2019
EMPLOYEE BENEFITS PLAN

January 1, 2019 to December 31, 2019

City of Greenville and Greenville Utilities
Consolidated Employee Benefits Program

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The City of Greenville and Greenville Utilities are dedicated to providing all citizens with high quality services, thereby enhancing the quality of life for those we serve. This is made possible through the exceptional service of all of you, our valued employees.

The Human Resources teams of the City of Greenville and Greenville Utilities have worked diligently to put together a NEW progressive and comprehensive benefits package for employees. It is our hope that these benefits will enhance your quality of life and show our gratitude for your service to our community.

This enrollment booklet is intended to help you better understand the benefits that are available to you and your eligible dependents. We encourage you to carefully review all of the materials within this benefits booklet which outline the details of your 2019 benefits package.

For additional details or specific questions, please contact your respective benefits representative.

Thanks for all you do to make the City of Greenville and Greenville Utilities Commission a great place to work and serve.

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City of Greenville & Greenville Utilities

are offering all eligible employees a comprehensive benefits plan.

- This is neither an insurance contract nor a summary plan description and only the actual policy provisions will prevail.
- All information in this booklet, including premiums, is subject to change.
- All policy descriptions are for information purposes only.

New hires must enroll within 30 days of hire to qualify for guarantee issue.

Contact: **kphelps@greenvillenc.gov**

Contact: **herrinlr@guc.com**

Your Benefits Coverage

Eligibility Information

You are eligible for medical and dental benefits if you are a full-time employee or a designated part-time employee working a minimum of 30 hours per week. You may also enroll your eligible dependents for medical and dental coverage. Eligible retirees may also enroll in medical benefits. Part-time, temporary, or seasonal employees are not eligible to receive benefits.

Making Changes During the Year

Generally, you can only change your benefit elections during the annual benefits Open Enrollment period unless you experience a Qualified Life Event (QLE) listed below.

- Marriage, divorce, legal separation, or annulment
- Death of your spouse or dependent child
- Birth or adoption of a child
- Your dependent gains or loses benefits eligibility
- Taking or returning from an eligible leave of absence
- A change in work schedule or status that causes you to gain or lose benefits eligibility

You must notify Human Resources within 30 days of any QLE change or wait until the next enrollment period to make benefit changes. Proof of the change will be required (example: marriage license, birth/death certificate, legal decree, adoption papers). Any changes you make to your benefit choices must be directly related to the Qualified Life Event.

Use Your Medical Benefits to Stay Healthy

There's nothing more valuable than your good health. The City of Greenville/Greenville Utilities Commission's Medical Benefits encourage you to access quality services – in sickness and in health. You can choose from the following plans:

- Cigna Open Access Plus Core Plan
- Cigna Open Access Plus Enhanced Plan
- Cigna Health Savings Account Plan

All medical plans include the vision plan. Participants in a medical plan have the right to opt out of vision coverage upon request; however, there is no change to your payroll deduction. If for any reason you would like to opt out of the vision plan, please contact HR.

Summary of Upcoming Changes for 2019

With the goal of containing costs while minimizing design changes and maintaining the current health insurance plan choices, the City of Greenville and Greenville Utilities Commission have made the following change for 2019:

- Minor premium increases to the medical and dental plans

Reminders

- In addition to our home delivery program, you may also fill a 90-day prescription for maintenance medications at select in-network pharmacies with any of the three medical plans (subject to applicable copays or coinsurance).
- You have access to **Cigna Telehealth Connection Services**, a convenient and affordable alternative to visiting your physician in person for non-urgent care. You continue to have 24/7/365 access to a network of quality licensed, board-certified, U.S.-based physicians via phone or video conference.

Comparing Plans

All the plans offer choice and convenience, as well as access to Cigna's broad national provider network. Other similarities include flexible, high-quality, easy-to-use programs. Some differences between the plans include:

- **HSA Plan:** Your contribution deducted from your paycheck is significantly less than the Enhanced and Core Plans, but the deductible is higher. (See Pg. 5 & 6 for more details)
- **Core Plan:** Your contribution deducted from your paycheck is less than the Enhanced Plan, but the deductible and out-of-pocket maximums are higher. (See Pg. 6 for more details)
- **Enhanced Plan:** Your contribution deducted from your paycheck is more than the Core and HSA Plans, but deductibles and out-of-pocket maximums are less. (See Pg. 7 for more details)

More Information

Please see HR for additional information about the benefits described in this guide. For questions regarding your medical, prescription drug, dental, or vision benefits with Cigna, contact Cigna Member Services at 1 (800) 244-6224, or online at **www.mycigna.com**.

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Your Medical Benefit Choices

Health Savings Account (HSA)

An HSA gives you more control over how you spend and save your health care dollars. It consists of two parts:

1) HDHP: A traditional PPO medical plan with a higher deductible and lower monthly premiums. The HDHP with HSA Plan will cover the same medical services as our other plans.

2) HSA: Your personal Health Savings Account, which allows you to contribute money each paycheck on a pre-tax basis to use for eligible health care expenses.

Highlights of the HSA Plan include:

- **Health Savings Account (HSA):** When you sign up for the HDHP, you can enroll in an HSA. With an HSA, you can use pre-tax funds for health care expenses or save money in your HSA for future expenses.
- **Provider choice.** You can go to any provider you choose.
- **Network savings.** When you use network providers, you save money and don't need to file claim forms or get referrals.
- **Employer contribution.** If you elect the HSA plan, COG/GUC will contribute $500 (individual) or $1,000 (family) into your HSA to help pay for the deductible.
- **2019 bonus.** As an added incentive to elect the HSA plan, COG/GUC will give a bonus of $250 (individual) or $500 (family) into your HSA, if you enroll in the HSA for the first time. This is in addition to the employer contribution listed above.
- **Annual contribution limits.** You are able to contribute up to **$3,500** (individual) and **$7,000** (family) into your HSA each year. These limits include any contributions COG/GUC make as well as any additional contributions you make as an employee.
- **Catch-up contributions.** The IRS allows employees age 55 to 65 to contribute an additional $1,000 each year above the annual contribution limits listed above. The "catch-up" contribution may be made anytime during the year in which you turn age 55.
- **Triple tax advantage.** Contributions are made pre-tax, any interest earned on the account is not taxed, and funds are tax-free when withdrawn from an HSA to pay for qualified medical expenses.
- **Account portability.** All money in the account is yours. Even if you retire or leave COG/GUC, the funds are yours to keep.
- **Funds roll over from year to year.** Unlike a Flexible Spending Account, you don't need to use up all the funds each year. You can keep the unused dollars from one year to the next.
- **Limited Purpose FSA eligibility.** To be used only for qualified dental and/or vision expenses in addition to the HSA.
- **Preventive drug coverage.** Certain generic and preferred brand preventive medications are available at absolutely no cost to you at an in-network retail pharmacy or through mail order. For a list of these specific medications, please contact HR. All other medications will be subject to both the deductible and coinsurance until the annual out-of-pocket maximum is met.

For a detailed list of HSA-qualified expenses, please see IRS publication 502, Medical and Dental Expenses. A copy of the publication can be found at **www.irs.gov**. Select "Search Forms & Instructions," then select "List All Current Forms & Instructions."

HSA Eligibility

Setting up the actual HSA to accompany your HDHP medical plan is an individual decision. If you decide the account is for you, you will first want to ensure you meet the IRS eligibility requirements, including:

- You must be enrolled in a qualifying high deductible health plan (HDHP) (only our HSA Plan qualifies).
- You cannot be enrolled in any other health plan that is not an HDHP (e.g. our Core or Enhanced plans or a spouse's plan).
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.
- You cannot have TriCare.
- You cannot have received non-service-related VA benefits in the last 90 days.

Out-of-Pocket Maximum Protects You Financially

Regardless of the plan you choose, the out-of-pocket maximum limits the amount you have to pay out of your own pocket each calendar year for covered medical expenses. Your out-of-pocket maximum includes your plan's deductible, coinsurance, and copays. Remember, once you meet your out-of-pocket maximum, the plan will pay 100% of any covered expenses for the remainder of the plan year. With the out-of-pocket maximum, you and your family are protected from financial hardship if you have significant medical expenses during any one year.

If You Do Not Enroll

All employees who do not make an election during the Open Enrollment period will have to wait until the next annual Open Enrollment period unless they experience a Qualified Life Event.

When Coverage Ends

All benefits end the last day of the month in which your employment ends. However, under certain circumstances, you may continue your medical and dental benefits coverage through COBRA.

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Your Medical Benefit Choices

HSA, Core, & Enhanced Plans

The table below shows your benefits for common medical services and prescription drugs. The amounts and percentages shown are what you pay. This is not a complete list of benefits. Please see your Summary Plan Description (SPD) for more information.

Coverage	HSA Plan		Core Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible • Individual • Family	$1,500 $3,000	$3,000 $6,000	$750 $1,500	$1,500 $3,000
Out-of-Pocket Maximum • Individual • Family	$3,000 $6,000	$6,000 $12,000	$3,500 $7,000	$7,000 $14,000
Coinsurance	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physician's Services in Office • Primary Care Physician (PCP) • Specialists • Surgery	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible	$20 copay per office visit $40 copay per office visit Subject to office visit copay	40% after deductible 40% after deductible 40% after deductible
Telehealth Visit	20% after deductible	In-Network coverage only	$20 copay per visit	In-Network coverage only
Emergency/Urgent Care Services • Emergency room • Urgent care facility • Ambulance	20% after deductible 20% after deductible 20% after deductible	20% after deductible 20% after deductible 20% after deductible	$150 copay if not admitted, then 20%[1] $35 copay, then 20%[1] 20% after deductible	$150 copay if not admitted, then 20%[1] $35 copay, then 20%[1] 20% after deductible[2]
Preventive Care[3]	Covered at 100%	In-Network coverage only	Covered at 100%	In-Network coverage only
Diagnostics[4]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Maternity Care • Initial office visit to confirm pregnancy • All subsequent prenatal visits, postnatal visits, and physician's delivery charges • Inpatient hospital/birthing center charges	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible	$20 PCP/$40 Specialist 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
Laboratory and Radiology Services • Physician's office • Outpatient hospital, independent X-ray, and/or lab facilities	20% after deductible 20% after deductible	40% after deductible 40% after deductible	No charge after PCP or Specialist copay 20% after deductible	40% after deductible 40% after deductible
Advanced Radiology Services (MRIs, MRAs, CAT/PET scans, etc.) • Physician's office • Outpatient facility • Inpatient facility	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible	Covered at 100% 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
Hospital Coverage • Facility services (Inpatient/Outpatient) • Professional services (Inpatient/Outpatient)	20% after deductible 20% after deductible	40% after deductible 40% after deductible	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Mental Health/Substance Abuse • Inpatient • Outpatient	20% after deductible 20% after deductible	40% after deductible 40% after deductible	20% after deductible $20 copay	40% after deductible 40% after deductible
Short-Term Rehabilitation Therapies/ Chiropractic Care[5]	20% after deductible	40% after deductible	$20 PCP/$40 Specialist	40% after deductible
HSA Employer Funding • Individual/Family	$500/$1,000		N/A	
HSA Year-One Employer Funding • Individual/Family	$250/$500		N/A	
Prescription Drug Benefits • Retail (30-day supply) Generic | Preferred | Nonpreferred • Retail (90-day supply)[6] Generic | Preferred | Nonpreferred • Mail-Order (90-day supply) Generic | Preferred | Nonpreferred • Specialty	20% after deductible[7] 20% after deductible[7] 20% after deductible[7] 20% after deductible[7]	40% after deductible In-Network coverage only In-Network coverage only In-Network coverage only	$10 | $30 | $50 $20 | $60 | $100 Free ($0) | $60 | $80 $100	40% In-Network coverage only In-Network coverage only In-Network coverage only
Vision Benefits • Annual examination copay • Materials copay • Single vision lenses • Bifocal | Trifocal | Lenticular Lenses • Elective contact lenses • Therapeutic contact lenses • Frames (every 24 months)	$15 $30 $0 $0 $100 allowance $0 $100 allowance	In-Network coverage only In-Network coverage only $32 allowance Allowance: $55 | $65 | $80 $87 allowance $210 allowance $55 allowance	$15 $30 $0 $0 $100 allowance $0 $100 allowance	In-Network coverage only In-Network coverage only $32 allowance Allowance: $55 | $65 | $80 $87 allowance $210 allowance $55 allowance

