **Pre-Diabetes or Diabetes**. Participant will be paired with a pharmacist care manager for private face-to-face appointments 4-6 times per year. Most sessions are scheduled for 30-45 minutes to discuss pertinent health information. For your convenience, appointments will be scheduled at the worksite and during work hours.

Do You Qualify?

Do you take medication for diabetes or pre-diabetes? If you answered **YES**, you qualify!

What's In It For You?

- **Participation Incentive**: Participants can earn up to $250 per year.
- **Self-Monitoring Technology**: Participants will receive a blood pressure monitor that has Bluetooth® capabilities with an app to track readings.

How Do You Enroll?

Enroll Online: Scan QR Code
Use Customer/Sponsor Code: 2004
Contact HealthMapRx Program Support

- Phone: (336) 580-0340
- Fax: (877) 828-2467
- Email: admin@emailmm.com
- Website: www.ppcn.org

Visit the next page to learn about the **Medical Weight Care Management Program!**

Medical Weight Care Management

Do you struggle with the **need to lose weight?** Is it **difficult for you to keep your weight off?** Harnett County recognizes this struggle and how it affects your health and well-being!

What is HealthMapRx?

- A free health benefit available to employees and their dependents who are covered by Harnett County's health insurance.
- Though the benefit program is employer sponsored, the County WILL NOT have access to any personal health information.
- To view a testimonial video, select hyperlink: Medical Weight Management Testimonial Video Link (Control + Select)

Do You Qualify?

- If you have a BMI (body mass index) of 40 or more and do not have diabetes, you may qualify for the Medical Weight Management Program.

What's In It For You?

- **Education and on-going Support**: Participants engage in a series of virtual small group educational activities and weekly electronic check-ins with their MWMP health coach; in addition to routine meetings (4 times per year) with their assigned Pharmacist Care Manager.
- **Participation Incentive**: Participants can earn up to $120 per year.
- **$0 Co-pay for Medications**: Co-pays are waived for preferred medications.
- **Self-Monitoring Technology**: Participants will receive a digital scale that has Bluetooth® capabilities with an app to track weekly weigh-ins.

For more Information: Contact HealthMapRx Program Support
Phone: (336) 580-0340
Email: admin@emailmm.com

Save With GoodRx

Never Over-Pay for Your Prescriptions Again!!

GoodRx is a great way to help save money on your prescriptions and the best thing is that it's completely **FREE** to use for your whole family. GoodRx compiles discount coupons that enable you to take advantage of the best pricing on your medications. You'll be surprised at how inexpensive you might be able to get your medications. Check GoodRx every time you get a prescription to see your possible savings.

Features

- ✓ **Search & Compare Prices**. Find the lowest local prices for your prescriptions at more than 70,000 U.S. pharmacies.
- ✓ **Get Free Coupons**. GoodRx coupons can save you up to 80% on your prescriptions at no cost to you.
- ✓ **Save your prescriptions**. Track prices and get notified with the latest saving alerts for your prescriptions.
- ✓ **Show To Your Pharmacist**. It's easy, just show the GoodRx app to your pharmacist when picking up your prescription.

How Do I Use GoodRx?

1. Download the the GoodRx app on the iTunes and Google Play App stores or enter your mobile number at https://www.goodrx.com/mobile to have the app texted to you.
2. Look up your prescriptions and compare prices at multiple pharmacies.
3. Click the print, email, or text button above the coupon on your computer to print or send it to your phone.
4. Show the printed coupon or the digital coupon on your phone when you drop off your prescription.

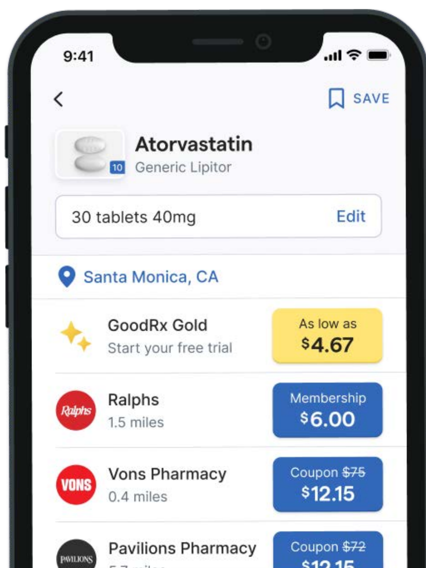
P.S. If you're picking up a prescription your doctor called in, please show your GoodRx coupon before they scan your medication to begin checkout.

Who Accepts GoodRx Discounts?

GoodRx is accepted at over 70,000 pharmacies in all 50 states, Puerto Rico, and the U.S. Virgin Islands. That includes major chains like CVS, Walgreens, Kroger, Rite Aid, Costco, Walmart, and many more!

Access the below medications at a discounted rate!

- ✓ Piqray (chemotherapy)
- ✓ Tremfya/Stelara/Skyrizi (psoriasis medication)
- ✓ Ozempic (Type II diabetes)
- ✓ Trulicity (diabetes)



Save Up To 80% On Your Prescriptions With The Free GoodRx App

GoodRx is the #1 free medical app for iOS and Android. Download the app today and start saving on your prescriptions!

Flexible Spending Account

What Is A Flexible Spending Account?

A Flexible Spending Account (FSA) allows you to set aside a portion of your pay pre-tax to use for medical, dental, vision, and child care/elder care expenses that are not covered by insurance, or only partially covered. Because it is deducted from your pay before taxes, you can save up to 30% on your dollar (depending on your tax bracket)! Estimate how much you usually spend on these types of expenses in a year and set aside that dollar amount into your FSA.

Rules to Remember

- **Plan Year**: July 1, 2024 - June 30, 2025
- **Health FSA Carry Forward**: An employer-chosen provision allowing a minimum of $25 and up to a maximum of $500 of unused Health FSA funds to roll over into the next plan year.
- **Run-Out Period**: Participants have until September 30, 2024 to submit for expenses incurred during the plan year.
- **Use or Lose Rule**: Unused Dependent Care Account balances or any amount under $25 and over $500 in the Health FSA will not rollover. Remember, only contribute money you are confident you will use to pay for qualified expenses during the plan year.
- **Over-the-Counter (OTC)**: Medications are now reimbursable under Flexible Spending Accounts without requiring a prescription or completing a Letter of Medical Necessity Form. This provision is retroactive to January 1, 2020. Menstrual care products are also now reimbursable as eligible expenses, including tampons and pads.

Accounts Available

Health FSA - Covers the cost of medical, dental, and vision expenses incurred by you and or your eligible dependent(s). Eligible expenses include deductibles, co-pays, prescriptions, eyeglasses, and dental work.

- **Minimum annual election amount: $100 Maximum annual election amount: $3,200**

Dependent Care/Daycare Assistance Account - Covers the amount you pay to daycare centers, babysitters, after school programs and day camp programs (for dependents up to age 13) as well as eldercare facilities. This account does NOT reimburse medical expenses for your dependent(s). It is for qualified daycare expenses only.

- **$5,000 (household annual maximum); $2,500 if married and filing a separate return.**

P&A Benefits Card

Your employer offers a Benefits MasterCard for employees who participate in the plan. The Benefits MasterCard works like a debit card. When you incur an eligible expense present your Benefits Card to the provider of the goods or services you are purchasing. Swipe your card at the point-of-service and the expense will automatically be deducted from your FSA balance. If you are unable to use your Benefits Card you can still be reimbursed for all eligible expenses. Save your receipt and submit a claim to P&A Group using one of the methods below. For all purchases we encourage you to save your receipts in case documentation is requested. NOTE: This card cannot be used at an ATM machine to withdraw cash.

Your debit card is valid for three years from the date of issue. If this is your third year enrolling with P&A Group, you may be receiving a new benefits card in the mail. When it is time for you to receive a new card your card will automatically be mailed to your home address in a plain white envelope.

How To Submit A Claim

QuickClaim. Instantly submit claims and receipts directly from your smartphone.

1. Capture a picture of your receipt or other supporting documentation of your eligible expense.
2. Log into your P&A Account at www.padmin.com from your mobile device by selecting Account Login and follow the prompts on your screen.

Electronic Claim Upload. Submit claims directly online at P&A's website www.padmin.com by logging into your P&A account. Select Upload Claim/Documentation under the Member Tools tab.

Fax or Mail a Paper Claim. Claim forms are available online at www.padmin.com.

FAX: (877) 855-7105
MAIL: P&A Group 17 Court St. Suite 500 Buffalo, NY 14202

When submitting a claim make sure to include proof of service/documentation (itemized receipt, etc.).

FSA Calculator

Use this online tool to help estimate your calculated savings when you sign up for an FSA. Log into your account at www.padmin.com to access the calculator or go to www.padmin.com, select Benefit Programs, then Tools & Resources.

Eligible Health FSA Expenses

- Acupuncture
- Alcoholism treatment
- Allergy medication, nasal sprays
- Ambulance
- Analgesics, fever reducers, pain reducers (aspirin, ibuprofen, acetaminophen)
- Antacids and heartburn relief
- Antibiotic ointments
- Anti-itch creams and hydrocortisone creams
- Arthritis pain relieving creams
- Athlete's foot treatment, anti-fungal creams
- At-home COVID-19 tests
- Artificial teeth/dentures
- Bandages
- Birth control
- Blood pressure monitors
- Braces
- Braille-books and magazines
- Breast pumps and lactation supplies
- Cancer screening
- Chiropractors
- Chondroitin
- Co-insurance amount you pay
- Cold/hot packs
- Cold medicines, tablets, syrups, cough drops & lozenges
- Co-pay amount you pay
- Compression hose (30-40 mmHg or higher)
- Condoms
- Contact lenses and eyeglasses
- Contact lens solutions
- Cost of medically necessary operations and related treatments
- Crutches
- Deductible medical coverage (amounts you pay)
- Dental fees
- Diabetic supplies
- Diaper rash ointment
- Drug addiction treatment
- Ear wax removal kits
- Eye exams, eye surgery
- Eye glasses (protection plans/warranties are NOT eligible expenses)
- Eczema treatments
- Feminine hygiene products
- Fertility treatments (in vitro fertilization, surgery)
- First-aid cream
- Glucosamine
- Hearing devices and batteries
- Hemorrhoid treatments
- Hospital services
- Incontinence products
- Infertility treatments
- Insulin
- Laboratory fees
- Lactose intolerance tablets
- Lamaze classes
- Latex gloves
- Laxatives
- Medical alert bracelets
- Medical information plan
- Menstrual pain relievers
- Mentally handicapped persons cost of special home care
- Motion sickness pills
- Nasal spray and strips
- Nicotine gum, patches
- Nursing services (including boarding)
- Obstetrical expenses
- Orthotics
- Over-the-counter medications
- Oxygen
- PPE (i.e., face masks, hand sanitizer, sanitizing wipes)
- Petroleum jelly
- Prosthesis
- Pregnancy tests
- Prenatal vitamins
- Psychiatrists' and psychologists' fees
- Radial keratotomy and Lasik eye surgery
- Routine physical & other non diagnostic services or treatments
- Sinus medication
- Smoking cessation programs
- Speech therapy
- Special education for the blind
- Special plumbing for handicapped
- Sterilization (i.e., tubal ligation, vasectomy) and reversal
- Stomach and digestive relief items
- Sunburn cream (Solar Caine)
- Surgical fees
- Telephone, special for hearing impaired
- Television audio display equipment for hearing impaired
- Therapeutic care for drug and alcohol addiction received as medical treatment
- Thermometers
- Toothache and teething pain relievers
- Transportation expenses for person to receive medical care
- Urinary pain relief medication
- Vaccines
- Walkers
- Wart removal, i.e., W Freeze Off (certain wart medicines may require a prescription)
- Wheelchair
- X-rays
- Yeast infection medication

Text Messaging Features

Log into your online P&A Account and update your profile with your mobile number. Then text one of the codes below to the number 70626 and you'll receive a text message with your account information!

- *Account balance - text BAL*
- *Claim status - text CLM*
- *Deposit update - text DEP*

Questions?

Customer service hours are M - F, 8:30 am - 10:00 pm ET.
PH: (800) 688-2611
WEB: www.padmin.com
MAIL: 17 Court Street
Suite 500
Buffalo, NY 14202

Eligible Dependent Care FSA Expenses

- Babysitters
- Daycare centers
- Nursery schools
- After-school programs
- Day camp
- Eldercare
- (Overnight camps are NOT eligible)

This is not a complete list of Eligible Expenses.

Expense eligibility is subject to change. If you are unsure if an expense is eligible for reimbursement, please call P&A Group at (716) 852-2611 or chat with a Participant Support Specialist through online webchat at www.padmin.com.

Dental Plan

Delta Dental Summary of Benefits	*Delta Dental PPO Dentist*	*Delta Dental Premier Dentist*	*Nonparticipating Dentist**
Diagnostic & Preventive Services			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs – to bridges, implants, and dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Through age 18 and under		

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee may be less than what your dentist charges, which means that you will be responsible for the difference.*

The explanation and sample calculation of how these services will be paid can be found in Section VI – How Payment is Made in your Certificate.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per benefit year for people age 14 and under.
- Bitewing X-rays are payable twice per benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are payable on posterior teeth.
- Vestibuloplasty is a Covered Service.
- Full and partial dentures are payable once in any five-year period. Reline and rebase of dentures are payable once in any two-year period.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – $25 Deductible per person total per Benefit Year limited to a maximum Deductible of $75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following 30 days of employment.

Eligible People – All full-time employees of the Contractor working at least 30 hours per week who choose the dental plan: Active (0001), County Commissioners (0002), Pre 65 and Medicare Retirees (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099). The Contractor pays the full cost of this plan for Subscribers. The Subscriber pays the additional cost of dependent coverage.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an Enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (excluding COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the day that is defined by the Governmental Unit at the time of implementation.

Delta Dental – Monthly Rates

Delta Dental Rates	
Employee Only	$0.00 (Paid by Employer)
Employee + Spouse	$30.46
Employee + Children	$34.04
Family	$85.44

Get Started Today With Member Portal!

Member Portal gives you 24/7 access to important information about your dental benefits.

With Member Portal, you can: See which members are covered on your plan, now and in the future; Find an in-network dentist; See common procedures; Access an online ID card; View the status of all claims and toggle between different family member claims; View and print Explanation of Benefits (EOBs).

1. Visit www.memberportal.com
2. Log in using your existing Consumer Toolkit® credentials
3. If you do not have existing credentials, click "**Sign up**"

Complete the required fields and follow the on-screen instructions to register as a new user.

Questions? Call Toolkit Support at 866-356-0301

NOTE: You will need the subscriber's ID (the person whose name is on the benefit package). The member ID is an assigned number unique to the subscriber. In many cases, the member ID is the same as the subscriber's Social Security number.

Delta Dental Mobile App!

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.

Using the mobile app without logging in. Anyone can use the Delta Dental mobile app without logging in to search for a dentist near you, access our toothbrush timer, LifeSmile Score risk assessment and Cost Estimator.

Logging in to view benefits. Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental mobile app.

Stay In-Network and Save!

As a Delta Dental PPO plus Premier™ member, you may see any dentist you like. However, there are advantages to choosing a dentist who belongs to one of Delta Dental's two dentist networks.

Delta Dental PPO™ dentists

- No balance billing on covered services
- Most significant network discounts with more than 2,681 dentists in North Carolina[1]
- Dentists file claims for member

Delta Dental Premier® dentists

- No balance billing on covered services
- Significant network discounts with more than 3,705 dentists in North Carolina*[1]
- Dentists file claims for member

Out-of-network dentists

- May be balance billed
- No network discounts
- May need to file own claims

[1] Delta Dental of North Carolina internal data, 2021.

How it works—As shown below, your lowest out-of-pocket costs result from going to a Delta Dental PPO™ dentist.

Example savings for a crown by network	*Estimated charge*	*Maximum allowed fees*	*Percentage paid by Delta Dental*	*Amount Delta Dental pays*	*Amount dentist can balance bill*	*Total amount you pay*	*Your total cost savings*
Delta Dental PPO™	$1,500	$900	50%	$450	$0	$450	$600
Delta Dental Premier®	$1,500	$1,000	50%	$500	$0	$500	$500
Out-of-network	$1,500	$1,200	50%	$600	$300	$900	$0

Delta Dental PPO™ dentists	*Delta Dental Premier® dentists*	*Delta Dental PPO™ dentists*
Delta Dental PPO™ dentists have agreed to charge $900 for the $1,500 service, a savings of $600. Your Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $450 and you'll pay $450.	Delta Dental Premier dentists have agreed to charge $1,000—a savings of $500 compared to the fee the dentist usually charges. Assuming you've met your deductible, Delta Dental will cover 50 percent of that $1,000, paying $500. You'll also pay $500. That's an extra $50 tacked on to your share of the bill when compared to what you would have paid with a Delta Dental PPO™ dentist.	Out-of-network dentists have not agreed to charge lower fees and can bill the full $1,500. Delta Dental has set a limit on the accepted amount at $1,200, which means Delta Dental's share of the tab is $600. The dentist can bill you the difference between Delta Dental's payment and what they charge. This leaves you with a bill of $900, which includes the $300 the out-of-network dentist can "balance bill."

**This number is inclusive of the PPO network.*
NOTE: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.

Find a Delta Dental Participating Dentist

Your Delta Dental PPO plus Premier plan allows you to visit any dentist you like. However, there are advantages to choosing a dentist who belongs to one of Delta Dental's two dentist networks. You can save the most money and receive the highest levels of coverage when you visit a Delta Dental PPOTM dentist.

If you visit a dentist who does not participate in Delta Dental PPO, you can still save money if that dentist participates in Delta Dental Premier®. To find a participating dentist in your area, follow the simple steps below.

Step 1
Visit www.deltadentalnc.com.
Scroll down on the homepage to the "Find a Dentist" tool.
You may also go directly to www.deltadentalnc.com/findadentist.

Step 2
The Specialty menu defaults to any dentist. If you want to search for a specific specialty, select the specialty from the drop-down menu. Then, select the Your plan menu and choose the appropriate network option for you.

- **Delta Dental PPO**—all providers who participate in Delta Dental PPO.
- **Delta Dental Premier**—all providers who participate in Delta Dental Premier.
- **Delta Dental PPO plus Premier**—all providers who participate in both Delta Dental PPO and Delta Dental Premier.

The search will display results that fit your criteria, and whether or not those providers also participate in other networks.

Next, select Yes to search by current location or No to search by address or ZIP code. Choosing "Yes" may require you to change a location setting or you may need to go back and select "No" and manually enter your physical address if you receive an error message.

Select Find a Dentist to begin search.

Step 3
Your results will be displayed.

Optional: You can filter your search results by distance, number of results, dental specialty, languages spoken and gender. You can also search for a specific dentist by name or office name.

In addition to viewing your search results online, you can print or email your results, or view your results as a PDF under My list. To add dentists to your list, select the Add to my list or Add all to my list checkboxes. Once you have added results to your list, select the down arrow to save as a PDF, print or email your list.

Find Delta Dental participating dentists near you by using the search feature on our website at www.deltadentalnc.com/findadentist, or by calling Delta Dental toll-free at 800-662-8856.

Vision Plan

SuperiorVision By MetLife

Copayment: *$10 Exam*
$25 Materials[1]
$25 Contact Lens Fitting Fee (Standard & Specialty)

How to Use the Plan

Welcome to Superior Vision by MetLife vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologist, optometrists, and opticians. The plan also contract with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Visit www.metlife.com and scroll to '**How can we help you**' section and click '**Find a Vision Provider**'. Select '**Superior Vision by MetLife**' and enter your location and complete the form.

Remember that a routine eye exam in important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnose a variety of health issues - not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

Benefits	*Frequency*	*In-Network*	*Non-Network*
Comprehensive Exam (by an Ophthalmologist)	12 Months	Covered in Full	Up to $44.00
Comprehensive Exam (by a Optometrist)	12 Months	Covered in Full	Up to $39.00
Frames (Standard)	24 Months	$150.00 retail allowance	Up to $60.00
Contact Lens Fitting Standard[2] Specialty[2]	12 Months	Covered in Full $50.00 retail allowance	Not Covered Not Covered
Lenses (Standard) per pair Single Bifocal Trifocal Progressive lens upgrade Polycarbonate for dependent children	12 Months	Covered in Full Covered in Full Covered in Full See description[3] Covered in Full	Up to $26.00 Up to $34.00 Up to $50.00 Up to $50.00 Not Covered
Contact Lenses[4]	12 Months	$150 retail allowance	Up to $100.00

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements.
[1]Materials co-pay applies to lenses and frames only, not contact lenses
[2]See your benefits materials for definitions of standard and specialty contact lens fittings
[3]Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay.
[4]Contact lenses are in lieu of eyeglass lenses and frames benefit

Discounts on Covered Materials[1]	
Frames	20% off amount over allowance
Conventional Contacts	20% off amount over allowance
Disposable Contacts	10% off amount over allowance

These discounts apply to the glasses and contacts that are covered under the vision benefits.

Discounts on Non-Covered Exam & Materials[1]	
Exams, Frames, and prescription lenses	30% off retail
Contacts, miscellaneous options	20% off retail
Disposable	10% off retail
Retinal Imaging	$39 maximum member out-of-pocket

We offer discounts on unlimited materials after the initial benefit is utilized.

Lens Type*	Member out-of-pocket[1]
Scratch coat	$15
Ultraviolet coat	$12
Tints, solid	$15
Tints, gradients	$18
Polycarbonate	$40
Blue light filtering	$15
Digital single vision	$30
Progressives lenses • Standard | Premium | Ultra | Unlimited	$55 | $110 | $150 | $225
Anti-Reflective coating • Standard | Premium | Ultra | Unlimited	$50 | $70 | $85 | $120
Polarized lenses	$75
Plastic photochromic lenses	$80
High index (1.67|1.74)	$80|$120

**The above table highlights some of the most popular lens types and is not a complete listing. This table outlines member out-of-pocket costs[1] and are not available for premium/upgraded options unless otherwise noted.*

Laser Vision Correction (LASIK)[1]

A National LASIK Network of laser vision correction providers, featuring QualSight, offers Superior Vision members a discount on services. These discounts should be verified prior to service.

Hearing Discounts[1]

A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Superior Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

[1]Not all providers participate in Superior Vision Discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all Superior Vision providers/all locations.

Superior Vision Rates

Insured	Monthly Rates
Employee Only	$6.46
Employee + Spouse	$12.28
Employee + Child(ren)	$12.93
Employee + Family	$19.00

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for you vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.

STAY WELL

Voluntary Benefit options that enhance you and your family's well being.

Cancer Plan

Plan Features

- ✓ Donor Benefits
- ✓ Wellness Benefits
- ✓ Many Benefits have No Lifetime Maximum
- ✓ Covers certain Lodging & Transportation
- ✓ Portable (take it with you)
- ✓ In & Out of hospital benefits
- ✓ Pays regardless of other coverage

Benefit	Benefit Option
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, Hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	1. $0 2. $2,500 3. $0 4. $5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or .50¢ per mile if a personal vehicle is used
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging .50¢ per mile if a personal vehicle is used
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Up to $3,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	a. $200 b. Actual billed charges for round trip coach fare; or personal automobile expense of .50¢ per mile c. Actual billed charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay Incurred Expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	Up to 25% of surgical benefit paid. $100 max per covered person for skin cancer
Ambulatory Surgical Center. We will pay the actual billed charges at an Ambulatory Surgical Center. No Lifetime Maximum	$250 per day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	1 & 2: Incurred Expenses up to $2,500 per month 3 & 4: Incurred Expenses up to $5,000 per month

Benefit	Benefit Option
Miscellaneous Diagnostic Charges. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime max of $10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to $4,000 per month
Colony Stimulating Factors. We will pay incurred expenses for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Incurred Expenses up to $500 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	$35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	$100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if a Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non- Local Transportation Benefits of the policy.	Actual billed charges limited to a lifetime max up to $750 for evaluation. Actual billed charges limited to a lifetime max up to $350 for transportation & lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to $1,500 lifetime max per amputation
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	$35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	$300 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	$50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	$100 per day
New or Experimental Treatment. We will pay the actual billed charges by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	$50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day
Hairpiece. We will pay the actual billed charges per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual billed charges up to a lifetime max of $150
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 per day

Other Specified Diseases Covered:

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

Payment of Benefits

Benefits are payable for a Covered Person's Positive Diagnosis, subject to the Pre-Existing Condition Limitation, unless coverage replaces a prior plan of similar coverage that was in force when the Policy was issued.