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Enhanced Plan	
In-Network	Out-of-Network
Unlimited	Unlimited
$600 $1,200	$1,200 $2,400
$2,500 $5,000	$5,000 $10,000
20% after deductible	40% after deductible
$20 copay per office visit $40 copay per office visit Subject to office visit copay	40% after deductible 40% after deductible 40% after deductible
$20 copay per visit	In-Network coverage only
$150 copay if not admitted, then 20%[1] $35 copay, then 20%[1] 20% after deductible	$150 copay if not admitted, then 20%[1] $35 copay[2], then 20%[1] 20% after deductible
Covered at 100%	In-Network coverage only
20% after deductible	40% after deductible
$20 PCP/$40 Specialist 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
No charge after PCP or Specialist copay 20% after deductible	40% after deductible 40% after deductible
Covered at 100% 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
20% after deductible 20% after deductible	40% after deductible 40% after deductible
20% after deductible $20 copay	40% after deductible 40% after deductible
$20 PCP/$40 Specialist	40% after deductible
N/A	
N/A	
$10 | $30 | $50 $20 | $60 | $100 $0 | $60 | $100 $100	40% In-Network coverage only In-Network coverage only In-Network coverage only
$15 $30 $0 $0 $100 allowance $0 $100 allowance	In-Network coverage only In-Network coverage only $32 allowance Allowance: $55 | $65 | $80 $87 allowance $210 allowance $55 allowance

2019 Employee Medical Cost (bi-weekly)	Annual Salary			
	<$32,278	$32,278-$46,951	$46,952-$61,623	>$61,623
HSA				
• Employee Only	$6.34	$7.53	$8.72	$9.90
• Employee + Spouse	$53.23	$63.20	$73.19	$83.18
• Employee + Child(ren)	$51.97	$61.71	$71.46	$81.18
• Family	$75.99	$90.26	$104.50	$118.76
CORE				
• Employee Only	$19.60	$21.51	$25.46	$29.39
• Employee + Spouse	$82.29	$90.33	$106.90	$123.44
• Employee + Child(ren)	$80.35	$88.18	$104.36	$120.52
• Family	$117.50	$128.97	$152.61	$176.24
ENHANCED				
• Employee Only	$35.65	$38.01	$42.87	$47.72
• Employee + Spouse	$149.73	$159.63	$180.03	$200.42
• Employee + Child(ren)	$146.16	$155.80	$175.75	$195.66
• Family	$213.80	$227.91	$257.04	$286.17

2019 Retiree Medical Cost (monthly)

CORE	
• Employee Only	$33.73
• Employee + Spouse	$775.80
• Employee + Child(ren)	$742.07
• Family	$1,381.72
ENHANCED	
• Employee Only	$77.15
• Employee + Spouse	$866.91
• Employee + Child(ren)	$831.02
• Family	$1,511.83

Prescription Plan

To encourage our employees to try lower-cost, alternative prescriptions, we have asked Cigna to implement the following:

1 – "Dispense as Written" (DAW)

This means a pharmacist will dispense a prescription exactly as written by your doctor. If you choose to alter what was prescribed, you will pay the full cost difference.

Here's an example: Joe's doctor prescribed a generic medication to him, but he prefers the brand-name. He is trying to decide between the $80 brand-name medication and its $35 generic equivalent. His plan has a $10 copay for a 30-day supply of generic medications and a $20 copay for the preferred brand. If Joe chooses the generic, he will pay the generic copay of $10. If he opts for the brand-name, he pays the following:

$20	preferred brand-name copay
+ $45	brand-name cost ($80) – generic cost ($35)
= $65	TOTAL brand-name cost

2 – "Step Therapy"

When there are several equally effective medication choices available, it makes sense to try the least expensive options first. Step therapy requires that individuals use one or more lower-cost medications first before moving to higher-cost brand-name drugs. There will be an initial grace period of 90 days, during which educational letters will be sent to those employees who fill a step therapy prescription. These prescriptions can be filled during this initial grace period to give you and your doctor time to consider alternatives. A letter will be sent to you and your doctor advising you if a medication is subject to step therapy requirements.

The step therapy medication categories are: ADD/ADHD, Allergy, Asthma, Cholesterol Lowering, Depression, Heartburn/Ulcer, High Blood Pressure, Mental Health, Osteoporosis, Overactive Bladder, Narcotic Pain Relievers, Non-narcotic Pain Relievers, Skin Conditions, and Sleep Disorders.

[1] Not subject to deductible.
[2] If not a true emergency, then 70% after deductible.
[3] Includes well-child care to age 18, immunizations, routine physicals, GYN exams (including Pap smear exams), mammogram (one baseline, ages 35-39; one per calendar year, age 40 and older), prostate cancer screenings, colonoscopies (one per calendar year, age 50 and older).
[4] Diagnostics for mammograms, prostate cancer, and colonoscopies (in-network costs and reimbursements for colonoscopies vary based on facility in which performed).
[5] Includes physical therapy, speech therapy, occupational therapy, chiropractic therapy, cardiac rehab, pulmonary rehab, and cognitive therapy (60 days combined maximum per calendar year). For a complete list of covered services, please refer to your Summary Plan Description.
[6] Only available at select in-network retail pharmacies. See HR for list of participating pharmacies.
[7] Deductible does not apply for certain generic and preferred brand preventive medications covered by Cigna. See HR for specific list of applicable medications.

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Your Dental Benefit Choices

Basic & Plus Plans

This is a summary of benefits for your Dental PPO plan options. We are now offering two dental plan options to help better meet the needs of you and your family. All deductibles, plan maximums, and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network. This is not a complete list of benefits, exclusions, or limitations. Please see your Summary Plan Description for more information.

Cigna Radius Network Benefits	Cigna Dental		Cigna Dental Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Maximum Class I, II, and III expenses	$1,000	$1,000	$2,000	$2,000
Calendar Year Deductible • Individual • Family	$50 $100	$50 $100	$25 $50	$25 $50
Class I Expenses – Preventive & Diagnostic Care • Oral exams • Cleanings • Routine X-rays • Fluoride application • Sealants • Space maintainers (limited to nonorthodontic treatment) • Nonroutine X-rays • Emergency care to relieve pain	100%, no deductible	100%, no deductible	100%, no deductible	100%, no deductible
Class II Expenses – Basic Restorative Care • Fillings • Oral surgery • Surgical extraction of impacted teeth • Anesthetics • Major & minor periodontics • Root canal therapy/endodontics • Relines, rebases, and adjustments • Repairs – bridges, crowns, inlays, and dentures	70% after deductible	70% after deductible	80% after deductible	80% after deductible
Class III Expenses – Major Restorative Care • Crowns, inlays, onlays • Dentures, bridges • Surgical implants	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible
Class IV Expenses – Orthodontia • Lifetime maximum	Not covered	Not covered	50%, no ortho ded. $3,000	50%, no ortho ded. $3,000

Out-of-Network Reimbursement: 90th percentile of MRC (Maximum Reimbursable Charge). The MRC is the usual charge for a given procedure charged by most dentists in a given area with similar training and experience. Cigna collects claim data to determine what is customary in a geographic area for each covered procedure, and uses that average to calculate what your dental plan will pay when you visit a non-network dentist. Each dentist decides what to charge patients for dental care. Some dentists will charge less than the MRC in their area while others will charge more. When you visit a non-network dentist, you are responsible for all charges above what your plan pays, even if that dentist's regular charge is higher than the MRC.

2019 Dental Contributions	Cigna Dental	Cigna Dental Plus
	Biweekly Contributions	Biweekly Contributions
Employee Only	$3.37	$9.36
Employee + Spouse	$12.85	$25.41
Employee + Child(ren)	$11.32	$22.38
Employee + Family	$18.38	$36.32

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ER Care

Choosing Appropriate Care

Save the ER for true emergencies. Treatment for nonemergency conditions in an emergency room (ER) costs hundred of dollars more than treatment at an urgent care center or your doctor's office. When your condition isn't life threatening, you can save time and money by going to the most appropriate place for care. This chart highlights the type of treatment provided by each type of facility, and the cost comparisons.

Facility	Conditions Treated*	Your Cost and Time
Emergency Room (ER) For immediate treatment of critical injuries or illness. For life-threatening issues, call 911 or go to the nearest ER. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose	• Highest cost • No appointment needed • Wait times may be longer
Urgent Care Center For conditions that aren't life threatening. Staffed by nurses & doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Costs lower than ER • No appointment needed • Wait times vary
Doctor's Office The best place for routine or preventive care and to keep track of medications.	• General health issues • Preventive care • Routine checkups • Immunizations/ screenings	• May charge copay/ coinsurance and/or deductible** • Usually need appointment • Short wait times
Convenience Care Clinic Treats minor medical concerns. Staffed by nurse practitioners & physician assistants. Located in retail stores & pharmacies. Often open nights and weekends.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccines	• Same or lower than doctor's office • No appointment needed • Wait times usually shorter

* For a complete list of covered services, please refer to your Summary Plan Description.
** Copay, coinsurance, and deductible all apply toward your out-of-pocket maximum.

Surcharges

Spousal Surcharge

The spousal surcharge will continue to be $100 per month. If your spouse has access to comprehensive health coverage through his or her employer and you choose to enroll your spouse in the City of Greenville/Greenville Utilities health plan, the spousal surcharge of $100 per month will be deducted from your pay. An affidavit will need to be signed to waive this surcharge.

Tobacco Surcharge

If you are a tobacco user enrolled in COG/GUC's medical insurance plan, you will pay a monthly surcharge of $100 for your health insurance coverage. All employees are required to sign a "tobacco affidavit" stating whether they smoke or use other tobacco products or e-cigarettes.

As a reminder, the tobacco surcharge applies to all tobacco use for active employees, including cigarettes, pipes, cigars, smokeless tobacco, and electronic cigarettes. Tobacco use is the leading preventable cause of serious disease.

If you make the healthy choice not to use tobacco, COG/GUC believes you should pay less for your coverage. So, if you don't use tobacco, or you commit to quit, you will save up to $1,200 in avoided surcharges on your medical plan this year.

You can get help to quit tobacco so you don't have to pay more for health insurance. Cigna offers tobacco cessation assistance and free services to help you quit:

- **Tobacco Cessation Program** – This program includes coaching via a certified tobacco treatment specialist to help you successfully quit tobacco.
- **Quit smoking group sessions** – Group sessions are available at various times and locations.
- **Health plan prescription benefit** – COG/GUC's prescription drug benefit includes coverage for Varenicline (Chantix™), a drug used for tobacco treatment.
- **Health Care FSA** – Keep in mind, you may take advantage of your Flexible Spending Account for additional tax savings on over-the-counter products used for smoking cessation, such as lozenges, nicotine patches, or gum, as long as you have a doctor's prescription.

To find support to stop smoking, call **1-800-QUIT-NOW**, visit **www.quitlineNC.com**, or log on to **www.MyCigna.com** for more information.

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Flexible Spending Accounts

Flexible Spending Account

The better you plan, the more you save! By taking advantage of tax laws, the Flexible Spending Account works with your benefits to save you money.

The Flexible Spending Account offers a unique way to help pay for some of your health care expenses and dependent care expenses that are not covered by insurance. The key is that your eligible expenses are paid for with tax-free dollars. You will not pay any federal, state, or Social Security taxes on funds placed in the FSA. You will save, on an average, 28%–38% for every $100 you set aside.

Examples of Health Care Eligible Expenses

- Fees/copays/deductibles
- Glasses/contacts/contact lens supplies
- Diabetic supplies
- Orthodontic expenses
- Nicotine gum/patches

Examples of Dependent Care Eligible Expenses

- Babysitters or nannies
- Licensed day care centers
- Private preschools
- Before- and after-school care
- Day care for elderly or disabled dependent

For a complete listing of eligible expenses, visit **www.irs.gov**.

A debit Mastercard® is available for account reimbursement. It works like a prepaid credit card with no required PIN number. Additional cards are available for your spouse and dependents over age 18.

The “use-it-or-lose-it” provision has been modified to allow participants to roll over a maximum of $500 from your health care spending account into the next calendar year if not used during the current plan year. Dependent care account balances remain as “use-it-or-lose-it.”

You can enroll during new employee orientation or during the annual Open Enrollment period in October/November.