Pre-Existing Condition Limitation

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

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

Exceptions & Other Limitations

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

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

Termination of Coverage

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

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

Portability

On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates. The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

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

Child (Children) means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

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

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

Hospital Intensive Care Confinement Benefit
You may choose the benefit of $325 (Option 2) or $625 (Option 4) per day. It is reduced by one-half at age 75.

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

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

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

Exceptions and Other Limitations

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

Group Cancer Rate Quote

Monthly Rates				
Coverage Tier	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Employee	$17.65	$23.38	$19.63	$30.89
Employee + Spouse	$35.57	$47.60	$39.44	$62.87
Employee + Child(ren)	$25.19	$33.20	$27.64	$43.36
Family	$43.10	$57.43	$47.45	$75.34

Variable Benefit Elections				
Benefit	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Hospital Confinement	$100	$100	$100	$100
Surgical	$3,000	$3,000	$3,000	$3,000
Radiation/ Chemotherapy	$2,500 per month	$2,500 per month	$5,000 per month	$5,000 per month
First Diagnosis	$0	$2,500	$0	$5,000
Colony Stimulating Factors	$500 per month	$500 per month	$500 per month	$500 per month
Wellness	$100	$100	$100	$100
Intensive Care Rider	$0	$325	$0	$625

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company. This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected. Upon receipt of your policy, please review it and your application. If any information is incorrect, please contact: Bay Bridge Administrators P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519

Group Accident Plan

Plan Features

- ✓ Pays you directly, so you can choose how to spend the money.
- ✓ Pays you for what happens, regardless of your other coverage.
- ✓ Goes with you if you leave your employer.
- ✓ Provides coverage without answering any medical questions.
- ✓ Gives you the option to cover your spouse and children.
- ✓ Pays an additional 25 percent benefit if your child, 18 or under, is injured playing organized sports.
- ✓ You pay the same premium for as long as you have your coverage.
- ✓ Provides the convenience of having your premium payments deducted directly from your paycheck.

How it Works

1. **You have an accident**. Your health insurance covers some costs, after you meet your deductible. But you still have copays and a lot of out-of-pocket expenses.
2. **We send you a check**. The Standard will send a check directly to you – not to your medical providers – upon approval of your claim. You decide how you spend the money.
3. **You focus on getting better**. With The Standard helping you handle the unexpected expenses, you get to pay attention to what matters most – your health.

Here's an Example

You're injured during your city league soccer game. An ER visit and scans reveal a concussion, broken leg, torn ACL and meniscus – requiring a 2 day hospital stay and surgery.

Here's what your plan would cover for this example:

Benefits Paid to You	*Benefit Amounts*
Emergency Room Visit	$500
X-ray	$300
Concussion	$500
Leg Fracture (Surgical)	$2,400
Knee Cartilage Repair	$750
Hospital Admission	$2,000
2 Days Hospital Confinement	$1,200
Medical Appliance	$500
Physician Follow-Up Appointment	$350
2 Physical Therapy Appointments	$350
TOTAL	**$9,200**

Here's What it Would Cost You

Coverage for	*Monthly Premiums*
You	$11.11
You and your spouse	$17.76
You and your children	$21.37
You, your spouse and your children	$33.37

Accident Insurance Includes 70+ Benefits for Covered Injuries & Treatment

This is only a partial listing of benefits offered. The specific benefit amounts you'd receive may vary. Please consult with your human resources representative or plan administrator for more details.

Injury	Emergency	Surgery
✓ Burns ✓ Dislocations ✓ Eye Injuries ✓ Concussion ✓ Loss of Hearing ✓ Lacerations ✓ Fractures ✓ Coma ✓ Paralysis	✓ Emergency Dental ✓ Urgent Care ✓ Ambulance ✓ Emergency Room ✓ X-ray ✓ Major Diagnostic Exam	✓ Abdominal/Thoracic Surgery ✓ Outpatient Surgical Facility ✓ Skin Grafts ✓ Knee Cartilage/Ligament/Tendon Repair ✓ Ruptured Disk ✓ Rotator Cuff

Hospitalization	Follow-Up Care	Value Added Benefits
✓ Hospital Admission ✓ Hospital Confinement ✓ CCU Confinement ✓ CCU Admission	✓ Chiropractor ✓ Medical Appliance ✓ Hearing Device ✓ Physical Therapy ✓ Physician Care ✓ Prosthesis ✓ Rehab Facility	✓ Transportation ✓ Lodging ✓ Youth Organized Sports Benefit

Additional Benefits

- **24-hour coverage** – includes coverage for accidents that occur on and off the job.
- **Accidental Death & Dismemberment** – Includes a benefit for an accidental death or covered dismemberment for you or your dependents.
- **Line of Duty Benefit** – Provides an additional benefit for public safety officers who suffer an accidental death or covered dismemberment or impairment while on the job.
- **Health Maintenance Screening Benefit** – Pays a $75 benefit once per calendar year when you or your dependents go to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram.

Portability

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates or your insurance ends because you no longer meet the eligibility requirements.

Eligibility Requirements

To be eligible for this coverage, you must be 18 years old or older, a regular employee (other than an Elected Official), actively working in the United States at least 20 hours per week and a citizen or resident of the United States. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

You can choose to cover your spouse, 18 years old or older, a person to whom you are legally married. You can also cover your children from birth through age 25. Your children cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

A minimum number of eligible employees must apply and qualify for the proposed plan before Accident insurance coverage can become effective.

Your Effective Date

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

Exclusions
Benefits are not payable if an accident is caused by or contributed to any of the following:

- War or any act of war
- Suicide while sane or insane
- Committing or attempting to commit an assault, felony or act of terrorism
- Active participation in a violent disorder or riot
- The voluntary use or consumption of any poison, chemical compound, drug or alcohol in excess of the legal limit in the state your accident occurred
- Sickness existing at the time of the accident, including any medical or surgical treatment or diagnostic procedure for a sickness
- Travel or flight in or on any aircraft, except as a fare paying passenger on a commercial aircraft
- Engaging in high-risk sports or activities such as (but not limited to) bungee jumping, parachuting, base jumping, mixed martial arts or mountain climbing
- Practicing for, or participating in, any semiprofessional or professional competitive athletic contests for which any type of compensation or remuneration is received
- Routine eye exams and dental procedures other than a crown or extraction for a tooth or teeth as a result of a covered accident
- Riding in or driving any automobile in a race, stunt show or speed test
- Cosmetic surgery or other procedure to improve appearance, unless it is necessary to correct a deformity or restore bodily function after a covered accident
- An accident that occurs while you or your dependent is incarcerated in a jail or penal or correctional institution

When Your Insurance Ends
Your insurance ends if you notify your employer or policyholder to terminate your coverage, you stop making premium payments, your employment terminates, you cease meeting the member definition or the group policy terminates.

Child and spouse insurance ends when your insurance ends, they cease to meet the definition of child or spouse, you stop making premium payments for child or spouse insurance, spouse or child insurance is no longer offered under the group policy or the group policy terminates.

Group Insurance Certificate
If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance. Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Group Hospital Indemnity Plan

Hospital Indemnity Insurance

Medical insurance is important. Especially when you have a hospital stay – planned or unplanned. But it can leave you with unexpected bills and out-of-pocket costs. Group Hospital Indemnity insurance can help cover unexpected out-of-pocket expenses such as copays, deductibles and out-of-network charges, as well as everyday living expenses. It pays a benefit directly to you for hospital stays, regardless of your treatment costs or other insurance coverage you might have.

How it Works

Even the best budgeters can forget to set aside money for medical expenses. Hospital Indemnity insurance provides a way to cover unexpected out-of-pocket expenses when you end up in the hospital. It also allows you to:

- ✓ **Choose how to spend your benefit.** It's your money — spend it however you want, whether it's to pay for your groceries, rent or medical bills.
- ✓ **Take it with you.** If you leave your job, you can take your coverage with you.
- ✓ **Receive a benefit for taking care of your health.** You can get a Health Maintenance Screening Benefit of $50 once a calendar year just for going to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram — that typically cost you nothing under your medical plan.
- ✓ **Get a break from paying premiums during long hospital stays.** If you are in the hospital for more than 30 days, you will be able to stop making premium payments until you're discharged.

Here's an Example

Kim is out of town on a business trip when she experiences abdominal pain and a racing heartbeat. Diagnosis: ruptured gastric ulcer. She is rushed to the hospital in an ambulance, admitted and taken into surgery. She ends up being hospitalized for 10 days, three of which are in a critical care unit. Kim's husband leaves their two kids with their daycare provider and flies to be at her side. The family now faces additional costs for travel and childcare. After Kim is discharged and returns home, she follows up with her healthcare provider.

Sample Out-of-Pocket Expenses	
Medical plan deductible/coinsurance	$3,000
Other non-medical expenses	$475
Travel expenses (flights, change fees, etc.)	$350
Childcare	$500
Total Expenses	**$4,325**

Benefits For:	
Ambulance trip	$300
Hospital admission	$1,500
Hospital confinement (10 days x $200 per day)	$2,000
CCU admission	$500
CCU confinement (3 days x $100 per day)	$300
Healthcare provider follow-up appointment	$25
Total Paid to You	**$4,625**
Net Out-of-Pocket Expenses	$300

Costs are hypothetical. Actual costs will vary by state, condition, treatments received and personal factors.

Affordable Group Monthly Rates

Because you'll be buying this insurance through your employer, you'll have access to affordable group rates. You'll also have the convenience of having your premiums deducted directly from your paycheck.

Coverage for:	
You	$31.51
You and your spouse	$52.51
You and your children	$44.96
You, your spouse and your children	$78.76

You'll receive $200 for each day you're hospitalized, up to a maximum of 30 days. And if you are confined for more than 30 days, your premium payment will be waived until the last day of the month of your hospitalization.

These are actual benefits each covered person could receive under a Hospital Indemnity plan:

Emergency Care Benefits	
Ambulance – Air (maximum 1 per calendar year)	$500
Ambulance – Ground (maximum 1 per calendar year)	$300
Emergency Room Visit (maximum 1 per calendar year)	$100
Urgent Care Visit (maximum 4 per calendar year)	$50

Hospital Benefits	
Hospital Admission[1] (maximum 1 per calendar year)	$1,500 per day
Daily Hospital Confinement[1] (maximum 30 days per stay)	$200 per day
Critical Care Unit Admission[1,2] (maximum 1 per calendar year)	$500 per day
Daily Critical Care Unit Confinement[1,2] (maximum 15 days per stay)	$100 per day
Daily Rehabilitation Facility (maximum 15 days per confinement)	$50 per day
Daily Skilled Nursing Facility (maximum 30 days per confinement)	$50 per day

[1] *Defined as a stay for at least 20 consecutive hours in a hospital setting.*
[2] *Payable in addition to the Hospital Admission and/or Daily Hospital Confinement benefit you may be eligible to receive.*

Inpatient Benefits	
Surgery (maximum 1 surgery per day up to 2 per calendar year)	$500
Surgical Anesthesia (maximum 2 days per calendar year)	25% of the Inpatient Surgery Benefit
Daily Mental Disorder (maximum 15 days per calendar year)	$50 per day
Daily Substance Abuse (maximum 15 days per calendar year)	$50 per day

Outpatient Benefits	
Healthcare Provider Follow-up (maximum 4 days per insured per calendar year, not to exceed 12 days per family per calendar year)	$25
Major Diagnostic Exam (maximum 4 days per insured per calendar year, not to exceed 12 days per family per calendar year)	$50
Hearing Device	$1,500 per lifetime
X-ray and Lab (maximum 1 per calendar year)	$50

Additional Benefits	
Waiver of Premium	Premium waived if you are confined to a hospital for more than 30 days
Health Maintenance Screening	$50 once per calendar year when visiting the doctor for a covered wellness screening

Portability

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates or your insurance ends because you no longer meet the eligibility requirements.

Eligibility Requirements

To be eligible for this coverage, you must be 18 years old or older, a regular employee of County of Harnett, actively working in the United States at least 20 hours per week and a citizen or resident of the United States. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

You can choose to cover your spouse, 18 years old or older, a person to whom you are legally married. You can also cover your children from birth through age 25. Your child cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

A minimum number of eligible employees must apply and qualify for the proposed plan before Hospital Indemnity insurance coverage can become effective.

Your Effective Date

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

Annual Open Enrollment

You may enroll for coverage for you and your dependents if you enroll within 31 days after becoming eligible. However, if you do not enroll during this period, you may do so during your employer's annual open enrollment period.