Limited Purpose Flexible Spending Account

Given the special tax advantages of the HSA, the IRS does not allow individuals or employers to contribute to a Health Savings Account if the employee or their spouse, if the spouse is a tax dependent, has dollars in a traditional FSA. However, you are allowed to enroll in a Limited Purpose FSA (LPFSA) and contribute to the HSA.

A Limited Purpose FSA allows you to pay for eligible dental and vision care expenses with pre-tax dollars while reserving your HSA for medical expenses and/or other dental and vision expenses now or in the future.

- If you are currently enrolled in a traditional FSA and elect the HSA plan in 2019, or elect the HSA in 2019 and would like to elect an FSA for the first time, you will be automatically enrolled in an LPFSA in 2019.
- If your spouse is your tax dependent and has money in a traditional FSA, your spouse will need to spend down that account by December 31, 2018, or convert it to an LPFSA at their employer in order for you and your employer to contribute to your HSA.
- If you are currently enrolled in an FSA, you may roll over up to $500 from 2018 to your 2019 Limited Purpose FSA. However, these funds will not be available for use until April 1.
- Any new contributions to your LPFSA for 2019 will be available January 1.
- The maximum amount you can contribute to your LPFSA each year is determined by the IRS.
- Being enrolled in the HSA does not impact the Dependent Care FSA; you are still able to contribute to it and use it as you normally would.

In order to set up an online account and view your account balance, transaction history, and gain more knowledge on an FSA, visit **www.mywealthcareonline.com/fba**.

You may contact Flexible Benefit Administrators by phone: **1-800-437-3539**, email: **flexdivision@flex-admin.com**, fax: **757-431-1155**, online chat: **www.flex-admin.com**.

2019 FSA limits will be issued by the IRS at a later date. The FSA limits were not available at the time of printing.

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City of Greenville & Greenville Utilities Health Clinic

Convenient, quality healthcare for our employees

City of Greenville Health Clinic

Service Hours:

M-F 7:00 am – 4:00 pm

Provider Hours:

Mon: 1:00 pm – 4:00 pm
Wed: 7:00 am – 12:00 pm
Fri: 7:30 am – 11:30 am

For appointments or information:

252-329-HLTH (4584)
HealthClinic@greenvillenc.gov

Location

1400 Brownlea Dr.
Beside Peppermint Park

Greenville Utilities Health Clinic

Service Hours:

M-F 7:00 am – 5:30 pm

Provider Hours:

Tues: 1:00 pm – 5:00 pm
Wed: 1:00 pm – 5:00 pm
Thurs: 7:30 am – 11:30 am

For appointments or information:

252-329-2167

Location

801 Mumford Rd.
Operations Center

Minor Sick Visits	Preventive Care	Disease Management
The clinic offers fast and affordable treatment of minor health issues such as: • Cold or flu symptoms • Allergies • Sinus infections/respiratory problems • Sprains or strains • Lab work • Minor injuries • Urinary tract infections	The clinic offers office visits and routine checkups to help you avoid serious illness: • Wellness screenings • Health coaching • Tobacco cessation including medication evaluation • Sports physicals	The clinic **coordinates** with your primary care provider to **assist** you with managing chronic health conditions such as: • Diabetes • High blood pressure • High cholesterol • Chronic Obstructive Pulmonary Disease (COPD) • Asthma • Other chronic health conditions

Health Clinic services are available to City of Greenville and Greenville Utilities employees on the Cigna medical insurance plan.The clinics are also open to spouses and dependents ages 13 and older on the Cigna medical insurance plan.

Advantages of Using the Onsite Health Clinic

- **Free –** All services at the health clinics are free to users. No copay required.
- **Timely –** Most visits to the health clinic last about 30 minutes or less.
- **Waiting Areas –** Waiting areas are small and private.
- **Onsite Pharmacy** – Can provide certain acute care medications free of charge to prevent traveling to an outside pharmacy.

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Employee Benefits Overview: City of Greenville & Greenville Utilities

Pre-Tax Benefits

Cancer Insurance - Transamerica Life Insurance Company

Post-Tax Benefits

Group Critical Illness Insurance* - Aflac
Group Accident Insurance* - Aflac
***If enrolled in Accident or Critical Illness Insurance with Aflac, additional benefits include: Medical Bill Saver and Health Advocate Group**
Disability Insurance - Dearborn National Life Insurance Company
Term Life - Dearborn National Life Insurance Company
Supplemental Term Life Insurance - Dearborn National Life Insurance Company
Lifetime Benefit Term - Chubb

Important Information

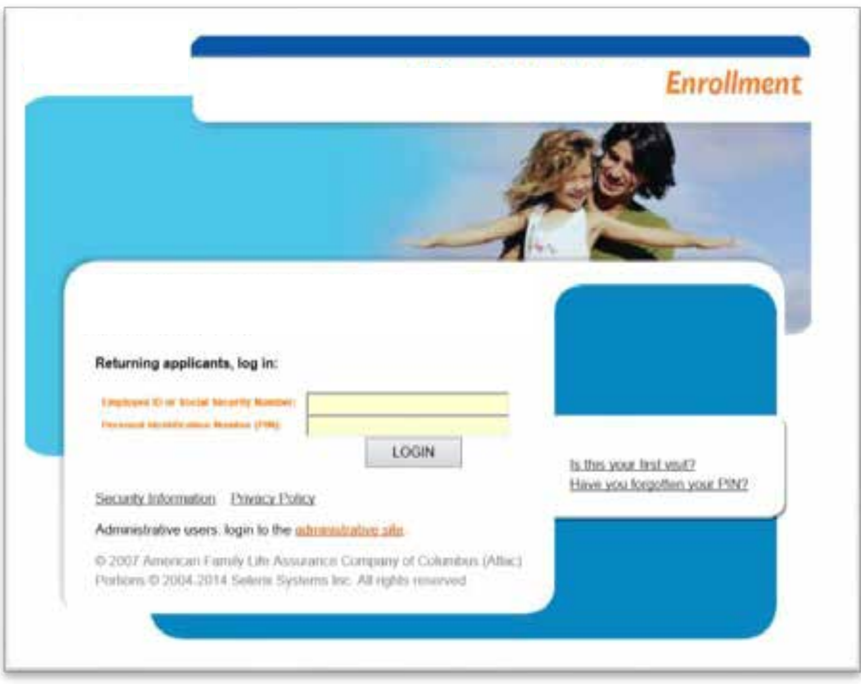
- **The plan year is January 1, 2019 through December 31, 2019.**
- **If signing up for any coverage on your spouse and/or children, please have their dates of birth and social security numbers available when meeting with a Benefit Counselor.**
- **New Hires may enroll within 30 days of Date of Hire**

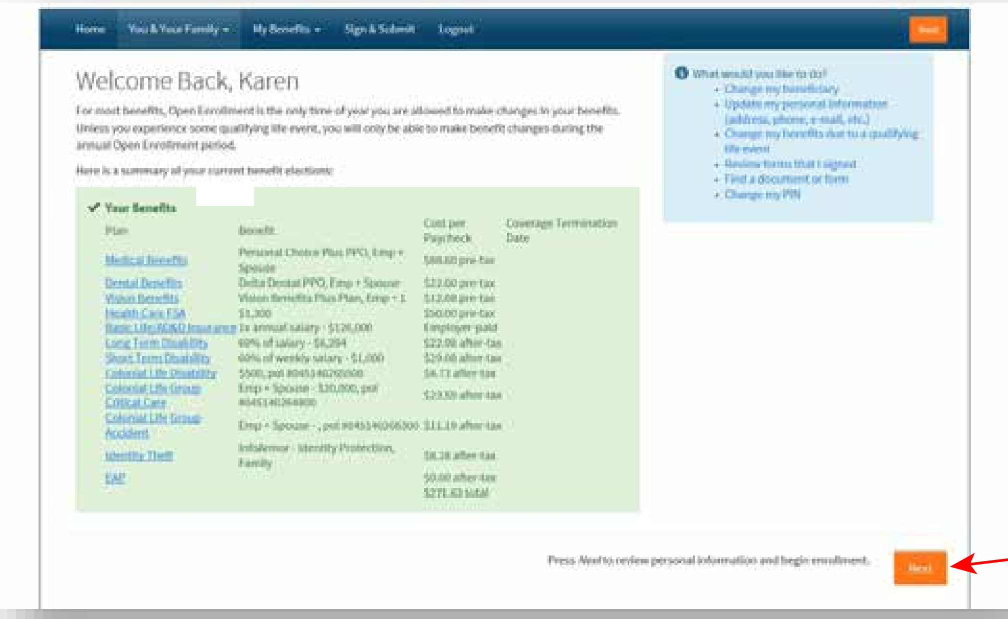
How to Enroll: City of Greenville & Greenville Utilities

You must meet with a benefit representative to enroll. (New hires, your enrollment is completed online; you will not receive any paper forms. To begin your benefits enrollment follow the steps below.)

Step 1 - Connect to the Website through your web browser at https://pierceins.com/city-of-greenville/ or https://pierceins.com/greenville-utilities/ depending upon your employer. *You may use your desktop computer or any mobile device to complete your enrollment.*

Step 2 - At the "Employee Login" screen, enter your *Social Security Number (no dashes)* and your personal identification number (PIN). Your PIN is a combination of the last 4 digits of your Social Security Number and the 2-digit year of your birth. *For example, if the last 4 digits of your SSN are 3214 and you were born on September 21, 1968, your Pin would be "321468".* You will be asked to change your PIN the first time you log on to the system. Be sure to make note of the new secure PIN for future use. If you are having trouble logging on the system, contact your HR department.





Step 3-When the Welcome Page appears on your screen that means you are in! Follow the onscreen instructions to enroll in your benefits, find answers to your questions, download forms and more. **Click Next** to move to the next page.

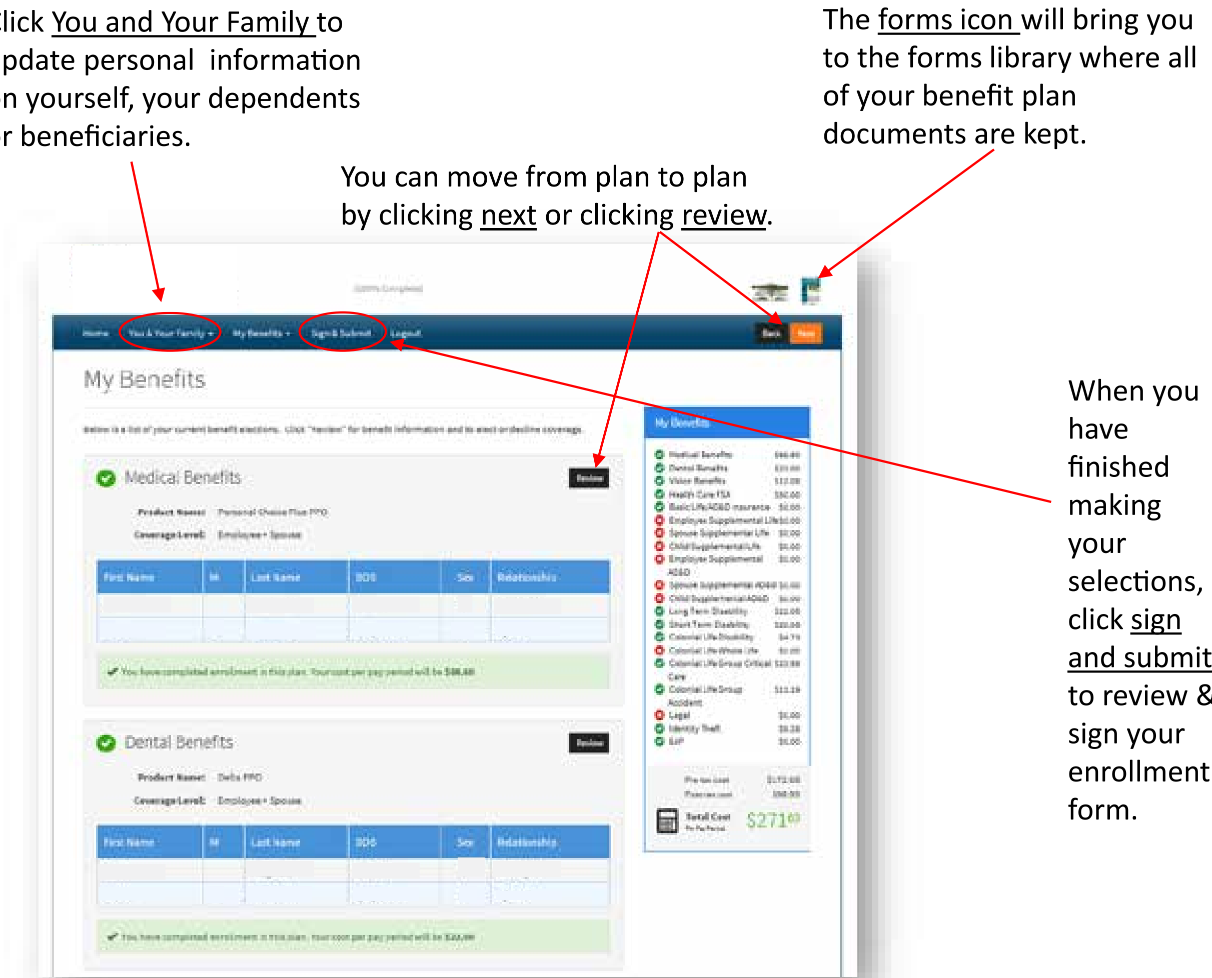
How to Enroll: City of Greenville & Greenville Utilities

Click You and Your Family to update personal information on yourself, your dependents or beneficiaries.

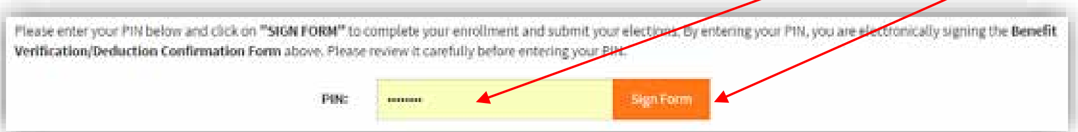
The forms icon will bring you to the forms library where all of your benefit plan documents are kept.

You can move from plan to plan by clicking next or clicking review.

When you have finished making your selections, click sign and submit to review & sign your enrollment form.



To sign and submit your enrollment form you will need to enter your PIN and click sign form.



To learn more or enroll:

https://pierceins.com/city-of-greenville/

https://pierceins.com/greenville-utilities/

Cancer Insurance

CancerSelect® Plus

Cancer-only indemnity insurance | Underwritten by Transamerica Life Insurance Company

Nancy watched as a co-worker battled lung cancer. Everyone rallied around him for support, but he still faced major financial strain due to missed work and high deductibles. Knowing her pack-a-day habit and family history, Nancy doesn't worry if she'll get cancer, but when. And when the time comes, she's afraid medical insurance might not be enough.

Good medical insurance helps, but is it enough?

While some individuals diagnosed with cancer have meaningful and adequate health insurance to pay for most of the cost of treatment, privately insured workers face the prospect of crippling out-of-pocket costs.

If cancer is the disease you worry about most, you're not alone.

If you or one of your family members were to be diagnosed with cancer, would you want to face those chances? Now there's a way you can add more benefits for you and your family.

With this supplemental benefit your employer is making available, you'll not only have more resources to cope with any future diagnosis of cancer, but you'll also have wellness benefits to help you detect cancer early when it's most treatable.

Product highlights

- Pays benefits directly to you
- Spouse and dependent benefits available
- Payroll-deducted premiums
- Easy enrollment process

Contact information

VISIT
transamericabenefits.com

CUSTOMER SERVICE
1-888-763-7474

You can insure yourself or add your eligible spouse and children.

If you are 18 years old or older, you can purchase this valuable supplemental benefit. You can also choose to insure your eligible family members, including your spouse age 18 or older, and your children from birth through age 25.

Valuable benefits for your life.

Review the attached benefits and costs for the insurance policy your employer has designed for your consideration. It's a long list of benefits, but they're all important. As you read through the list of all the ways this supplemental insurance pays, think about how you could possibly pay for all these costs on your own. Fighting cancer can be challenging both financially and emotionally, and the more resources you have, the better prepared you and your family will be.

This is a brief summary of CancerSelect® Plus, Group Cancer Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa Policy form series CPCAN200 and CCCAN200 Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

EDB TSCGEG 0918

Product Details: Cancer Insurance

Hospital Benefits	Plan Option 1 - 1.00 Units	Policy Pays
Hospital Confinement	$100	per day of covered confinement
Extended Benefits	$200	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$20	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$15	per day while hospital confined
Private Duty Nurse	$100	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$100	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	$100	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$100	per day of covered confinement; in lieu of all other benefits
Hospice Care	$100	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined
Surgery Benefits	**Plan Option 1 - 2.00 Units**	**Policy Pays**
Surgery – Inpatient	$2,000	maximum benefit; actual benefit is determined by the surgery schedule in the contract; for multiple procedures in same incision only the highest benefit is paid; for multiple procedures in separate incisions will pay highest benefit and then 50% for each lesser procedure
Surgery – Outpatient	$3,000	
Anesthesia	25%	of covered surgery benefit
Prosthesis	$1,000	maximum benefit; pays actual charges per device requiring implantation
Hair Prosthesis	$100	maximum benefit; pays actual charges for wig to cover hair loss from cancer treatment
Reconstructive Surgery – Breast Cancer – simple or total mastectomy	$240	for reconstructive surgery within 2 years of the initial cancer removal; excludes skin cancer and malignant melanoma; benefit not payable if paid under any other provision of the policy
Reconstructive Surgery – Breast Cancer – radical mastectomy	$340	
Reconstructive Surgery – Cancers of the male or female genitalia	$340	
Reconstructive Surgery – Cancer of the head, neck, or oral cancers	$500	

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Product Details: Cancer Insurance

Second Surgical Opinion	$200	when surgery is prescribed; excludes skin cancer
Ambulatory Surgical Center	$300	maximum per day; pays actual charges for outpatient surgery at an ambulatory surgical center
Skin Cancer – One removal	$150	for removal of skin cancer (skin cancer does not include malignant melanoma or mycosis fungoides)
Skin Cancer – Per additional removal	$70	
Radiation and Chemotherapy Benefits	**Plan Option 1 - 2.00 Units**	**Policy Pays**
Radiation and Chemotherapy	$10,000	maximum benefit per 12-month period; pays actual charges
Associated Radiation & Chemo Expenses	$500	maximum benefit per 12-month period; pays actual charges for treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant	$10,000	maximum benefit per 12-month period; pays actual charges
Associated Blood & Plasma Expenses	$500	maximum benefit per 12-month period; pays actual charges for administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
New or Experimental Treatment	$10,000	maximum benefit per 12-month period; pays actual charges for drugs or chemical substances approved by the FDA for experimental use on humans or surgery or therapy endorsed by either the NCI or ACS for experimental studies received in the US or its territories

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Product Details: Cancer Insurance

Wellness & Non-Medical Benefits	Plan Option 1 - 2.00 Units	Policy Pays
Annual Cancer Screening	$100	per calendar year for cancer screening tests: • mammogram • pap smear • flexible sigmoidoscopy • prostate-specific antigen test • chest x-ray • hemocult stool specimen • ultrasound • CEA • CA125 • biopsy • thermography • colonoscopy • serum protein electrophoresis • bone marrow testing • blood screening
Magnetic Resonance Imaging (MRI) Scan	$100	per calendar year for MRI scan used as diagnostic tool for breast cancer
Non-Local Transportation	Included	round-trip charges or private vehicle allowance, up to 750 miles at $0.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for an insured person and an adult immediate family member during confinement; payable once per confinement
Family Member Lodging	$100	per day (maximum 50 days per 12 month period) for lodging expenses for an adult immediate family member when non-local hospital confinement is required
Outpatient Lodging	$100	per day (maximum 50 days per 12 month period) for lodging expenses for an insured person to receive radiation or chemotherapy on an outpatient basis if not available locally
Physical Therapy & Speech Therapy	$50	per treatment; limit one treatment per day
At-Home Nursing	$100	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Waiver of Premium	Included	waives premium for total disability due to cancer after 60 consecutive days of total disability; total disability must begin prior to the insured person's 70th birthday

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Product Details: Cancer Insurance

Cancer Maintenance Therapy Benefit	Plan Option 1 - 1.00 Units	Policy Pays
• Cancer Suppressive Therapy • Hematological Drugs • Anti-Nausea Drugs • Motility Agents	$1,000	maximum benefit per 12-month period; pays actual charges
First Occurrence Rider (Rider Form Series CROCC100, 200 or 300)	**Plan Option 1 - 2.00 Units**	**Policy Pays**
Initial Diagnosis Benefit	$2,000	pays a one-time, lump-sum benefit when an insured person is initially diagnosed with cancer (except skin cancer), based on a microscopic examination of fixed tissue or preparations from the hemic system. Clinical diagnosis is accepted under certain conditions.

Actual charges means the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.

Bi-Weekly Premium	Individual	Single Parent Family	Family
Plan Option 1	$9.07	$10.47	$16.66

Issue State: North Carolina
Rate generation date: March 14, 2018

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Limitations & Exclusions : Cancer Insurance

We provide benefits only for cancer as defined herein, which is positively diagnosed while insurance is in force. It does not provide benefits for any other illness or disease.

- We may reduce or deny a claim or void insurance for loss incurred by an insured person during the first 2 years from the effective date of such insurance for any misstatements in the application which would have materially affected our acceptance of the risk.
- We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of cancer, except as specifically covered under the contract.
- If a covered hospital confinement is due to more than one covered condition, benefits will be payable as though the confinement or expense were due to one condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
- Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for pre-existing conditions for which the insured person has been diagnosed, treated, or for which the insured person has incurred expense or has taken medication within 12 months prior to the effective date of such person's policy.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer but only until the employee has reached the maximum point of recovery and is still totally disabled. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. On or after age 65, Total Disability will mean that a physician has certified that the employee is unable to perform two or more Activities of Daily Living (continence, transferring, dressing, toileting, eating and bathing) without direct personal assistance as a result of cancer.

12-Month Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the insured person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each insured person.

First Occurrence Rider

Benefits are not payable:
- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from insurance by name or specific description.

Termination of Insurance

Employee insurance will terminate on the earliest of:
- The date of the employee's death;
- The date on which the employee ceases to be eligible for insurance;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel insurance.

Dependent insurance will terminate on the earliest of:
- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent insurance; or
- The date the employee sends us a written notice to cancel dependent insurance.

We will have the right to terminate the insurance of any insured person who submits a fraudulent claim under the policy.

EDB TSCGEG 0918

Limitations & Exclusions : Cancer Insurance

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this insurance.

EDB TSCGEG 0918

Critical Illness Insurance

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

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

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

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

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

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

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.

THIS IS NOT A MEDICARE SUPPLEMENT PLAN.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

EDB TSCGEG 0918

Summary of Benefits: Critical Illness Insurance

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

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

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

The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
  - Severe Burn
  - Coma
  - Paralysis
  - Loss of Sight / Hearing / Speech
- Health Screening Benefit

Features:

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

How it works

You visit the emergency room.

A physician determines that you have had suffered a heart attack.

Aflac Group Critical Illness Advantage pays a First Occurrence Benefit of

$10,000

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

Summary of Benefits: Critical Illness Insurance

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN*	100%
PARALYSIS**	100%
COMA**	100%
LOSS OF SPEECH / SIGHT / HEARING**	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

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

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

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

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

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

*This benefit is only payable for a burn due to, caused by, and attributed to, a covered accident.
**These benefits are payable for loss due to a covered underlying disease or a covered accident.

Summary of Benefits: Critical Illness Insurance

WAIVER OF PREMIUM

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

SUCCESSOR INSURED BENEFIT

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

HEALTH SCREENING BENEFIT (Employee and Spouse only)

We will pay $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

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

COVERED HEALTH SCREENING TESTS INCLUDE:

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

OCCUPATIONAL HIV RIDER	100%

This benefit pays the applicable maximum benefit amount for the initial positive diagnosis of occupational human immunodeficiency virus (HIV), as a result of a covered injury. This benefit is payable once, and once the benefit is paid, coverage for that individual will terminate.

This benefit is paid based on your selected Critical Illness Benefit amount.