Waiver of Premium

Your insurance will continue without payment of premiums if you are confined in a hospital for more than 30 days in a row. We will waive payment of premium for your insurance from the 31st day of your confinement until the last day of the month you are in the hospital.

Exclusions

Benefits are not payable if an injury or sickness is caused or contributed to by any of the following:

- War or any act of war
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane
- Committing or attempting to commit an assault, felony or act of terrorism
- Active participation in a violent disorder or riot
- Alcoholism, drug abuse, misuse of alcohol or any other substance, the voluntary use or consumption of any drug or alcohol in excess of the legal limit in the state in which an injury occurred, or taking of drugs unless used or consumed according to the directions of a healthcare provider
- Travel or flight in or on any aircraft, except as a fare paying passenger on a commercial aircraft
- Cosmetic surgery or other procedure to improve appearance, unless it is necessary to correct a deformity or restore bodily function resulting from an injury or sickness
- Any injury or sickness which arises out of or in the course of you or your dependent being incarcerated in a jail, penal or correctional institution
- Dental care or dental procedures, unless treatment is the result of an injury
- Routine newborn nursing or well-baby care
- Hospital confinement of a newborn child following the child's birth unless the confinement is as a result of an injury or sickness
- Riding in or driving any automobile in a race, stunt show or speed test

Preexisting Condition Limitation

Preexisting conditions can affect your coverage if they occurred at any time during the 365-day period just before the date your or your dependent's insurance or an increase in insurance becomes effective. Preexisting conditions are defined as any of the following:

- A mental or physical condition (whether or not diagnosed) for which you or your dependent consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures including self administered procedures; or taken prescribed drugs or medications.
- You or your dependent's pregnancy
- A mental or physical condition that was discovered as a result of any medical examination, including a routine examination

No benefits or insurance increase will be paid if the sickness triggering a benefit or confinement is caused or contributed to by a preexisting condition or medical or surgical treatment of a preexisting condition, unless on the date the benefit would first become payable or a period of confinement begins:

- You or your dependent have been continuously insured under the group policy for 12 months
- You have been actively at work for at least one full day after the end of that 12 months.

Any confinements for the same or related sickness that are separated by not more than 30 days of non-confinement will be treated as one continuous period of confinement.

When Your Insurance Ends

Your insurance ends if you notify your employer or policyholder to terminate your coverage, you stop making premium payments, your employment terminates, you cease meeting the member definition or the group policy terminates.

Child and spouse insurance ends when your insurance ends, they cease to meet the definition of child or spouse, you stop making premium payments for child or spouse insurance, spouse or child insurance is no longer offered under the group policy or the group policy terminates.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance. Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Group Critical Illness Plan

An Extra Layer of Protection

Critical Illness insurance can make a big difference in your ability to pay out-of-pocket expenses associated with a serious illness. It pays a lump-sum benefit directly to you upon diagnosis of a covered illness, regardless of your treatment costs or what's covered by your medical insurance. Elect coverage in $5,000 increments between $5,000 and $30,000.

Plan Features

- ✓ **Update your coverage as needed**. As your life circumstances change, increase or decrease your coverage, in accordance with your employer's plan.
- ✓ **Lock in your rate**. For example, if you're 35 when your coverage becomes effective, you'll pay a 35-year-old's rate for as long as you have the coverage. If you increase your coverage amount at age 45, you will continue to pay a 35-year-old's rate for that increased coverage amount for so long as you have that increased coverage amount.
- ✓ **Take it with you**. If you leave your job, you can take your coverage with you.
- ✓ **Pick and choose how to spend your benefit**. Spend your lump-sum benefit however you want.
- ✓ **Protect your loved ones**. Cover your spouse up to $30,000, as long as it's not more than your benefit amount. Your kids are automatically covered at 50 percent of the amount elected for yourself for the same critical illnesses that you are. Kids are also covered for 21 additional childhood diseases, including cystic fibrosis, Down syndrome, muscular dystrophy, spina bifida and cerebral palsy.
- ✓ **Access a Health Advocate**. Additional services available through Health Advocate, include access to specialists for a second opinion upon approval of a covered claim.
- ✓ **Receive a benefit for taking care of your health**. You and your covered loved ones receive a Health Maintenance Screening benefit of $100 once per calendar year when visiting the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram — that typically cost you nothing under your medical insurance.
- ✓ **Receive additional benefits**. If you are diagnosed with a covered illness again after a treatment-free period of 12 months, you will receive 100 percent of the original benefit amount. If you are diagnosed with a different and subsequent covered illness at least 30 days after the diagnosis of the first critical illness, you will receive an additional Critical Illness insurance benefit.

Here's How it Works

John has $15,000 Critical Illness insurance coverage. He makes an appointment with his doctor after feeling off for the past few weeks. Diagnosis: cancer, with a good prognosis but a long road ahead. Within days of making a claim, John receives his Critical Illness insurance benefit paid directly to him. As John undergoes intensive treatment over the next few months, he can use the benefit for any purpose, including to pay for things that his medical insurance does not cover. Things like the deductible, copays, child care, certain medications, time away from work, alternative treatments and a special diet.

Here's what your plan would cover for this example:

Sample of Out-of-Pocket Expenses	
Medical insurance deductible	$1,300
Out-of-Pocket expenses over the course of six months	$5,000
Lost wages	$4,500
Alternative treatments & diets not covered by medical plan	$4,500
TOTAL OUT-OF-POCKET EXPENSES	**$15,300**
CRITICAL ILLNESS BENEFIT	**$15,000**
OUT-OF-POCKET EXPENSES	**$300**

Costs are hypothetical. Actual costs will vary by state, cancer type, stage at diagnosis, treatments received and personal factors.

Annual Open Enrollment

You may enroll for coverage for you and your spouse up to the maximum amount if you enroll within 31 days after becoming eligible. However, if you do not enroll during this period or want to increase your coverage up to the maximum amount, you may do so during your employer's annual open enrollment period.

Covered Conditions

Receive 100 percent of your coverage amount for:

- Heart attack
- Stroke
- Cancer
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational HIV
- Occupational hepatitis
- ALS (Lou Gehrig's disease)
- Advanced Alzheimer's disease
- Advanced Multiple sclerosis
- Advanced Parkinson's disease
- Benign brain tumor
- Bone marrow transplant
- Loss of hearing
- Loss of speech

Receive 25 percent of your coverage amount for:

- Severe coronary artery disease with recommendation for bypass surgery
- Carcinoma in situ (cancer that has not metastasized)

Diagnosis and recommendation must occur after your coverage becomes effective.

Affordable Group Rates

Because you'll be buying this insurance through your employer, you'll have access to affordable group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. Your rates will not increase as you grow older – meaning you'll have the same biweekly payment for as long as you have your coverage.

Coverage for	Coverage Amount
You	$5,000 - $30,000 in increments of $5,000
Your spouse	$5,000 - $30,000 in increments of $5,000, as long as it's not more than your coverage amount
Your child(ren) through age 25	Automatically covered at 50% of your coverage amount

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Premiums

Employee & Spouse Non-Tobacco Monthly Issue Age Premiums						
	Employee Age					
Coverage Amount	**18-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$5,000	$2.70	$4.05	$6.85	$10.90	$17.90	$30.90
$10,000	$5.40	$8.10	$13.70	$21.80	$35.80	$61.80
$15,000	$8.10	$12.15	$20.55	$32.70	$53.70	$92.70
$20,000	$10.80	$16.20	$27.40	$43.60	$71.60	$123.60
$25,000	$13.50	$20.25	$34.25	$54.50	$89.50	$154.50
$30,000	$16.20	$24.30	$41.10	$65.40	$107.40	$185.40

Employee & Spouse Tobacco Monthly Issue Age Premiums						
	Employee Age					
Coverage Amount	**18-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$5,000	$3.20	$5.50	$11.10	$20.50	$37.10	$60.75
$10,000	$6.40	$11.00	$22.20	$41.00	$74.20	$121.50
$15,000	$9.60	$16.50	$33.30	$61.50	$111.30	$182.25
$20,000	$12.80	$22.00	$44.40	$82.00	$148.40	$243.00
$25,000	$16.00	$27.50	$55.50	$102.50	$185.50	$303.75
$30,000	$19.20	$33.00	$66.60	$123.00	$222.60	$364.50

Spouse Monthly Issue Age Premiums – Based on Employee's Age and Non-Tobacco/Tobacco Status

Portability

This coverage is portable. That means that you may be able to continue your coverage through direct bill — at the same rate you would pay today — if your employment ends, the group policy terminates or your insurance ends because you no longer meet the eligibility requirements.

Eligibility Requirements

To be eligible for this coverage, you must be 18 years old or older, a regular employee (other than an Elected Official), actively working in the United States at least 20 hours per week and a citizen or resident of the United States. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible. You can choose to cover your spouse, 18 years old or older, a person to whom you are legally married. You can also cover your child(ren) from birth through age 25. Your child(ren) cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent. A minimum number of eligible employees must apply and qualify for the proposed plan before Critical Illness insurance coverage can become effective.

Your Effective Date

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance. If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

Family Status Change

In the event of a family status change, you and your spouse may enroll for coverage if you or your spouse enroll within 31 days of the change. Family status change include:

- Your marriage or divorce
- The birth of your child
- The adoption of a child
- The death of your dependent
- The commencement or termination of your spouse's employment
- A change in employment from full-time to part-time by your spouse
- A loss of critical illness insurance through your spouse's employment

Reoccurrence Benefit

If you or your dependents receive a benefit for a covered critical illness and are later diagnosed with the same critical illness, a one-time reoccurrence benefit will be paid if you or your dependents have:

- Been continuously insured under the group policy between the initial and subsequent diagnosis or recommendation
- Served a 3-month treatment-free period in connection with the critical illness during which you or your dependents did not:
    - Consult a physician or other licensed medical professional
    - Receive medical treatment, services or advice
    - Undergo diagnostic procedures, including self-administered procedures
    - Take prescribed drugs or medications

Exclusions

Benefits are not payable if a critical illness is caused or contributed to by any of the following:

- War or any act of war
- Attempted suicide while sane or insane
- Committing or attempting to commit an assault, felony or act of terrorism
- Active participation in a violent disorder or riot
- The voluntary use or consumption of any poison, chemical compound, drug or alcohol in excess of the legal limit in the state the critical illness occurred, unless used or consumed according to the directions of a physician
- Elective surgery or other procedure which:
    - Does not promote the proper function of your or your dependent's body or prevent or treat sickness or injury
    - Is directed at improving your or your dependent's appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or disfigurement

Note: This exclusion will not apply to a critical illness caused or contributed to by your or your dependent's donation of an organ or tissue.

When Your Insurance Ends

Your insurance ends if you notify your employer or policyholder to terminate your coverage, you stop making premium payments, your employment terminates, you cease meeting the member definition or the group policy terminates.

Child and spouse insurance ends when your insurance ends, they cease to meet the definition of child or spouse, you stop making premium payments for child or spouse insurance, spouse or child insurance is no longer offered under the group policy or the group policy terminates.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance. Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance. Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Short-Term Disability Plan

Class Description
All Eligible Employees working a minimum of 40 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

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

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $3,000. The minimum monthly benefit is $500.

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

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

Basis of Coverage
24 Hour Coverage, on or off the job.

Maternity Coverage
Maternity claims are standardly paid at 6 weeks for normal delivery and 8 weeks for c- section, minus the elimination period. If there are any complications with supporting medical documentation, benefits could be extended after review from the claims analyst. Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

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

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

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability.

You have 31 days from your date of termination to apply for portability by calling 800-553-5318. The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment

Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1,000 monthly benefit without medical questions. Employees may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group, the group policy will prevail.

AUL Short-Term Disability Monthly Rates – 13 Week Benefit Duration

Monthly Benefit	Monthly Premium
$500	$10.36
$600	$12.43
$700	$14.50
$800	$16.57
$900	$18.64
$1,000	$20.71
$1,100	$22.78
$1,200	$24.85
$1,300	$26.92
$1,400	$28.99
$1,500	$31.07
$1,600	$33.14
$1,700	$35.21
$1,800	$37.28
$1,900	$39.35
$2,000	$41.42
$2,100	$43.49
$2,200	$45.56
$2,300	$47.63
$2,400	$49.70
$2,500	$51.78
$2,600	$53.85
$2,700	$55.92
$2,800	$57.99
$2,900	$60.06
$3,000	$62.13

Customer Service: 800-553-5318 | Disability Claims: 855-517-6365 | Fax: 844-287-9499
Disability Claims Email: Disability.Claims@oneamerica.com | www.employeebenefits.aul.com

Long-Term Disability Plan

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

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

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

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

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

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

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

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

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

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

Pre-Existing Condition Exclusion

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

Continuity of Coverage will apply if the employee was insured under the employers' prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

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

Annual Enrollment

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

Exclusions and Limitations

This plan will not cover any disability resulting from certain events or conditions such as but not limited to war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. Additional exclusions and limitations may apply.

AUL Long-Term Disability Monthly Rates

Monthly Benefit Amount	Age 0 - 29	Age 30 - 39	Age 40 - 49	Age 50 - 59	Age 60 +
$500	$3.75	$6.25	$8.15	$22.00	$33.00
$1,000	$7.50	$12.50	$16.30	$44.00	$66.00
$1,500	$11.25	$18.75	$24.45	$66.00	$99.00
$2,000	$15.00	$25.00	$32.60	$88.00	$132.00

AMERICAN UNITED LIFE INSURANCE COMPANY®
a ONEAMERICA® company

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

Basic Term Life Plan

Basic Term Life and Accidental Death & Dismemberment (AD&D)
You want to make sure your family is taken care of, but you don't know what the future holds. If you pass away, Unum Life Insurance can help your family cover expenses, such as funeral costs, day-to-day expenses and bills.

Eligibility
All full-time employees working 30 hours or more per week.

Contributions
Employer pays 100% for the cost of coverage.

Employee Benefit Amount
1x annual salary to a maximum of $175,000 (rounded to the next higher $1,000).

Non-Medical Maximum
$175,000

Reduction Schedule
Reduces to 65% at the age of 65. Reduces to 50% at the age of 70.

Education Benefit
Pays an additional lump sum benefit, to each qualified child of a deceased insured employee (provided death occurs within 365 days of the accidental bodily injury), equal to the lesser of:

- 6% of the employee's AD&D benefit amount; or
- $6,000

Maximum Benefit Payments: 4 per lifetime
Maximum Benefit Amount: $24,000
Maximum Benefit Period: 6 years from the date of the first benefit payment

In order to qualify, a child must continue to be enrolled full-time in an accredited post-secondary institution of higher learning beyond the 12th grade level. If still at the 12th grade level, then the child must enroll in such an institution within 365 days of the employee's date of death.

Accelerated Death Benefit
Pays a portion of the insured employee's life benefit in the event the the insured employee becomes terminally ill, and the employee's life expectancy has been reduced to less than 12 months. The employee's death benefit will be reduced by the Accelerated Life Benefit paid.

Portability
Allows an insured employee to elect portable coverage, at group rates, if the employee terminates employment, reduces hours or retires from the employer.

Life Planning Financial & Legal Resources
This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Employee Assistance Program
A program that provides a variety of information and support services to employees and employers. Work-Life Balance Employee Assistance Program not only provides support around disabilities, but can also provide employees and employers with services and information that can help prevent disabilities.

Worldwide Emergency Travel Assistance Service
Delivers global travel assistance including medical and legal emergency support for employees and their families who travel for business or pleasure more than 100 miles from home.

Note: This is not a legal document. In case of any discrepancies or questions, the policy contract will be the final authority.

Voluntary Term Life Plan

Buy-Up Voluntary Term Life and Accidental Death & Dismemberment (AD&D)
You want to make sure your family is taken care of, but you don't know what the future holds. If you pass away, Unum Life Insurance can help your family cover expenses, such as funeral costs, day-to-day expenses and bills.

Eligibility
All full-time employees working 30 hours or more per week.

Contributions
Employee pays 100% for the cost of coverage.

Employee Benefit Amount
Options in $10,000 increments up to the lesser of $500,000 or 5x annual salary.

Spouse Benefit Amount
Options in $5,000 increments up to the lesser of 100% of the employee amount or $250,000.

Child Benefit Amount
Less than 14 days - $0
14 days to 6 months - $1,000
6 months to age 26 - $5,000 increments to the lesser of 100% of the employee amount or $10,000

Guaranteed Issue Amounts
Employee - $150,000 | Spouse - $30,000

Reduction Schedule
Reduces to 65% at the age of 70. Reduces to 50% at the age of 75.

Annual Enrollment Feature
If you are newly eligible for coverage you may elect coverage from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings with no health questions asked during your initial enrollment. If you previously purchased coverage, you can increase it up to 1 increment level, with no medical underwriting. If you previously declined coverage or wish to increase more than one level you may have to answer some more health questions.

Accelerated Death Benefit
Pays a portion of the insured employee's life benefit in the event the the insured employee becomes terminally ill, and the employee's life expectancy has been reduced to less than 12 months. The employee's death benefit will be reduced by the Accelerated Life Benefit paid.

Portability
Allows an insured employee to elect portable coverage, at group rates, if the employee terminates employment, reduces hours or retires from the employer.

Survivor Financial Counseling Services
Provides no-cost professional counseling related to estate planning, benefit elections, COBRA, income tax planning and educational needs for beneficiaries of deceased or terminally ill employees.

Employee Assistance Program
A program that provides a variety of information and support services to employees and employers. Work-Life Balance Employee Assistance Program not only provides support around disabilities, but can also provide employees and employers with services and information that can help prevent disabilities.

Worldwide Emergency Travel Assistance Service
Delivers global travel assistance including medical and legal emergency support for employees and their families who travel for business or pleasure more than 100 miles from home.

Note: This is not a legal document. In case of any discrepancies or questions, the policy contract will be the final authority.

Delayed Effective Date of Coverage:

- **Employee**: Coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.
- **Dependent**: Coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"*Totally disabled*" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition.

Employee & Spouse Voluntary Term Life Insurance Monthly Deductions															
Age of Employee	*$10,000*	*$20,000*	*$30,000*	*$40,000*	*$50,000*	*$60,000*	*$70,000*	*$80,000*	*$90,000*	*$100,000*	*$110,000*	*$120,000*	*$130,000*	*$140,000*	*$150,000*
15 - 34	$0.76	$1.52	$2.28	$3.04	$3.80	$4.56	$5.32	$6.08	$6.84	$7.91	$8.36	$9.12	$9.88	$10.64	$11.40
35 - 39	$1.14	$2.28	$3.42	$4.56	$5.70	$6.84	$7.98	$9.12	$10.26	$11.40	$12.54	$13.68	$14.82	$15.96	$17.10
40 - 44	$1.90	$3.80	$5.70	$7.91	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00	$20.90	$22.80	$24.70	$26.91	$28.50
45 - 49	$2.75	$5.50	$8.25	$11.00	$13.75	$16.50	$19.25	$22.00	$24.75	$27.50	$30.25	$33.00	$35.75	$38.50	$41.25
50 - 54	$4.65	$9.30	$13.95	$18.60	$23.25	$27.90	$32.55	$37.20	$41.85	$46.50	$51.15	$55.80	$91.45	$65.10	$89.75
55 - 59	$7.50	$15.00	$22.50	$30.00	$37.50	$45.00	$52.50	$60.00	$67.50	$75.00	$82.50	$90.00	$97.50	$105.00	$112.50
60 - 64	$11.78	$23.56	$35.34	$47.12	$58.90	$70.68	$82.46	$94.24	$106.02	$117.80	$129.58	$141.36	$153.14	$164.92	$176.70
65 - 69	$18.90	$37.80	$56.70	$75.60	$94.50	$113.40	$132.30	$151.20	$170.10	$189.00	$207.90	$226.80	$245.70	$264.60	$283.50
70 - 74	$29.45	$58.90	$88.35	$117.80	$147.25	$176.70	$206.15	$235.60	$265.05	$294.50	$323.95	$353.40	$382.85	$412.30	$441.75
75 +	$52.54	$105.08	$157.62	$210.16	$262.70	$315.24	$367.78	$420.32	$472.86	$525.40	$577.94	$630.48	$683.02	$735.56	$788.10

AD&D Benefit Amount															
All Ages	*$10,000*	*$20,000*	*$30,000*	*$40,000*	*$50,000*	*$60,000*	*$70,000*	*$80,000*	*$90,000*	*$100,000*	*$110,000*	*$120,000*	*$130,000*	*$140,000*	*$150,000*
	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00	$3.30	$3.60	$3.90	$4.20	$4.50

- Guarantee Issue: $150,000 for Employees and $30,000 for Spouse
- Rates change as employees age into higher age brackets.
- The employee's age determines the rate for both the employee and the spouse.
- The maximum amount of spouse coverage is the lesser of the employee's coverage amount of $250,000.
- The employee's age determines the age-benefit reduction for both the employee and the spouse.
- Employee and spouse coverage amounts reduce to 65% at age 65, to 50% at age 70, and terminate at retirement. Terminated coverage is portable.

Child Monthly Deductions		
Coverage Amount	$5,000	$10,000
Life Insurance	$0.95	$1.90
AD&D Benefit	$0.14	$0.27

- All eligible children are covered for one premium.
- An employee must elect at least $10,000 coverage in order for children to be eligible for any coverage.
- Children are eligible for coverage from birth to age 26, as long as they qualify as dependents of the employee.

This information has been prepared to give you the highlights of additional coverage now being offered by your Employer to meet your insurance needs. For details please ask your personnel office or refer to the certificate of insurance that you will receive after you have signed up for protection.

Whole Life Plan

Group Whole Life Insurance at a Glance

Our group whole life insurance provides smart, convenient protection that also helps you achieve your financial goals.

Consider The Advantages:

MassMutual@work Group Whole Life Insurance provides coverage at a set premium, builds cash value over time you can borrow from[1] and pays a death benefit to your loved ones. Group Whole Life Insurance may be easier and more affordable than you think.

Provides Guarantees

- ✓ Guaranteed death benefit
- ✓ Guaranteed level premiums
- ✓ Guaranteed cash-value accumulation
- ✓ ***Guaranteed Issue (GI) amounts of $100,000 for employees and $25,000 for child/grandchildren. No GI for spouse.***

Dividend Eligible[2]

MassMutual@work whole life certificate owners are eligible to receive dividends. During enrollment, you'll have the opportunity to select the dividend option that fits you best. Options include:

- Cash
- Dividend accumulations
- Paid-up additional insurance

Portable, Lifelong Coverage

You own the certificate along with the accumulated cash values and you can take it with you even if you leave the company. Additionally, if you leave the company and take your certificate with you, you can change your dividend option and choose to have your dividend payments reduce your premiums.

Tax Advantages

Whole life insurance policies offer a combination of valuable tax advantages, including:

- Generally income-tax-free death benefit
- Tax-deferred cash-value growth

Accelerated Death Benefit Provisions[3]

As the certificate owner, you can receive an advance, or acceleration, of a portion of the death benefit under your certificate, if the insured is diagnosed with a terminal illness or if the insured has a chronic illness that has been certified by a Qualified Medical Practitioner.

- **Terminal Illness:** In most states, the Accelerated Death Benefit for Terminal Illness is payable when the insured meets the definition of Terminally Ill, generally diagnosed with an illness that will result in death within 12 months (24 months in some states).
- **Chronic Illness**: The Accelerated Death Benefit for Chronic Illness is payable when the insured meets the definition of Chronic Illness, generally having a permanent loss of two activities of daily living (eating, toileting, transferring, bathing, dressing, and continence) due to loss of functional capacity, or requiring substantial supervision due to permanent severe cognitive impairment. In North Carolina and Washington, generally, Chronic Illness is any medical condition that requires continuous confinement in an Eligible Institution, where the Insured is expected to remain there for the rest of their life.

Waiver of Premium

The waiver of premium rider ensures that your life insurance protection will stay in place, and your cash value will continue to grow, if you, the insured, are totally disabled and may not be able to pay the premiums. This rider is attached to each certificate for employees age 18–60 and activates following a continuous six–month waiting period. When activated, the premium for the certificate and any riders included with the certificate will be waived for the duration of the insured's disability. It will terminate when the insured reaches the attained age of 67 (state variations may apply). This rider is attached to each certificate. Your employer has elected this rider and it has an additional cost. You can elect to cancel the rider at any time; once canceled it cannot be reinstated.