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Summary of Benefits: Critical Illness Insurance

CRITICAL ILLNESS NON-TOBACCO / Employee / Biweekly Rates

Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.34	$3.29	$4.24	$5.19	$6.14	$7.10	$8.05	$9.00	$9.95	$10.90
30-39	$2.97	$4.55	$6.13	$7.71	$9.29	$10.86	$12.44	$14.02	$15.60	$17.18
40-49	$4.51	$7.63	$10.75	$13.86	$16.98	$20.10	$23.22	$26.34	$29.46	$32.57
50-59	$7.49	$13.59	$19.69	$25.78	$31.88	$37.98	$44.08	$50.18	$56.28	$62.38
60-69	$13.12	$24.86	$36.59	$48.33	$60.06	$71.80	$83.53	$95.27	$107.00	$118.74

CRITICAL ILLNESS NON-TOBACCO / Spouse / Biweekly Rates

Ages	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.32	$2.78	$3.25	$3.71	$4.17	$4.64	$5.10	$5.57	$6.03
30-39	$2.95	$3.72	$4.50	$5.28	$6.06	$6.84	$7.61	$8.39	$9.17
40-49	$4.49	$6.03	$7.58	$9.13	$10.68	$12.22	$13.77	$15.32	$16.87
50-59	$7.47	$10.50	$13.54	$16.58	$19.62	$22.65	$25.69	$28.73	$31.77
60+	$13.10	$18.96	$24.81	$30.67	$36.53	$42.38	$48.24	$54.09	$59.95

CRITICAL ILLNESS TOBACCO / Employee / Biweekly Rates

Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.75	$4.11	$5.47	$6.83	$8.18	$9.54	$10.90	$12.26	$13.62	$14.98
30-39	$3.89	$6.38	$8.88	$11.38	$13.88	$16.37	$18.87	$21.37	$23.86	$26.36
40-49	$6.34	$11.29	$16.23	$21.18	$26.13	$31.08	$36.02	$40.97	$45.92	$50.87
50-59	$11.32	$21.24	$31.17	$41.10	$51.02	$60.95	$70.88	$80.80	$90.73	$100.66
60-69	$19.82	$38.24	$56.67	$75.09	$93.52	$111.94	$130.37	$148.79	$167.22	$185.64

CRITICAL ILLNESS TOBACCO / Spouse / Biweekly Rates

Ages	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.73	$3.39	$4.06	$4.73	$5.40	$6.07	$6.73	$7.40	$8.07
30-39	$3.86	$5.10	$6.34	$7.58	$8.81	$10.05	$11.29	$12.52	$13.76
40-49	$6.31	$8.78	$11.24	$13.70	$16.16	$18.63	$21.09	$23.55	$26.01
50-59	$11.29	$16.25	$21.20	$26.15	$31.10	$36.05	$41.00	$45.96	$50.91
60+	$19.79	$28.99	$38.19	$47.40	$56.60	$65.80	$75.00	$84.20	$93.40

LIMITATIONS AND EXCLUSIONS

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

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

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict:**
  - War (declared or undeclared) or military conflicts; this does not include terrorism
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

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

Limitations & Exclusions: Critical Illness Insurance

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

TERMS YOU NEED TO KNOW

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

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

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

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

A malignant tumor characterized by:

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

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology.

Cancer (internal or invasive) also includes:

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

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

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

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

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

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

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

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

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

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

1. Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
   - A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the diagnosis,
   - A doctor is treating you for cancer or carcinoma in situ, or
   - A positive diagnosis cannot otherwise be made by a doctor without jeopardizing the life of the claimant.

   If a pathological or clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

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

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

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Critical Illness is one of the illnesses defined below:

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Date of Diagnosis is defined as follows:

- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place. Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a

Limitations & Exclusions: Critical Illness Insurance

portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.

- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, who is listed on your application. Dependent children are your or your spouse's natural children, foster children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn, adopted and foster children are equally considered under this plan. A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children will be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the foster home or placement for adoption.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must provide the company with proof of this incapacity and dependency to the company within 31 days following the dependent child's 26th birthday, but not more frequently than annually.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we:

- Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
- Will not disenroll or eliminate coverage of the child unless we are provided satisfactory written evidence that: a. The court or administrative order is no longer in effect; or b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return, or the child does not reside with the parent or in the insurer's service area.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma. To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

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

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

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

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

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

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

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

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

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

Limitations & Exclusions: Critical Illness Insurance

coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stroke does not include:

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

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

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

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

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

Total Disability or Totally Disabled means you are:

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

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

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

OCCUPATIONAL HIV RIDER DEFINITIONS

HIV means Human Immunodeficiency Virus.

HIV Positive means the presence of HIV antibodies in the blood. This must be evidenced by:

- A positive screening test enzyme-linked immunosorbent assay (ELISA) or
- A positive supplement test, such as the Western Blot

All such tests must be approved by the Food and Drug Administration (FDA), and the interpretation of positive results must be in keeping with the manufacturer's specifications.

Occupational HIV refers to your testing positive for HIV as a direct result of an HIV-specific covered injury, subject to the following provisions:

- The HIV-specific covered injury must occur during the normal course of duties for the occupation in which the insured is regularly engaged. The HIV infection must result from accidental exposure to HIV-contaminated body fluids during the normal course of performing an occupation for which remuneration is earned.
- The insured must file an incident report (notice of exposure) with his employer within 48 hours of the positive test result. This report must:
  - Be on a form acceptable to the company,
  - Describe the nature of the exposure to HIV, and
  - Be sent to the company as soon as reasonably possible after the HIV-specific covered injury.
- An insured must not have previously tested positive for HIV. If he had previously tested positive for HIV, he must have subsequently tested negative

Limitations & Exclusions: Critical Illness Insurance

for HIV before the date of the HIV-specific covered injury.

- An insured must have a preliminary HIV screening test—such as an ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing)— within 14 days of the covered injury at an authorized laboratory other than the laboratory of the insured's employer. We must receive notification of the negative results as soon as reasonably possible.
- Thereafter, the insured must test HIV positive within 26 weeks of the date of that HIV-specific covered injury.

REINSTATEMENT

If any renewal premium is not paid on time (as outlined in the initial payment agreement) for the plan, the company (or an agent who is authorized by the company) may accept the late premium and reinstate the plan without requiring a new application. If the company (or authorized agent) does require an application for reinstatement and issues a conditional receipt for the premium tendered, the plan will be reinstated upon the company's approval, or lacking such approval, upon the 45th day following the date of the conditional receipt (unless the company has previously notified the policyholder in writing of its disapproval of such application). Reinstatement is subject to the terms of the plan.

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION OF COVERAGE

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

NOTICES

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

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

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

Continental American Insurance Company • Columbia, South Carolina

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

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

This brochure is subject to the terms, conditions, and limitations of Policy Series C21000.

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

AGC1803380 IV (9/18)

Accident Insurance

Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

What you need, when you need it.

Group accident insurance pays cash benefits that you can use any way you see fit.

Underwritten by:
Continental American Insurance Company (CAIC)

In California, coverage is underwritten by Continental American Life Insurance Company.

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

Product Details: Accident Insurance

	HIGH	LOW
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following:		
Hospital emergency room with X-Ray / without X-Ray	$200/$150	$125/$100
Urgent care facility with X-Ray / without X-Ray	$200/$150	$125/$100
Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	$100/$75	$75/$50
AMBULANCE (once per day, within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury.	$300 Ground $900 Air	$200 Ground $600 Air
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center.	$150	$100
EMERGENCY ROOM OBSERVATION (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury.	$70 Each 24 hour period $35 Less than 24 hours, but at least 4 hours	$50 Each 24 hour period $25 Less than 24 hours, but at least 4 hours
PRESCRIPTIONS (2 times per accident, within 6 months after the accident) Payable for a prescription filled that - due to a covered accidental injury - is ordered by a doctor, dispensed by a licensed pharmacist and medically necessary for the care and treatment of the insured (in Alaska, Massachusetts and Montana prescriptions do not have to be medically necessary). This benefit is not payable for therapeutic devices or appliances; experimental drugs; drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or immunization agents, biological sera, blood or blood plasma. This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).	$5	$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury.	$200	$100
PAIN MANAGEMENT (once per accident, within 6 months after the accident) Payable when an insured, due to a covered accidental injury, is prescribed and receives a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is only payable for pain management techniques (as shown above) that are administered in a hospital or doctor's office. This benefit is not payable for an epidural administered during a surgical procedure.	$75	$50
CONCUSSION (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident.	$350	$250
TRAUMATIC BRAIN INJURY (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a covered accident. To qualify as TBI, the neurological deficit must require treatment by a neurologist and a prescribed course of physical, speech and/or occupational therapy under the direction of a neurologist.	$3,500	$2,500

Product Details: Accident Insurance

	HIGH	LOW
COMA (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident.	$7,500	$5,000
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident.	$30 Extraction $120 Repair with a crown	$25 Extraction $100 Repair with a crown
BURNS (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered.		
Second Degree		
Less than 10%	$75	$50
At least 10% but less than 25%	$150	$100
At least 25% but less than 35%	$375	$250
35% or more	$750	$500
Third Degree		
Less than 10%	$750	$500
At least 10% but less than 25%	$3,750	$2,500
At least 25% but less than 35%	$7,500	$5,000
35% or more	$15,000	$10,000
EYE INJURIES Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia.	$175	$125
FRACTURES (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.	Up to $3,000 based on a schedule	Up to $2,000 based on a schedule
DISLOCATIONS (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.	Up to $2,250 based on a schedule	Up to $1,500 based on a schedule
LACERATIONS (once per accident, within 7 days after the accident) Payable when an insured receives a laceration in a covered accident and the laceration is repaired by a doctor. For multiple lacerations, we will pay a maximum of 200% of the benefit for the largest single laceration requiring stitches. Lacerations requiring stitches (including liquid skin adhesive):		
Over 15 centimeters	$600	$400
5-15 centimeters	$300	$200
Under 5 centimeters	$75	$50
Lacerations not requiring stitches	$37.50	$25

Product Details: Accident Insurance

	HIGH	LOW
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$300	$200
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$75	$50
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount.	$35	$25
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$750	$500
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor	$350 Plane $150 Any ground transportation	$250 Plane $100 Any ground transportation

Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.

AFTER CARE BENEFITS	HIGH	LOW
APPLIANCES (within 6 months after the accident) Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion.		
Cane, Ankle Brace	$30	$20
Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar	$75	$50
Wheelchair, Knee Scooter, Body Jacket, Back Brace	$300	$200
ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident) Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident. Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment.	$35	$25
POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident) Payable if the insured is diagnosed with PTSD, a mental health condition triggered by a covered accident. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.	$150	$100

Product Details: Accident Insurance

	HIGH	LOW
REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured) Payable for each day that, due to a covered accidental injury, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid. We will pay the highest eligible benefit.	$75 per day	$50 per day
THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.	$35	$25
CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured receives acupuncture or chiropractic treatment.	$25	$15

HOSPITALIZATION BENEFITS	HIGH	LOW
HOSPITAL ADMISSION (once per accident, within 6 months after the accident) Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury. This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment.	$1,000 per confinement	$625 per confinement
HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident) Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury. If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.	$225 per day	$150 per day
HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$300 per day	$200 per day
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury. We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in an intermediate intensive care step-down unit and an insured becomes confined to an intermediate intensive care step-down unit again within 6 months because of the same condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$150 per day	$100 per day

Product Details: Accident Insurance

	HIGH	LOW
FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident) Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family. For this benefit to be payable: • The insured must be confined to a hospital for treatment of a covered accidental injury; • The hospital and motel/hotel must be more than 100 miles from the insured's residence; and • The treatment must be prescribed by the insured's treating doctor.	$150 per day	$100 per day

LIFE CHANGING EVENTS BENEFITS

DISMEMBERMENT (once per accident, within 6 months after the accident)
Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident.
Dismemberment means:
- Loss of a hand -The hand is removed at or above the wrist joint;
- Loss of a foot -The foot is removed at or above the ankle;
- Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or
- Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable).

If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

SINGLE LOSS (the loss of one hand, one foot, or the sight of one eye)	HIGH	LOW
Employee	$6,250	$6,250
Spouse	$2,500	$2,500
Child(ren)	$1,250	$1,250
DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)		
Employee	$12,500	$12,500
Spouse	$5,000	$5,000
Child(ren)	$2,500	$2,500
LOSS OF ONE OR MORE FINGERS OR TOES		
Employee	$625	$625
Spouse	$250	$250
Child(ren)	$125	$125
PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)		
Employee	$62.50	$62.50
Spouse	$62.50	$62.50
Child(ren)	$62.50	$62.50
PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident) Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.		
Paraplegia	$2,500	$2,500
Quadriplegia	$5,000	$5,000
PROSTHESIS (once per accident, up to 2 prosthetic devices and one replacement per device per insured)* Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury. Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices* and /or joint replacements. * We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.	$1,500	$1,500

Product Details: Accident Insurance

	HIGH	LOW
RESIDENCE/VEHICLE MODIFICATION (once per accident, within one year after the accident) Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of one of the following, due to a covered accidental injury: • The sight of one eye; • The use of one hand/arm; or • The use of one foot/leg.	$1,000	$1,000

WELLNESS RIDER

WELLNESS BENEFIT (once per calendar year)
Payable for the following wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

- Annual physical exams
- Flexible Sigmoidoscopy
- Mammograms
- PSA Tests
- Pap Smears
- Ultrasounds
- Eye Examinations
- Blood Screening
- Immunizations

THE AMOUNT PAID WILL BE BASED ON WHEN THE WELLNESS TEST WAS PERFORMED:	HIGH	LOW
First year of certificate and thereafter	$50	$50

ORGANIZED ATHLETIC ACTIVITY RIDER	HIGH	LOW
ORGANIZED ATHLETIC ACTIVITY BENEFIT We will pay an additional percentage of the benefit amount payable under the Aflac Group Accident plan for covered accidental injuries sustained while participating in an organized athletic event.	20%	20%

ACCIDENTAL DEATH RIDER	HIGH ONLY
ACCIDENTAL DEATH BENEFIT (within 90 days after the accident*) Payable if a covered accidental injury causes the insured to die.	$50,000 Employee $25,000 Spouse $10,000 Child
ACCIDENTAL COMMON-CARRIER DEATH BENEFIT Payable if the insured: • Is a fare-paying passenger on a common carrier; • Is injured in a covered accident; and • Dies within 90 days* after the covered accident. *In Oregon and Utah, within 180 days after the accident; in Pennsylvania, there is no limitation on the number of days.	$100,000 Employee $50,000 Spouse $20,000 Child

Product Details: Accident Insurance

GUNSHOT WOUND RIDER	HIGH ONLY
Payable once per accident if on the job (or in the line of duty), the employee receives an unintentional gunshot wound from a conventional fire arm in a covered accident that does not cause death. The injury must result in treatment within 24 hours and admission to a hospital as an inpatient (in New Hampshire, admission is not required). If the insured is shot more than once in a 24-hour period, we will pay benefits only for the first wound. If, within 90 days (in Utah, 180 days), the insured loses a finger/toe, a hand/foot, or the sight of an eye or eyes, or dies as the result of the same covered accident, we will pay only one benefit. We will pay the larger of the applicable Gunshot Wound Benefit, Dismemberment Benefit, or Accidental Death Benefit (if available).	$1,000 Employee Only

CATASTROPHIC ACCIDENT RIDER	HIGH ONLY
Payable at the end of the elimination period if any insured (365–day elimination period) • Sustains a catastrophic loss as the result of a covered accident, • Is under the appropriate care of a doctor during the catastrophic accident elimination period, • Remains alive at the end of the catastrophic accident elimination period, and • Is actively at work when the accident occurs. The benefits provided in this rider are reduced by any benefits paid under the Accidental Death, Dismemberment, or Paralysis Benefits (if available).	$250,000 Employee $100,000 Spouse/ Children

HIGH PLAN	BIWEEKLY RATES
Employee	$7.85
Employee and Spouse	$13.03
Employee and Dependent Children	$17.12
Family	$22.30

LOW PLAN	BIWEEKLY RATES
Employee	$4.58
Employee and Spouse	$7.98
Employee and Dependent Children	$11.17
Family	$14.57

INITIAL ACCIDENT EXCLUSIONS
EXCLUSIONS

Plan exclusions apply to all riders unless otherwise noted.

We will not pay benefits for accidental injury, disability or death contributed to, caused by, or resulting from*:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
  - In California: voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection or riot.
  - In Idaho: participating in any war or act of war, declared or undeclared, or participating or serving in the armed forces or units auxiliary thereto. War also includes participation in a riot or an insurrection.
  - In Illinois: the statement "war does not include acts of terrorism" is deleted.
  - In Michigan: voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
  - In North Carolina: War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes civil participation in an active riot. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
  - In Montana: committing or attempting to commit suicide, while sane
  - In Illinois, Michigan and Minnesota: this exclusion does not apply
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
  - Allergic reactions
  - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid or other arthropod bites or stings. In Illinois: any bacterial infection, except an infection which results from an accidental injury or an infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; any viral or microorganism infection or infestation; or any condition resulting from insect, arachnid or other arthropod bites or stings. In North Carolina: any viral or microorganism infestation or any condition resulting from insect, arachnid or other arthropod bites or stings
  - An error, mishap or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
  - Any related medical/surgical treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
  - In Idaho: intentionally self-inflicting injury.

Limitations & Exclusions: Accident Insurance

- In Montana: injuring or attempting to injure oneself intentionally, while sane
- In Michigan: this exclusion does not apply

- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
  - In Idaho: this exclusion does not apply
- **Illegal Occupation** – voluntarily participating in, committing or attempting to commit a felony or illegal act or activity, or voluntarily working at or being engaged in, an illegal occupation or job.
  - In California, Nebraska and Tennessee: voluntarily participating in, committing, or attempting to commit a felony; or voluntarily working at, or being engaged in, an illegal occupation or job.
  - In Illinois and Pennsylvania: committing or attempting to commit a felony or being engaged in an illegal occupation
  - In Michigan: voluntarily participating in, committing or attempting to commit a felony, or being engaged in an illegal occupation
  - In Idaho and South Dakota: this exclusion does not apply
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
  - In California and Idaho: participating in any organized sport in a professional capacity for pay or profit
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
  - In Alaska, Massachusetts and Montana: having cosmetic surgery, other elective procedures or dental treatment except as a result of a covered accident.
  - In California: having cosmetic surgery or other elective procedures that are not medically necessary ("cosmetic surgery" does not include reconstructive surgery when the service is related to or follows surgery resulting from a covered accident); or having dental treatment except as a result of a covered accident.
  - In Idaho: having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident. Cosmetic surgery shall not include reconstructive surgery because of a Congenital Anomaly of a covered dependent child.
- **Felony** (In Idaho only) – participation in a felony

For 24-Hour Coverage, the following exclusions will not apply:
An injury arising from any employment.
An injury or sickness covered by worker's compensation.
In North Carolina: services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina workers' compensation act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
*"Contributed to" language doesn't apply in Illinois

DEFINITIONS

Accidental Injury means accidental bodily damage to an insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. **A Covered Accidental Injury** is an accidental injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

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

Dependent Child or Dependent Children means your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (and in Louisiana, unmarried). Newborn children may be automatically covered from the moment of birth for 60 days. Newly adopted children (and foster children in North Carolina and Florida) may also be automatically covered for 60 days. See certificate for details.

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

In Montana, for purposes of treatment, the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor, or advanced practice registered nurse.

A Doctor does not include the insured or an insured's family member. In South Dakota however, a doctor who is an employee's family member may treat the insured if that doctor is the only doctor in the area and acts within the scope of his practice. For the purposes of this definition, family member includes the employee's spouse as well as the following members of the employee's immediate family son, daughter, mother, father, sister, and brother. This includes step-family members and family-members-in-law.

The term **Hospital** specifically excludes any facility not meeting the definition of hospital as defined in this plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,
- A facility for the treatment of alcoholism or drug addiction, or
- An assisted living facility.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

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

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

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

HOSPITALIZATION BENEFITS

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the hospital called a hospital intensive care unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the hospital intensive care unit 24 hours a day; and
- Has a doctor assigned to the hospital intensive care unit on a full-time basis.

The term **Hospital Intensive Care Unit** specifically excludes any type of facility not meeting the definition of hospital intensive care unit as defined in this plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units and the following step-down units:

- A progressive care unit;
- A sub-acute intensive care unit; or

Product Details: Accident Insurance

- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit;
- A sub-acute intensive care unit;
- An intermediate care unit; or
- A pre- or post-intensive care unit.

An intermediate intensive care step-down unit is not a hospital intensive care unit as defined in this plan.

AFTER CARE BENEFITS

Psychologist is a clinical, mental health professional who works with patients. A psychologist is not a doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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

ACCIDENTAL DEATH RIDER

Common Carrier means:

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

WAIVER OF PREMIUM RIDER

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered accidental injury (or a covered sickness if applicable), and
- Unable to work.

Unable to Work means either:

- You are unable to work at the occupation you were performing when your total disability began, which was during the first 365 days of total disability; or
- You are unable to work at any gainful occupation for which you are suited by education, training, or experience after the first 365 days of total disability.

Definitions in Maine:

Total Disability or Totally Disabled means you are:

- Unable to engage in any employment or occupation for which you are or become qualified by reason of education, training, or experience, and are not, in fact, engaged in any employment or occupation for wage or profit.
- Under the care of a doctor for the treatment of a covered accidental injury (or a covered sickness if applicable).

ORGANIZED ATHLETIC ACTIVITY RIDER

EXCLUSIONS

The Organized Athletic Activity Benefit is not payable for accidental injuries that are caused by or occur as a result of an insured's participating in any sport or sporting activity for wage, compensation, or profit, including officiating, coaching, or racing any type vehicle in an organized event (in Idaho, in a professional capacity).

This benefit is also not payable for accidental injuries that occur during or are due to physical education classes (except in Idaho).

DEFINITION

Organized Athletic Activity means an athletic competition or supervised organized practice for an athletic competition. Organized Athletic Activities take place on a regularly occurring and scheduled basis, often during a pre-determined season. The competition must be governed by a set of written rules and officiated by someone certified to act in that capacity. The competition must also be overseen by a legal entity such as a public school system or sports conference. The legal entity must have a set of bylaws and competition must take place on a regulation playing surface. Participation must be on an amateur basis.

GUNSHOT WOUND RIDER

DEFINITION

A **Conventional Firearm** is a weapon that fires a shot (bullet) by gun powder or compressed gas.

CATASTROPHIC ACCIDENT RIDER EXCLUSIONS

We will pay the Catastrophic Accident Benefit once per lifetime for each insured covered under the rider.

DEFINITIONS

Catastrophic Accident Elimination Period is the period of days after the date of a Covered Accident for which no benefits are payable under this rider.

Catastrophic Loss refers to an injury from a covered accident that causes total and irrecoverable:

- Loss of both hands or both feet; or
- Loss or loss of use of both arms or both legs; or
- Loss of one hand and one foot; or
- Loss of use of one arm and one leg; or
- Loss of sight of both eyes; or
- Loss of hearing in both ears; or
- Loss of the ability to speak.

Note:

- The loss of use of an arm means the functional loss of the entire arm from the shoulder to the hand.
- The loss of use of a leg means the functional loss of the entire leg from the hip to the foot.
- The loss of sight means both eyes are totally blind and that no sight can be restored.
- The loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device.
- The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

YOU MAY CONTINUE YOUR COVERAGE

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

TERMINATION OF COVERAGE

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

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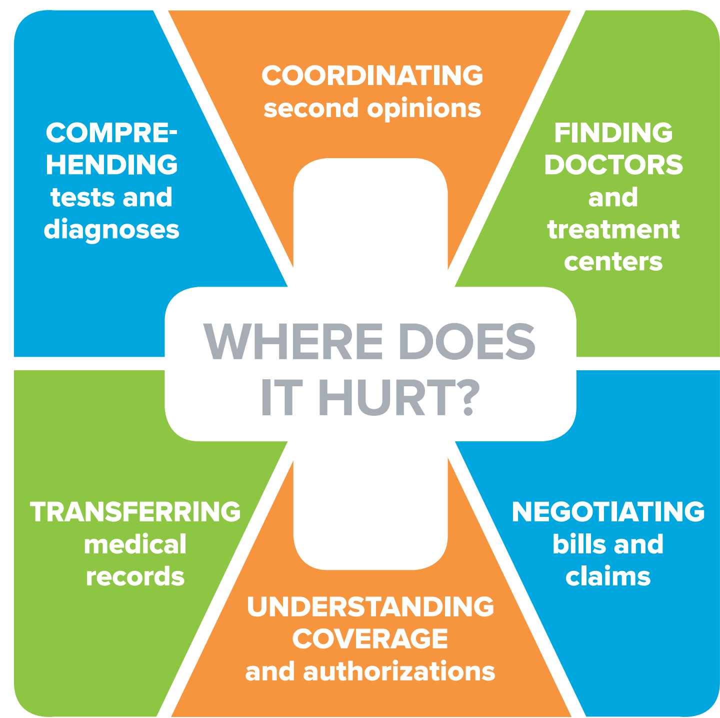
With Health Advocacy, you have a team of experts who can help solve your health care and insurance-related questions. They can assist you with a variety of needs like finding specialists, clarifying coverage, addressing claim issues, getting second opinions — and even help negotiating medical bills.