Whole Life Premiums

Sample rates are listed on the next page. Please refer to the Group Whole Life Insurance rate cards for full rate information. Visit https://mymarkiii.com/harnettcountync/policy-information/ to view the full set of rates or scan the QR code below.

[1] Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.
[2] Dividends are not guaranteed. The certificate is eligible to receive dividends beginning on the second anniversary.
[3] Except in Washington and North Carolina, the acceleration of the death benefit is intended to receive favorable tax treatment under §101(g) of the Internal Revenue Code. Accessing other similar benefits may cause the per diem limit to be exceeded. The insured must be chronically ill or terminally ill, as defined in 26 USC 7702B. Certificate owners should seek advice from a tax advisor prior to requesting a benefit payment. Receipt of accelerated death benefits may be taxable. For group policies issued in Washington or North Carolina, the Chronic Care Benefit defines a chronic illness in accordance with state insurance requirements, and may be taxable, as the state prescribed definition differs from the federal tax law definition.

These benefits are not long term care insurance and may be used for any purpose. In many cases, these benefits allow access to more funds than would be available through a certificate loan or certificate cash surrender value. There is a fee taken from the Chronic Care Benefit. Consult with your tax advisor regarding a request for accelerated benefits. Certificate owners who have exercised the Accelerated Death Benefit for Terminal Illness benefit cannot use the Chronic Care Benefit. However, the Terminal Illness Benefit will still be available on the remaining face amount after a Chronic Care Benefit payment has been made.

Accelerating the payment of your death benefit may affect your eligibility for public assistance programs, including MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI"). Contact the Medicaid Unit of the local Department of Public Welfare and the Social Security Administration Office for more information.

An acceleration of the death benefit will reduce the certificate's death benefit, any cash value and any loan values. The certificate's premium payments will be based on the reduced amount of insurance at the current rate. There is no premium required for either the chronic care or terminal illness benefits, however, there is a fee if the chronic care benefit provision is exercised. The fee for the Chronic Care Benefit is a present value adjustment shown as a percentage of the Eligible Amount for the Chronic Care Benefit The percentage depends on the Insured's age at the time the benefit is exercised: 18% for ages 45 and above; 27% for ages 44–35; 36% for under age 35. In the situs states of Kansas, Minnesota, North Carolina and Washington the term "fee" is replaced with "Actuarial Discount." For Montana, "fee" is replaced with "Reduction."

Please carefully read the accelerated death benefit disclosure provided at application. Restrictions and limitations will apply.

MassMutual

The information provided is not written or intended as specific tax or legal advice. MassMutual, its subsidiaries, employees and representatives are not authorized to give tax or legal advice. Individuals are encouraged to seek advice from their own tax or legal counsel.

MassMutual@WORK Group Whole Life Insurance Sample Monthly Rates

Sample rates are shown below. Rates are tobacco distinct and employee's will answer a yes or no question at the time of application to determine their rate. Rates are based on nonsmoker, unisex rates with Waiver. Rates will differ for tobacco users.

Issue Age	$10,000	$25,000	$50,000
18	$10.01	$18.43	$32.45
19	$10.12	$18.70	$33.00
20	$10.23	$18.98	$33.55
21	$10.34	$19.25	$34.10
22	$10.45	$19.53	$34.65
23	$10.56	$19.80	$35.20
24	$10.67	$20.08	$35.75
25	$10.78	$20.35	$36.30
26	$11.00	$20.90	$37.40
27	$11.44	$22.00	$39.60
28	$11.77	$22.83	$41.25
29	$12.10	$23.65	$42.90
30	$12.54	$24.75	$45.10
31	$12.98	$25.85	$47.30
32	$13.42	$26.95	$49.50
33	$13.97	$28.33	$52.25
34	$14.30	$29.15	$53.90
35	$14.41	$29.43	$54.45
36	$15.07	$31.08	$57.75
37	$15.95	$33.28	$62.15
38	$16.72	$35.20	$66.00
39	$17.49	$37.13	$69.85
40	$18.37	$39.33	$74.25
41	$19.14	$41.25	$78.10
42	$19.91	$43.18	$81.95
43	$20.79	$45.38	$86.35
44	$21.56	$47.30	$90.20
45	$21.67	$47.58	$90.75
46	$23.10	$51.15	$97.90
47	$24.53	$54.73	$105.05
48	$26.07	$58.58	$112.75
49	$27.61	$62.43	$120.45
50	$29.04	$66.00	$127.60
51	$30.58	$69.85	$135.30
52	$32.12	$73.70	$143.00
53	$33.55	$77.28	$150.15
54	$35.09	$81.13	$157.85
55	$35.20	$81.40	$158.40
56	$37.62	$87.45	$170.50
57	$40.15	$93.78	$183.15
58	$42.68	$100.10	$195.80
59	$45.21	$106.43	$208.45
60	$47.74	$112.75	$221.10
61	$45.70	$108.25	$212.50
62	$48.10	$114.25	$224.50
63	$50.40	$120.00	$236.00
64	$52.70	$125.75	$247.50
65	$52.80	$126.00	$248.00
66	$56.20	$134.50	$265.00
67	$60.90	$146.25	$288.50
68	$64.10	$154.25	$304.50
69	$69.10	$166.75	$329.50
70	$72.10	$174.25	$344.50
71	$75.20	$182.00	$360.00
72	$78.50	$190.25	$376.50
73	$82.10	$199.25	$394.50
74	$86.10	$209.25	$414.50
75	$90.60	$220.50	$437.00

Filing a Claim

Manhattan Life Group Cancer

Visit https://mymarkiii.com/harnettcountync/forms/ to download your claim form. Wellness Benefits can also be called into a Bay Bridge claim's examiner at (800) 845-7519. Please have the following information available: Claimant Name, Date of Service, Name of Service/Screening, Provider Name & Phone Number

The Standard Accident, Hospital Indemnity, & Critical Illness

Visit https://mymarkiii.com/harnettcountync/forms/ to download your claim form or visit https://login.standard.com/ to file a claim online. Mail or fax a copy of the itemized invoice or receipt imprinted with the provider's name and address along with the form to the contact information located on your claim form.

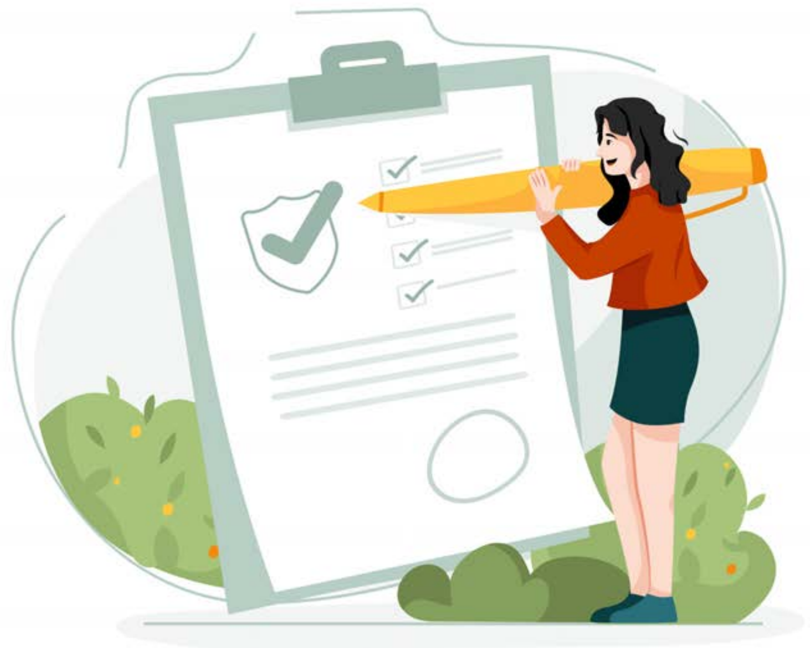
AUL Disability

Visit https://mymarkiii.com/harnettcountync/forms/ to download your claim form. Mail, fax, or email a copy of the itemized invoice or receipt imprinted with the provider's name and address along with the form to the contact information located on your claim form.

Employee Benefits Portal

Use your smartphone to scan the QR code or visit the link for quick access to your employee benefits portal page. Review your benefits guide online, download claim forms, access the online enrollment platform, and much more!

Visit: https://mymarkiii.com/harnettcountync/



Wellness Benefits

What is a Wellness Benefit?

Certain plans have a wellness feature built into your benefit options. This benefit gives ***money back to you*** for having a qualified screening test and then filing a claim for the screening test performed.

Qualified Screening Test*

- ✓ Hemoccult stool analysis
- ✓ Breast ultrasound
- ✓ Mammography
- ✓ CA 125 (blood test for ovarian cancer)
- ✓ CA 15-3 (blood test for breast cancer)
- ✓ CEA (blood test for colon cancer)
- ✓ Colonoscopy
- ✓ Pap smears
- ✓ Blood Screenings
- ✓ PSA (blood test for prostate cancer)
- ✓ Stress test (bicycle or treadmill)
- ✓ Electrocardiogram (EKG)
- ✓ Coronavirus Testing

***The list of screening test above is for illustrative purposes. Please see your plan provisions and limitations for a full list of qualified screening test.**

Get Paid by Staying Proactive!

- ✓ Manhattan Life Group Cancer Wellness Benefit Amount - **$100**
- ✓ The Standard Accident Wellness Amount - **$75**
- ✓ The Standard Hospital Indemnity Wellness Amount - **$50**
- ✓ The Standard Critical Illness Wellness Amount - **$100**

Download Your Wellness Claim(s)

Visit your employee benefits portal to download your wellness benefit claim form(s).

Link: https://mymarkiii.com/harnettcountync/forms/

Scan me!

FOR YOUR REFERENCE

Additional benefit information from your employer.

Employee Health & Wellness Clinic

Harnett County Health Clinic

All Harnett County employees and their dependents may use the Employee Health Clinic for sick visits, laboratory tests, and vaccines. *Most services are covered at no cost to you.**

Clinic Hours: Monday - Friday 8:00 AM - 11:00 AM and 1:00 PM - 4:00 PM

**The Employee clinic is closed during Harnett County observed holidays.*

Phone: Call 910-893-7550 for Appointments

Location: Harnett County Health Department | 307 W. Cornelius Harnett Blvd, Lillington, NC

Services Include:

- ✓ Sick visits
- ✓ Certain minor procedures such as stitches, wart removal, wound care, etc.
- ✓ Ordering imaging studies such as x-rays, ultrasounds as necessary
- ✓ Routine laboratory tests* (See below)
- ✓ Vaccines including Influenza(flu), COVID-19, Pneumonia, Tdap vaccine can prevent tetanus, diphtheria, and pertussis and others

Lab Tests Provided At No Cost Include:

- ✓ Complete blood count
- ✓ Lipid panel
- ✓ Hemoglobin Ale
- ✓ Vitamin D
- ✓ Basic metabolic panel
- ✓ Liver function panel
- ✓ PSA
- ✓ Urinalysis/ Culture & Sensitivity
- ✓ Glucose Thyroid panel
- ✓ Vitamin B12
- ✓ Flu and strep

**Other labs can be provided at the Clinic, but insurance will be billed by LabCorp.*

Lab results can be faxed to your primary care provider if a signed order is presented at the time of the blood draw. Otherwise, results will only be released to the patient.

On a Personal Note...

One of the top priorities here in Harnett County local Government is the well-being of our employees. Dealing with confusing and uncomfortable situations in our personal life happens to all of us from time to time. Confronting financial, marital, substance abuse, from difficult teenagers to aging parents, or an array of personal emotional difficulties can be very overwhelming and upsetting. Often times, we may prefer to talk with a neutral, third party who can listen and possibly present a different perspective regarding the situation or someone who could give you guidance in getting the best assistance available in a most confidential and respectful way.

If this is something you feel could be beneficial for yourself or those you love, it is time to tap into one of the most valuable resources offered to you by Harnett County. Our Employee Assistance Program (EAP) is readily available to help in providing counseling or referrals to provider resources in the area. The County has retained the services of Health Advocate to administer our program. They will confidentially assist you with a wide range of personal situations through 24 hour access via their website, phone consultations, face-to-face meetings, or educational materials.

We urge you to take advantage of this opportunity to get the guidance you need to reduce stress and assist you in regaining some level of normalcy in your life. Please refer to the following page for additional contact information.

Additionally, do not hesitate to contact your Human Resources Department if we can be of help at 910-893-7567.