Get care for your health care.



HEALTH ADVOCACY AND MEDICAL BILL SAVER CAN HELP:

FIND DOCTORS AND TREATMENT CENTERS

COORDINATE CARE AND SECOND OPINIONS

UNTANGLE MEDICAL BILL AND CLAIM ISSUES

NEGOTIATE BILLS $400 OR MORE

AVAILABLE 24/7, ANYTIME, ANYWHERE

Medical Bill Saver

VALUE ADDED BENEFIT

IF ENROLLED IN CRITICAL ILLNESS OR ACCIDENT WITH AFLAC GROUP

Get confidential, personalized help with Health Advocate:

Find doctors, specialists, hospitals and other providers

Schedule appointments for treatments and tests

Coordinate second opinions and care

Resolve issues, from claims problems and medical bills, to coordinating benefits

Get help with eldercare issues, including Medicare and related healthcare issues for your parents and parents-in-law

Get answers about your test results, treatments, prescriptions and more

Work with your insurance companies to get approvals and clarify coverage

Transfer medical records, lab results and X-rays

Here for you 24/7 by convenient app or phone

Medical Bill Saver™ gives you access to skilled negotiators who can help reduce your out-of-pocket costs from medical or dental bills not covered by insurance. And it's as easy as just sending in your bill.

HERE'S HOW IT WORKS:

1) Send in your medical or dental bills of $400 or more.
2) Your negotiator contacts the provider to negotiate a discount.
3) If an agreement is reached, the provider approves payment terms and conditions.
4) You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms.

HealthAdvocate℠

Health care just got easier with Health Advocacy and Medical Bill Saver.™

When your coverage begins, call **855.423.8585** or visit **healthadvocate.com/aflac**

Available through Aflac, powered by Health Advocate.

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

AGC1702757 IV (2/18)v

Group Benefit Program Summary for
City of Greenville & Greenville Utilities Commission

Voluntary Group Short-term Disability Insurance (STD)-Off the Job coverage only

Today, most Americans would not be able to make payments on their homes or keep their family financially stable without their current salary. STD reduces the burden during these unstable times. It is a convenient, economical way of securing an income while out of work from an unexpected injury or illness. Voluntary Group STD is a guaranteed issue coverage, which requires no health questionnaires to complete.

Eligibility	Option 1 - All Active Full-Time Employees enrolled in the 30/30 EP Plan Option 2 - All Active Full-Time Employees enrolled in the 60/60 EP Plan Option 3 - All Active Full-Time Employees enrolled in the 90/90 EP Plan
Group STD Benefit	$100 - $1,200 in increments of $100 not to exceed 60% of basic weekly earnings
Benefits Are Payable On	Option 1 - 31st day for Injury / 31st day for Sickness Option 2 - 61st day for Injury / 61st day for Sickness Option 3 - 91st day for Injury / 91st day for Sickness
Maximum Benefit Period	104 Weeks or until end of STD Duration
Total Disability	Total Disability means that due to Injury or Sickness the employee is unable to perform all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any, are less than the percentage (20%) of the employee's pre-disability weekly earnings.
Partial Disability	Partial Disability means that during the elimination period the employee is able to perform some, but not all, of the material and substantial duties of the employee's regular occupation. After the elimination period, partial disability means that due to Injury or Sickness the employee is able to perform some but not all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any are at least the minimum percentage (20%), but less than the maximum percentage of the employee's pre-disability weekly earnings (80%).
Pre-Existing Condition Limitation	3/6 - A Pre-Existing Condition is a Sickness or Injury for which you have received treatment within 3 months prior to your effective date. Any disability contributed to or caused by a Pre-Existing Condition within the first 6 months of your effective date will not be covered.
Additional Features	Survivor Benefit, Work Incentive Benefit, Worksite Modification Benefit, FMLA Coverage Extension, Recurrent Disability

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is solely responsible for the life and disability products described in this flier.

Product Details: Short-term Disability Insurance

VOLUNTARY GROUP SHORT TERM DISABILITY (STD)-Off the Job coverage only

PREMIUM RATE GRID

INCREMENTAL PURCHASE

City of Greenville & Greenville Utilities Commission

Eligibility

Option 1 - All Active Full-Time Employees enrolled in the 30/30 EP Plan
Option 2 - All Active Full-Time Employees enrolled in the 60/60 EP Plan
Option 3 - All Active Full-Time Employees enrolled in the 90/90 EP Plan

Benefit Schedule

You may choose a weekly benefit amount from $100 to $1,200 in $100 increments, not to exceed 60% of weekly earnings*.

Maximum Benefit Duration

104 weeks or until end of STD Duration

Elimination Period

Option 1 - 30 days for accident - 30 days for sickness
Option 2 - 60 days for accident - 60 days for sickness
Option 3 - 90 days for accident - 90 days for sickness

You may select a weekly benefit up to 60% of weekly earnings	**Bi-weekly Premium Cost** Based on 26 payroll deductions per year		
	Option 1	**Option 2**	**Option 3**
$ 100	$4.48	$3.37	$2.54
$ 200	$8.95	$6.74	$5.08
$ 300	$13.43	$10.11	$7.62
$ 400	$17.91	$13.48	$10.15
$ 500	$22.38	$16.85	$12.69
$ 600	$26.86	$20.22	$15.23
$ 700	$31.34	$23.58	$17.77
$ 800	$35.82	$26.95	$20.31
$ 900	$40.29	$30.32	$22.85
$ 1,000	$44.77	$33.69	$25.38
$ 1,100	$49.25	$37.06	$27.92
$ 1,200	$53.72	$40.43	$30.46

*Weekly Earnings means your weekly rate of earnings from your employer in effect immediately prior to the date disability begins. It includes total income before taxes including deduction made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include bonuses, overtime pay, any extra compensation or commissions. The information provided is only a summary of the benefits available. Refer to a certificate for details and limitations of coverage

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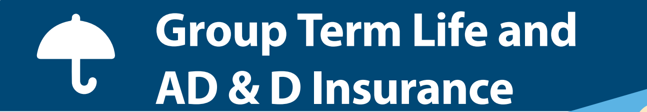
To learn more or enroll:

https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/



EMPLOYER PAID LIFE

Group Benefit Program Summary for City of Greenville & Greenville Utilities Commission Basic Term Life (Employer paid life)

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Dearborn National Life Insurance Company's Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All Active Full-Time Employees
Group Term Life Benefit: Employee	1 times salary to a maximum of $100,000 with a minimum of $10,000
Guarantee Issue Amount – Employee	$100,000
Group Term Life Benefit: Spouse (Includes Domestic Partners)	$2,000, not to exceed 100% of the employee benefit amount
Group Term Life Benefit: Child(ren)	Birth to age 26: $2,000
Group Term Life Age Reduction Schedule	Benefits reduce by 35% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.
Waiver of Premium	Elimination Period: 6 Months; Duration: To age 65
Accelerated Death Benefit (ADB)	Benefit: Up to 75% of the employee's life insurance; Life expectancy: 12 months or less
Portability Feature (Life Coverage)	Included (employee)
Conversion	Included
Beneficiary Resource Service	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Service	Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet.

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is solely responsible for the life and disability products described in this flier.

Product Details:

Group Term Life and AD & D Insurance

Group Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Group AD&D Benefit: Employee	Same as Basic Life
AD&D Age Reduction Schedule	Same as Basic Life

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- ▲ Seatbelt Benefit
- ▲ Airbag Benefit
- ▲ Repatriation Benefit
- ▲ Education Benefit
- ▲ In the Line of Duty Benefit

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Supplemental Term Life

Group Benefit Program Summary for City of Greenville/Greenville Utilities Commission Supplemental Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Dearborn National Life Insurance Company's Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All Active Full-Time Employees
Group Term Life Benefit: Employee	$10,000 - $500,000 in increments of $10,000
Grandfathering	Not Included
Guarantee Issue Amount – Employee	$150,000 (subject to eligibility rules and enrollment status guidelines)
Group Term Life Benefit: Spouse (Includes Domestic Partners)	$5,000 - $250,000 in increments of $5,000, not to exceed 50% of the employee benefit amount
Guarantee Issue Amount – Spouse	$10,000
Group Term Life Benefit: Child(ren)	Birth to age 26: $5,000 or $10,000
Group Term Life Age Reduction Schedule	Same as Basic Life
Premium Waiver Type	Same as Basic Life
Accelerated Death Benefit (ADB)	Same as Basic Life
Portability Feature (Life Coverage)	Included (employee)
Conversion	Included

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

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To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Supplemental Term Life

Eligibility
You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Supplemental Life
Employee Benefit: $10,000 to $500,000 in $10,000 increments.

Spouse Benefit*: $5,000 to $250,000 in $5,000 increments.
(not to exceed 50% of the employee benefit)
**Spouse may not have coverage unless the employee has coverage.*

Benefits reduce by 35% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.

Guarantee Issue
Employee: $150,000
Spouse: $10,000

Child Coverage
Birth to Age 26 $5,000 or $10,000

Bi-weekly Premium Cost
Based on 26 payroll deductions per year

Employee Premium		Spouse Premium	
Benefit Amount	Premium	Benefit Amount	Premium
$10,000	$1.02	$5,000	$0.51
$20,000	$2.03	$10,000	$1.02
$30,000	$3.05	$15,000	$1.52
$40,000	$4.06	$20,000	$2.03
$50,000	$5.08	$25,000	$2.54
$60,000	$6.09	$30,000	$3.05
$70,000	$7.11	$35,000	$3.55
$80,000	$8.12	$40,000	$4.06
$90,000	$9.14	$45,000	$4.57
$100,000	$10.15	$50,000	$5.08
$110,000	$11.17	$55,000	$5.58
$120,000	$12.18	$60,000	$6.09
$130,000	$13.20	$65,000	$6.60
$140,000	$14.22	$70,000	$7.11
$150,000	$15.23	$75,000	$7.62
$200,000	$20.31	$100,000	$10.15
$250,000	$25.38	$125,000	$12.69
$300,000	$30.46	$150,000	$15.23
$350,000	$35.54	$175,000	$17.77
$400,000	$40.62	$200,000	$20.31
$450,000	$45.69	$225,000	$22.85
$500,000	$50.77	$250,000	$25.38

Dependent Life (Children)
Bi-weekly Premium per Family

Benefit Amount	Premium
$5,000	$0.42
$10,000	$0.85

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CHUBB®

LifeTime Benefit Term

Life Insurance—Valuable protection for your loved ones

You work hard to provide a good life for your family. However, what if something happens to you? Chubb Lifetime Benefit Term provides the help you and your family needs to help pay for:

- Mortgage and Rent
- College and Education
- Retirement
- Household Expenses
- Long Term Care
- Childcare
- Family Debt
- Burial

LifeTime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living or nursing care. For about the same premium, Lifetime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Good things happen every day, and unfortunately hardship happens too.
Let us help you protect everything you value.

Creative Solutions for Term Life Insurance

Guaranteed Premiums
Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue to age 121.

Guaranteed Benefits During Working Years
Death Benefit is guaranteed 100% when it is needed most–during your working years when your family is relying on your income. While the policy is in force, the death benefit is 100% guaranteed for the longer of 25 years or age 70.

Guaranteed Benefits After Age 70
Even after age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50% of the original death benefit. And based on current interest rates and mortality assumptions, the full death benefit is designed to last a lifetime.

Paid-up Benefits
After 10 years, paid up benefits begin to accrue. At any point thereafter, if premiums stop, a reduced paid up benefit is guaranteed. Flexibility is perfect for retirement.