Employee Assistance Program (EAP)

Help When You Need It

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

Always By Your Side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ - helps you save on medical bills

Who Is Covered?

Unum's EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Help Is Easy To Access:

✓ **Online/phone support**: Unlimited, confidential, 24/7.
✓ **In-person**: You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Employee Assistance Program - Work/Life Balance

- Toll-free 24/7 access: 1-800-854-1446 (multi-lingual)
- www.unum.com/lifebalance

**The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.*

Holiday Schedule

Holiday	*2024 Holiday Schedule*	*2025 Holiday Schedule*
New Years Day	Monday, January 1, 2024	Wednesday, January 1, 2025
Martin Luther King Day	Monday, January 15, 2024	Monday, January 20, 2025
Good Friday	Friday, March 29, 2024	Friday, April 18, 2025
Memorial Day	Monday, May 27, 2024	Monday, May 26, 2025
Independence Day	Thursday, July 4, 2024	Friday, July 4, 2025
Labor Day	Monday, September 2, 2024	Monday, September 1, 2025
Veterans Day	Monday, November 11, 2024	Tuesday, November 11, 2025
Thanksgiving	Thursday & Friday November 28 & 29, 2024	Thursday & Friday November 27 & 28, 2025
Christmas	Tuesday, Wednesday, & Thursday December 24, 25 & 26, 2024	Wednesday, Thursday, & Friday December 24, 25 & 26, 2025

Employee Policies & Notices

Please review the Harnett County Personnel Ordinances on the Harnett County website: www.harnett.org

Sick Leave

Employees working 40 hours per week shall earn 8 hours per month. EMS and Sheriff's Departments accumulate sick leave per shift hours. Sick leave may be used for: sickness, injury, medical or dental examinations or treatment, exposure to a contagious disease when presence at the worksite would jeopardize the health of others, or for the death in employee's immediate family (not to exceed 3 days). Immediate family includes wife, husband, mother, father, brother, sister, daughter, son, grandmother, grandfather, grandson, granddaughter, aunt, and uncle. Included are the step, half, in-law, loco parentis relationship, and those living within the same household. Sick leave may also be used when the employee's presence is required because of the illness or medical appointment of a spouse, child, parent, or parent-in-law. Requests for sick leave must be submitted to the immediate supervisor as far in advance as practical/possible, but not later than 2 hours after the start of the next scheduled workday. If an employee is incapacitated by illness and not able to report for work, they are responsible for personally contacting their immediate supervisor to request sick leave. This request must be made as soon as possible but not later than 2 hours after the start of the workday.

Shared Leave Policy

This program provides a means for employees to share vacation leave with employees who have exhausted all their sick and vacation leave because of a serious and prolonged medical condition. This program provides an opportunity for employees to help each other by establishing a method for donating earned time.

Employees may donate leave or apply to be a recipient in accordance with the procedures outlined in the Harnett County Personnel Ordinance.

Volunteer Leave

Regular employees are authorized 1 ½ hours of administrative leave each week to perform volunteer work at a Harnett County school or Harnett County non-profit organization (Ex: Food Pantry or Meals-on-Wheels) of their choice. This leave may be used in conjunction with other leave and lunch periods but may not be accumulated and/or carried forward to the next week. To utilize this form of leave an employee must receive advanced approval (at least 48 hours) and is subject to workload requirements. The Supervisor, Department Head or County Manager may require documentation of use of Volunteer Leave.

Parental Involvement Leave

In compliance with NC General Statute 95-28.3, leave for Parent Involvement in Schools, an employee who is a parent, guardian, or person in standing loco parentis of a school-aged child will be allowed to use four hours per year of administrative leave to attend or otherwise be involved at that child's school. Parent Involvement Leave must be approved by the employee's Supervisor at least 48 hours in advance. The Supervisor, Department Head or the County Manager may require documentation of use of the employee's school involvement. Example: An employee may use this leave to attend a parent teacher conference, or chaperon a school trip.

Vacation

Regular employees working the basic workweek or greater shall earn vacation leave at the following monthly rates:

Regular Employees		
Years Worked	**Hours Per Month**	**Days Per Year**
Less than 2	6.67	10
2 but less than 5	8.00	12
5 but less than 10	10.00	15
10 but less than 15	12.00	18
15 but less than 20	14.00	21
20 plus	16.00	24

EMT (24 Hour Shifts)		
Years Worked	**Hours Per Month**	**Hours Per Year**
Less than 2	8.87	106.40
2 but less than 5	10.64	127.68
5 but less than 10	13.30	159.60
10 but less than 15	15.96	191.52
15 but less than 20	18.62	223.44
20 plus	21.28	255.36

Deputies		
Years Worked	**Hours Per Month**	**Hours Per Year**
Less than 2	7.13	85.60
2 but less than 5	8.56	102.72
5 but less than 10	10.70	128.40
10 but less than 15	12.84	154.08
15 but less than 20	14.98	179.76
20 plus	17.12	205.44

During initial employment, probationary employees will not be permitted to take vacation unless denial of such leave will create an unusual hardship on the employee and may be taken only with the prior approval of the Department Head. Law Enforcement Officers shall be allowed to take accumulated vacation leave after 6 months of service. On June 15th any employee with more than 240 hours of accumulated leave shall have the excess amount transferred to sick leave. The remaining 240 hours of vacation time will transfer over beginning on July 1st. Also an employee who retires may roll all accrued vacation in excess of 240 hours into sick leave on their last day of employment regardless of the month in which they retire. Request for Leave will be submitted by the employee to their immediate supervisor as far in advance as practical and possible.

Petty Leave

Petty Leave can be used to attend to personal matters such as time lost reporting to work, medical appointments and absences due to adverse weather conditions.

All full-time County employees shall be allowed fourteen (14) hours per year of petty leave with pay beginning February 1st of each calendar year. If an employee is hired after January 1st, they will receive petty leave on a prorated basis. These fourteen (14) hours are over and above any other leave an employee may accrue while in the service of the County. Petty Leave, therefore, may be used in conjunction with any other type of leave, but may only be used in increments of fifteen (15) minutes up to a maximum of three (3) hours at one time.

Petty leave may only be taken with the approval of a Supervisor, Department Head, or County Manager and must be used before December 15th of each calendar year. After December 15th, any petty leave an employee may have will be terminated and will not roll over to the next year.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) of 1993 gives eligible employees unpaid leave for a period of up to 12 work weeks for any FMLA-qualifying event. In the event of an FMLA-qualifying event, the County is responsible for designating leave as FMLA leave and providing notices to the employee of such designation. If the employee has FMLA leave available and the reason for the leave qualifies under the FMLA, the employee is required to take FMLA leave. Employees are required to use all of their accrued leave before unpaid FMLA leave is granted.

When the necessity for leave is foreseeable, the employee must give the County at least 30 days advance notice of the need for leave. If the need for leave is not foreseeable, the employee needs to give the County as much notice as practical. Request for Family and Medical Leave forms will be provided by the department/division/office head. When Human Resources becomes aware that an employee is absent due to a serious health condition (or when the request involves the health condition of a family member), the department approves the employee provisionally under the FMLA. A final determination is made when the completed FMLA forms are received within 15 days.

Final approval of an FMLA leave request is contingent upon the Human Resources Department’s confirmation of eligibility.

Civil Leave

When a County employee is called for jury duty or as a court witness for the federal or state governments or a subdivision thereof, they shall receive leave with pay for such duty during the required absence without charge to accumulated vacation, sick or petty leave. While on civil leave, benefits and leave shall accrue as though the employee were on regular duty. An employee may keep fees and travel allowances received for jury or witness duty in addition to regular compensation, except that employees must turn over to the County any witness fees or travel allowances awarded by the Court for Court appearances in connection with official duties.

NC State Retirement

Harnett County employees are required to contribute to the NC State Retirement System at the rate of 6% of their salary until retirement, regardless of age. Contributions to the retirement system are tax-deferred. State law provides that the County as a participant in the North Carolina Local Governmental Employees Retirement System (NC LGERS) may shelter the contributions payable to the system by its employees who are members of the system. This provision enables eligible members to have state and federal income taxes o on their contributions to their retirement deferred until after retirement.

The ORBIT online system allows members to access their individual account information on demand. You can review your salary history and reported earnings, service credits, and dates of participation as an active member of the retirement system. There are support tools available such as the Benefit Calculator to assist you in calculation of your monthly benefit. The Member Benefits booklet, another benefit tool, provides guidance and increased understanding. Visit ORBIT and logon at www.nctreasurer.com.

NC 401(k) Plan & NC 457 Plan

Harnett County also contributes to the retirement fund. The County’s contributions are based on an actuarial calculation so that employee benefits can be provided on a sound basis. Your retirement program offers several options. These options are discussed more fully in your North Carolina State Retirement handbook.

Plan Name	*Type*	*Tax Advantage*
401(k)	Supplemental Retirement	Pre-Tax
457 Deferred Compensation Plan	Supplemental Retirement	Pre-Tax
Roth 401(k)	Supplemental Retirement	Post-Tax

Any employee interested in participating in any of the plans listed above should contact Human Resources for additional information.

Grandfathered Retirement Health Insurance Benefits

Full-time employees as of June 30, 2015 shall continue to be eligible to Harnett County Health Insurance Benefits on a pro-rated basis for years of service indicated below. The retiree must be a Harnett County employee at time of retirement to be eligible.

Group Health Plan for Retirees Under Age 65 and Not Medicare Eligible

Consecutive Years of Service for Eligibility	Percentage of Cost Paid by the County Until Age 65 or Medicare Eligible
30 Years – Harnett County Service	100%
29 Years – Harnett County Service	96%
28 Years – Harnett County Service	94%
27 Years – Harnett County Service	91%
26 Years – Harnett County Service	88%
25 Years – Harnett County Service	85%
24 Years – Harnett County Service	83%
23 Years – Harnett County Service	81%
22 Years – Harnett County Service	79%
21 Years – Harnett County Service	77%
20 Years – Harnett County Service	75%
19 Years – Harnett County Service	70%
18 Years – Harnett County Service	65%
17 Years – Harnett County Service	60%
16 Years – Harnett County Service	55%
15 Years – Harnett County Service	50%
30 Years – *Local Government Service	50%
(*Includes 10 Years of Harnett County Service)	

Medicare Supplement for Retirees Older than Age 65 and/or Medicare Eligible

Consecutive Years of Service for Eligibility	**Percentage of Cost Paid by the County
30 Years – Harnett County Service	100%
29 Years – Harnett County Service	96%
28 Years – Harnett County Service	94%
27 Years – Harnett County Service	91%
26 Years – Harnett County Service	88%
25 Years – Harnett County Service	85%
24 Years – Harnett County Service	83%
23 Years – Harnett County Service	81%
22 Years – Harnett County Service	79%
21 Years – Harnett County Service	77%
20 Years – Harnett County Service	75%
19 Years – Harnett County Service	70%
18 Years – Harnett County Service	65%
17 Years – Harnett County Service	60%
16 Years – Harnett County Service	55%
15 Years – Harnett County Service	50%

**Medicare Supplement standard amount to be determined by the Board of Commissioners.

Non-Grandfathered Retirement Health Insurance Benefits

Full-time employees hired on or after July 1st, 2015, or those employees who leave the employment of the County and return to work on or after July 1st, 2015, shall be eligible for Retirement Health Benefits on a pro-rated basis for years of service indicated below.

Group Health Plan for Retirees Under Age 65 and Not Medicare Eligible

Minimum Consecutive Years of Service for Harnett County	Percentage of Cost Paid by the County Until Age 65 or Medicare Eligible
20 Years	50%
25 Years	75%
30 Years	100%

Medicare Supplement for Retirees Older than Age 65 and/or Medicare Eligible

Minimum Consecutive Years of Service for Harnett County	**Percentage of Cost Paid by the County
20 Years	50%
25 Years	75%
30 Years	100%

**Medicare Supplement standard amount to be determined by the Board of Commissioners.

What To Do When An Injury Occurs

The following instructions are for reporting work-related injuries or illness. Please read the information carefully. Failure to follow these instructions could result in loss or a delay of Worker's Compensation benefits.

Notify your supervisor immediately (within 24 hours if possible).
Failure to inform your employer within 40 days after an injury or development of an occupational disease may deprive you of the right to compensation.

Complete "Employee's Report of Accident/Incident"
This should be filled as soon as possible following the injury/incident. Be as detailed as possible. Submit the completed form to your supervisor within 24 hours if possible.

If necessary, seek medical treatment.
For an **emergency**, your supervisor or any other employee on the scene will call 911 for medical assistance and transport to the nearest medical facility. For **non-emergencies**, you must obtain treatment from the listed Credentialed Network Provider below:

Primary Care:
Lillington Family Medical Center
7 East Duncan St
Lillington, N.C. 27546
910 893-2641

If for any reason other than a medical emergency, you are not able to treat with Lillington Family Medical Center, please contact the Risk Management and Safety Coordinator immediately.

Prescriptions
If you need to have a prescription filled, please go to your pharmacy to get it filled and then submit the receipt and prescription information to Human Resources for reimbursement. Please remember to report accidents immediately.

Please contact Harnett County Human Resources at 893-7567 with questions.

Harnett County Departments

Animal Services
PO Box 940 (Mail)
1100 McKay Place (Phys)
Lillington NC 27546
P: 814-2952 F: 814-0438

Board of Elections
PO Box 356 (Mail)
308 W Duncan St (Phys)
Lillington NC 27546
P: 893-7553 F: 893-4655

Clerk of Court
301 W. Cornelius Harnett Blvd. Suite 100
Lillington NC 27546
P: 814-4600 F: 814-4560

Cooperative Extension
126 Alexander Drive Suite 300
Lillington NC 27546
P: 893-7530 F: 893-7539

County Manager's Office/ Board of Commissioners
PO Box 759 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7555 F: 814-8300

Department on Aging
309 W Cornelius Harnett Blvd
Lillington NC 27546
P: 893-7578 F: 814-2564

Economic Development
615 Airport Road
Erwin, NC 28339
P: 893-7524 F: 814-8298

Engineering/Solid Waste
PO Box 2773 (Mail)
200 Alexander Dr (Phys)
Lillington NC 27546
P: 814-6156

Emergency Medical Services
PO Box 370 (Mail)
1005 Edward Brothers Dr (Phys)
Lillington NC 27546
P: 893-7563 F: 814-2570

Facilities Maintenance
PO Box 621 (Mail)
200 Alexander Dr (Phys)
Lillington NC 27546
P: 893-7538 F: 814-6263

Finance Office
PO Box 760 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7557 F: 893-3445

Fire Marshal/Emergency Mgmt.
PO Box 370 (Mail)
1005 Edwards Brothers Dr (Phys)
Lillington NC 27546
P: 893-7580 F: 893-5025

Fleet Maintenance
PO Box 621 (Mail)
1100 E McNeill St (Phys)
Lillington NC 27546
P: 893-7517

General Services
PO Box 940 (Mail)
200 Alexander Dr (Phys)
Lillington NC 27546
P: 893-7536 F: 814-8263

GIS/911/Land Records
305 W Cornelius Harnett Blvd Suite 100
Lillington NC 27546
P: 893-7523 F: 814-8251

HARTS (Transportation)
PO Box 85 (Mail)
250 Alexander Dr (Phys)
Lillington NC 27546
P: 814-4019 F:814-4020

Health Department
307 W. Cornelius Harnett Blvd
Lillington NC 27546
P: 893-7550 F: 893-9429 (Main)
F: 814-4060 (Admin)

Human Resources & Risk Mgmt.
PO Box 778 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7567 F: 814-0350 Information

Information Technology
PO Box 1405 (Mail)
420 McKinney Pkwy (Phys)
Lillington NC 27546
P: 814-6388 F: 814-8250

Jetport
PO Box 940 (Mail)
615 Airport Road (Phys)
Erwin NC 28339
P: 814-2740 F: 893-8263

Job Link/ Workforce Development
900 South 9th Street
Lillington NC 27546
P: 893-2191 F: 814-4046

Legal Services
PO Box 238 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 814-6009 F: 814-0350

Library
PO Box 1149 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-3446 F: 893-3001

Parks & Recreation
PO Box 816 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7518 F: 814-2662

Planning & Inspections / Central Permitting (Development Services)
PO Box 65 (Mail)
420 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7525 F: 814-6459

Public Utilities
PO Box 1119 (Mail)
700 McKinney Parkway (Phys)
Lillington NC 27546
P: 893-7575 F: 893-6643 or 814-4002

Register of Deeds
305 W. Cornelius Harnett Blvd Suite 200
Lillington NC 27546
P: 893-7540 F: 814-0009

Sheriff's Office
PO Box 399 (Mail)
175 Bain St (Phys)
Lillington NC 27546
P: 893-9111 F: 893-6450

Social Services
PO Box 2169 (Mail)
311 W. Cornelius Harnett Blvd. (Phys)
Lillington NC 27546
P: 893-7500 F: 893-6604

Soil & Water Conservation District
PO Box 267 (Mail)
126 Alexander Dr. Suite 200 (Phys)
Lillington NC 27546
P: 893-7584

Tax Department
305 W. Cornelius Harnett Blvd Suite 101
Lillington NC 27546
P: 893-7520 F: 814-4017

Veteran's Services
PO Box 232 (Mail)
455 McKinney Pkwy (Phys)
Lillington NC 27546
P: 893-7574 F: 814-4005

COBRA Benefits

Continuing Your Health, Dental, and Vison Coverage

Under certain circumstances, you may continue your health care coverage when it would otherwise end as provided under the Public Health Services Act (PHSA) and stipulated by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA contains a provision giving certain former employees, retirees, spouses, and/or dependent children the right to temporary continuation of health coverage at group rates.

Health coverage for COBRA participants is usually more expensive than health coverage for active employees for two reasons:

1. The County pays a part of active employees' insurance premiums, but does not pay any part of COBRA premiums.
2. COBRA rates include an extra 2% administration fee collected by the COBRA administrator.

COBRA continuation coverage is only available in specific instances. If you are an employee of Harnett Count Government and covered by the County's health, dental, or vision insurance, or have a Health Care Flexible Spending Account, you have a right to choose COBRA continuation coverage for yourself and/or your covered dependents if:

- You lose your coverage under the plan because of a reduction in your hours or employment.
- Your employment is terminated for reasons other than gross misconduct on your part.

Once notified of one of these events, the County's COBRA administrator will notify you that you have the right to choose continuation coverage. **You have 60 days from the date you receive the necessary election forms from the COBRA administrator to inform the administrator that you want continuation coverage.**

If you do not choose continuation coverage, your coverage under the County's plan will end. If you choose continuation coverage, you will receive coverage identical to the coverage currently provided by the County's. The law requires that you be given the opportunity to maintain coverage for up to 18 months due to loss of coverage resulting from a termination of employment or reduction in hours.

If you, or a dependent on continuation coverage, become disabled for purposes for Social Security during the first 60 days of continuation coverage, the affected individual qualifies for 29 months of continuation coverage. **The County must receive notification of the disability determination within 60 days (and before the expiration of the original 18 month period)** in order for the affected individual to qualify for this extension. **You must also notify the County within 30 days of any final determination that the individual is no longer disabled.**

Dependents

If you are the spouse of an employee covered by the Harnett County Health, Dental, or Vision plans, you have the right to choose continuation coverage, if you lose coverage under the plans for any of the following reasons:

- Death of your spouse
- Divorce or legal separation from your spouse
- Termination of your spouse's employment for reasons other than gross misconduct
- Reduction in your spouse's hours of employment
- Your spouse becomes eligible for Medicare and chooses Medicare as the primary payer

Covered dependent children of an employee have the right to continuation coverage, if coverage under the plans is lost for any of the following reasons:

- Death of parent employed by the County
- Parent's divorce or legal separation
- Termination of the parent's employment for reasons other than gross misconduct
- Reduction in parent's hours of employment
- Parent employed by the County becomes eligible for Medicare and chooses Medicare as the primary payer

Under the continuation coverage law, the employee or a family member is responsible for informing the County's Human Resources Department of a divorce, or a legal separation within 30 days after this event occurs. Once notified that one of these events has occurred, the County's COBRA Administrator will notify you that you have the right to choose continuation coverage. You have 60 days from the date you receive the necessary election forms form the County's COBRA administrator to inform the administrator that you want continuation coverage.

If you do not choose continuation coverage, your coverage under the plan will end. If you choose continuation coverage, you will receive coverage identical to the coverage currently provided under the plan. The law requires that you be given the opportunity to maintain coverage for between 18 and 36 months, as applicable.

If you have any questions about COBRA, please contact the County's COBRA administrator:

P & A Group
17 Court Street, Suite 500 Buffalo, NY 14202
Phone: 800-688-2611
Website: www.padmin.com

Notice of Privacy Practices

Harnett County is committed to maintaining and protecting the confidentiality of our employees' personal information. This Notice of Privacy Practices applies to the County's employee benefit plans (the Plans) covered by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact Human Resources at 910-893-7567.

Harnett County Human Resources
Janice Lane
PO Box 778
Lillington, NC 27546
Phone: 910-893-7567

OUR OBLIGATIONS:
We are required by law to:
- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Harnett County Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Harnett County Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Harnett County Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Harnett County Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Harnett County Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.harnett.org (Click on the Human Resources & Risk Management Department page then click on Employee Benefits Information and Forms). To obtain a paper copy of this notice, contact Human Resources.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Harnett County Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

You may contact our office at:

Harnett County Human Resources
Janice Lane
PO Box 778
Lillington, NC 27546
Phone: 910-893-7567

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

Continuation of Benefits

If You Leave Employment

Medical, Dental, Vision, & Flexible Spending Account

Under the Medical, Dental, Vision, and Flexible Spending Account plan(s) you and your covered dependents are eligible to continue coverage through COBRA according to the following "qualifying events". If you and your dependents are enrolled in the plan(s), you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan(s), if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue coverage through COBRA. Also, while you are covered under the plan(s), your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. You will receive notification with premium and continuation options shortly following your termination of employment or you may call your COBRA administrator **P&A Group at 1-800-688-2611.**

Manhattan Life Group Cancer

When you leave employment, you may continue your cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For more information, contact **Bay Bridge Administrators, LLC (TPA) at 1-800-845-7519.**

AUL Short & Long-Term Disability

Once an employee is on the AUL disability plan(s) for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to port your coverage. For more information, contact **AUL at 1-800-553-5318.**

MassMutual Whole Life

When you leave employment, you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address. To set up direct bill to your home address, contact **MassMutual at 1-800-272-2216.**

The Standard Accident, Hospital Indemnity, and/or Critical Illness

When you leave employment, you may continue your Accident, Hospital Indemnity, and/or Critical Illness coverage by having the premiums that are currently deducted from your paycheck billed to your home address. To set up direct bill to your home address, contact **The Standard at 1-866-851-2429.**

Unum Voluntary Term Life

If you terminate employment, the portability provision allows you to take employee only voluntary life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be ACTIVELY at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information on how to convert your coverage, please contact **Unum at 1-800-421-0344.**

Contact Information

American United Life (AUL)
Claims: 1-855-517-6365
Customer Service: 1-800-553-5318
www.oneamerica.com

BlueCross BlueShield of NC
Customer Service: 1-877-275-9787
www.bcbsnc.com

Delta Dental
Customer Service: 1-800-662-8856
www.deltadentalnc.com

Employee Health Clinic
Phone: 910-893-7550
www.harnett.org

Manhattan Life Insurance Company
Bay Bridge Administrators, LLC
Phone: 1-800-845-7519 | Fax: 512-275-9350
www.bbadmin.com

Mark III Employee Benefits
Phone: 704-365-4280
Toll-Free: 1-800-532-1044
www.markiiieb.com

MassMutual Life Insurance
Phone: 1-800-272-2216
www.massmutual.com

North Carolina Retirement System
Phone: 877-627-3287
www.myncretirement.com

P&A Group (COBRA & FSA)
Customer Service: 1-800-688-2611
www.padmin.com

Superior Vision by MetLife
Phone: 1-833-393-5433
www.mybenefits.metlife.com

The Standard Insurance Company
Phone: 1-800-378-4668
www.standard.com

Unum Life
Contact HR about benefits and filing claims.
Status of Disability Claim: 1-800-633-7479
Other Questions: 1-800-421-0344
www.unum.com

NC 401(k) Plan & NC 457 Plan
Phone: 866-627-5267
www.myncplans.com

View additional benefits information
or download forms at: mymarkiii.com

Arranged and Enrolled by Mark III Brokerage, Inc.

211 Greenwich Road
Charlotte, NC 28211

(800) 532-1044
(704) 365-4280