Long Term Care (LTC)*
If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Extension of Benefits*
Extends the monthly Long Term Care benefit for up to an additional 50 months, after 100% of the base death benefit has been used for LTC.

Terminal Illness Benefit
After your coverage has been in force for two years, you can receive 50% of your death benefit, up to $100,000, if you are diagnosed as terminally ill.

This product is underwritten by Combined Insurance Company of America, a Chubb company.

Product Details: LifeTime Benefit Term

LifeTime Benefit Term Can Help

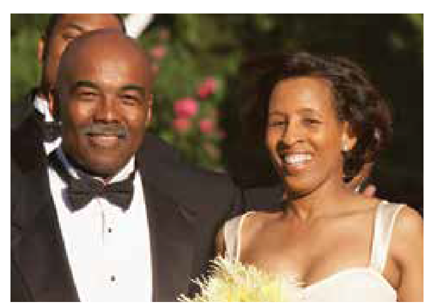
As Life Insurance
LifeTime Benefit Term protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long Term Care (LTC)
If you become chronically ill, LifeTime Benefit Term will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

- Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.
- With Extension of Benefits, if you continue to need LTC after you have exhausted your Death Benefits, you can receive up to 50 more months of benefits, for a total of 75 months of LTC benefits.

Restoration of Your Death Benefit
Ordinarily, accelerating your life coverage for Long Term Care benefits can reduce your death benefit to $0. While inforce, this rider restores your life coverage to not less than 25% of the death benefit on which your LTC benefits were based, not to exceed $50,000. This rider assures there will be a death benefit available for your beneficiary until you reach age 121.

For Terminal Illness
After your coverage has been in force for two years, you can receive 50% of your death benefit, up to $100,000, if you are diagnosed as terminally ill.



LifeTime Benefit Term Features

Affordable Financial Security
Lifelong protection with premiums beginning as low as $3 per week.

Dependable Guarantees
Guaranteed life insurance premium and death benefits last a lifetime.

Highly Competitive Rates
For the same premium, Lifetime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Fully Portable and Guaranteed Renewable for Life
Your coverage cannot be cancelled as long as premiums are paid as due.

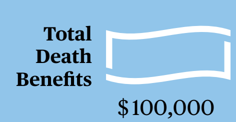
Family Coverage
Coverage is available for your spouse, children and dependent grandchildren.

Here's How LifeTime Benefit Term Works

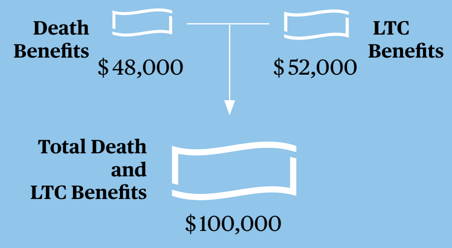
Once you make the promise to protect your family with LifeTime Benefit term, there are several ways it can work for you. You don't have to make any decisions on how you use your benefits until you actually need them.

Here is an example how LifeTime Benefit Term provides for you and your family.

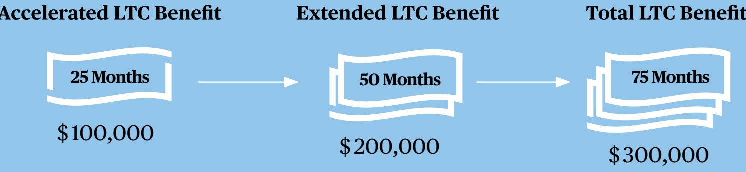
SCENARIO 1: Maximize Death Benefit
You lead a full life and don't need any long term care.



Scenario 2: Split Your Benefits
You lead a full life and need some home health care.



SCENARIO 3: Maximize Your Benefit
You lead a full life and need an assisted living lifestyle and/or nursing home care.



* LTC and Extension of Benefits premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums will not be increased solely because of an independent claim.

Product Details: LifeTime Benefit Term

Flexible and Customizable

Every plan starts with guaranteed death benefits and accelerated benefits for Long Term Care.

Benefit Summary

Benefit Options	Employee	Spouse
Long Term Care (LTC)	☑	☐
Extension of Benefits	☑	☐
Restoration of Death Benefits	☑	☐
Child Term	☐	☐

Employee Name:	Death Benefit	Deduction Amount
______	$______	$______
Spouse:	$______	$______
Children/Grandchildren: ______	$______	$______
______	$______	$______

Premium Deduction Mode:______ $______ Total Payroll Deduction

Additional Benefit Option

Child Term
Death Benefits available up to $25,000. Guaranteed conversion to individual coverage at age 26–up to 5 times the benefit amount.

LifeTime Benefit Term Exclusions

If the insured commits suicide, while sane or insane, within two years (one year in some states) from the Date of Issue, and while this Coverage is in force, We will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Long Term Care Exclusions

We will not pay Long Term Care benefits for care that is received or loss incurred as a result of: 1) an intentionally self-inflicted injury, or attempted suicide; or 2) war or any act of war, declared or undeclared, or service in the armed forces of any country; or 3) treatment of the Insured's alcohol, drug or other chemical dependence, except if the drug dependency was sustained or acquired at the hands of a Physician, or except while under treatment for an injury or sickness; or 4) the Insured's participation in a riot or insurrection, or the commission of, or attempt to commit, a felony.

We will not pay Long Term Care benefits if the Confinement, Home Health Care services, or Adult Day Care service: 1) is received outside the United States and its territories; or 2) is provided by ineligible providers; or 3) is rendered by members of the Certificateholder's or the Insured's Immediate Family.

If you have questions about this product contact (855) 241-9891.

This document is a brief description of Certificate Form No. C34544NC. Refer to your certificate of insurance for specific details about benefits, exclusions and limitations.

For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company.

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

To learn more or enroll:
https://pierceins.com/city-of-greenville/
https://pierceins.com/greenville-utilities/

Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. This insurance product is underwritten by Combined Insurance Company of America, Chicago, IL, a Chubb company.

CWB-LBT-LTC75-CGreen-NC-0818

Yes! I would like to keep my coverage.

When coverage is lost due to termination of employment or other losses of eligibility, employees and covered dependents may continue certain benefits. The following chart lists the continuation options.

Coverage	Option	Remarks
Dearborn National: Term Life Insurance	Convertible	Call Pierce Insurance Agency 800-421-3142
Dearborn National: Disability	Portable	Call Pierce Insurance Agency 800-421-3142
Transamerica: Cancer Insurance	Direct Bill	You will receive a continuation package from Transamerica on how to continue your policy on direct bill. If you have questions you may call 888-763-7474
Chubb: LifeTime Benefit Term Insurance	Portable	Call Pierce Insurance Agency 800-421-3142
Aflac Group: Accident Insurance	Direct Bill	Call customer service at 800-433-3036 and request a port packet to arrange for direct bill.
Aflac Group: Critical Illness Insurance	Direct Bill	Call customer service at 800-433-3036 and request a port packet to arrange for direct bill.

My premiums are no longer being payroll deducted. Complete this form, return to Pierce Insurance Agency today or call 800-421-3142.

Name: ____________________ **E-mail Address:** ____________________

Daytime Telephone Number: (   ) ____________________

Mailing Address: ____________________

Social Security Number or Date of Birth: ____________________

City: ____________________ **State:** ____________________ **Zip:** ____________________

Policy number(s) to be continued:

____

Which insurance do you want to continue? (check one or more)

☐ **Accident** ☐ **Cancer** ☐ **Critical Illness** ☐ **Term Life** ☐ **Disability** ☐ **LifeTime Benefit Term**

Return to:

Pierce Insurance
PO Box 727
Farmville, NC 27828

800-421-3142
info@pierceins.com
252-753-5941

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allows you and/or your dependents to continue your current Dental and Vision and HCFSA coverage for a specific period when you and/or your dependents are enrolled and coverage is lost due to a qualifying event. **You must pay the required cost of coverage.**

The following charts show the coverage provisions - **except for the duration of coverage for the HCFSA, which can only be continued to end of plan year.**

Qualifying Event	Qualifying Beneficiaries Who May Continue Coverage	Duration of Coverage
Your employment ends for any reason other than gross misconduct	You, spouse, dependent children	Up to 18 months
You lose benefit eligibility due to reduction in hours	You, spouse, dependent children	Up to 18 months
During the first 60 days of COBRA coverage you or your dependent become disabled under the Social Security Act	You, spouse, dependent children	Up to 29 months; months 1-18, 102% of premium: months 19-29, 150% of premium
You divorce or legally separate	Ex-spouse and/or dependent children	Up to 36 months from initial qualifying event
Your dependent children lose eligibility	Dependent children	Up to 36 months from initial qualifying event
You become covered by Medicare	Spouse and/or dependent children	Up to 36 months from initial qualifying event
Upon death of employee	Spouse and/or dependent children	Up to 36 months from initial qualifying event

Retirement Options

NC Retirement Systems Supplemental Benefits: www.ncretiree.com

When will I receive information on the North Carolina Retirement Systems Supplemental Benefits?

- After you have received your first retirement benefit payment, Pierce Insurance will mail you an enrollment book that summarizes the supplemental benefits that are available to you.
- Pierce Insurance will also send you an email summarizing your benefits and how to enroll.
- To obtain benefits you must complete the enrollment process within 60 days after you have received your first retirement benefit payment.

Where can I find information on Dental, Vision and Identity Theft Protection premiums?

- Go to www.ncretiree.com
- Call Pierce Insurance: 855-627-3847

What supplemental benefits are available to new retirees?

- Identity Theft Protection • Dental • Vision

Is there an association fee to participate?

No, all programs are offered directly through the North Carolina Retirement Systems.

What happens to my existing supplemental benefits when I retire?

This depends on the type of coverage you have and who your coverage is with. You should contact your Health Benefit Representative at your worksite to learn about your options.

How do I make sure I do not have a lapse in dental or vision coverage when I transition from employee to retiree?

You may need to continue your current plan(s) through COBRA until your North Carolina Retirement Systems plans are effective. Your Health Benefit Rep can advise you on your options.

Retirement —Your State Benefit Decisions

My NC Retirement for government employees, employers, and retirees. Here you'll find resources and tools to help you determine what actions to take to address your short-term and long-term financial and retirement planning needs. Learn more:

- https://www.nctreasurer.com/retirement-and-savings/Managing-My-Retirement/Pages/default.aspx
- 877-627-3287

Retirement – Other Helpful Information

- 50+ Insurance: www.pierceins.com/50plus
- The Official US Government Site for Medicare (https://www.medicare.gov/)
- Social Security Retirement Benefits (https://www.ssa.gov/retire/)
- Living Well in Retirement (http://www.webmd.com/healthy-aging/living-well-in-retirement-14/default.htm)

Contact Information for Questions and Claims

City of Greenville

Kimberly Phelps
kphelps@greenvillenc.gov
Phone 252-329-4496
Fax 252-329-4313

Pierce Insurance Agency, Inc.

3766 South Main Street, Farmville, NC 27828
Customer Service: 800-421-3142
www.pierceins.com/city-of-greenville/

Greenville Utilities

Leah Herring
herrinlr@guc.com
Phone 252-551-1473
Fax 252-551-1490

Pierce Insurance Agency, Inc.

3766 South Main Street, Farmville, NC 27828
Customer Service: 800-421-3142
www.pierceins.com/greenville-utilities/

Aflac - Group Accident & Critical Illness

Customer Service and Claims: 800-433-3036
https://aflacgroupinsurance.com/customer_service/

Chubb - LifeTime Benefit Term

Customer Service 855-241-9891, claims option 2, customer service option 3
Customer Service & Claims Fax 603-352-1179
Customer Service & Claims Email CSMail@selmanco.com

Dearborn National - Employer Paid Term Life, Supplemental Life and Disability

Life: Customer Service and Claims: 800-348-4512
Disability: Customer Service and Claims: 877-348-0487

Transamerica Life Insurance Company – Cancer

Claims Customer Service Department: 888-763-7474
Email Claim Documents to: tebclaimsscanning@transamerica.com

2019

EMPLOYEE BENEFITS PLAN

LEARN AND ENROLL:

MEDICAL AND DENTAL

CITY OF GREENVILLE

252-329-4496

KIMBERLY PHELPS • KPHELPS@GREENVILLENC.GOV

GREENVILLE UTILITIES

252-551-1473

LEAH HERRING • HERRINLR@GUC.COM

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800-421-3142

January 1, 2019 to December 31, 2019