EMPLOYEE BENEFITS PLAN

COASTAL CAROLINA COMMUNITY COLLEGE

PLAN YEAR: JULY 1, 2020 - JUNE 30, 2021

PIERCE GROUP BENEFITS

www.piercegroupbenefits.com

EMPLOYEE BENEFITS GUIDE

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Welcome to the Coastal Carolina Community College comprehensive benefits program. This booklet highlights the benefits offered to all eligible employees for the plan year listed below. Benefits described in this booklet are voluntary, employee-paid benefits unless otherwise noted.

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EFFECTIVE DATES: JULY 1, 2020 - JUNE 30, 2021

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** for informational purposes only

Rev. 03/25/2020

PRE-TAX & POST-TAX BENEFITS

COASTAL CAROLINA COMMUNITY COLLEGE

ENROLLMENT PERIOD: MARCH 30, 2020 - APRIL 9, 2020

EFFECTIVE DATES: JULY 1, 2020 - JUNE 30, 2021

PRE-TAX BENEFITS

*Flexible Spending Accounts**

IMS

- Medical Reimbursement Maximum: $2,750/year
- Dependent Care Reimbursement Maximum: $5,000/year

*You will need to re-sign for the spending accounts if you want them to continue next year.
IF YOU DO NOT RE-SIGN, YOUR CONTRIBUTION WILL STOP EFFECTIVE JUNE 30, 2020.

Dental Insurance

MetLife

Vision Insurance

Superior

Cancer Benefits

Colonial Life

*Disability Benefits***

Colonial Life

Accident Benefits

Colonial Life

Medical Bridge Benefits

Colonial Life

POST-TAX BENEFITS

*Disability Benefits***

Colonial Life

Critical Care Benefits

Colonial Life

Telemedicine

Call A Doctor Plus

Life Insurance

Colonial Life

- Term Life Insurance
- Whole Life Insurance

Pre-Tax or Post-Tax; Employee chooses tax status of Disability coverage.

Please note your insurance products will remain in effect unless you see a representative to change them.

THINGS YOU NEED TO KNOW

QUALIFICATIONS:

- Permanent Part-Time Employees and Permanent Full-Time Employees working 30 hours or more per week are eligible to participate.

IMPORTANT FACTS:

- The plan year for Colonial Insurance products, Spending Accounts, MetLife Dental, Superior Vision and Call A Doctor Plus Telemedicine lasts from July 1, 2020 through June 30, 2021.
- Deductions for Colonial Insurance products, MetLife Dental, Superior Vision and Call A Doctor Plus Telemedicine will begin June 2020. Deductions for Spending Accounts will begin July 2020.
- 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 the Benefits Representative.
- If you will be receiving a new debit card, whether you are a new participant or to replace your expired card, please be aware that it may take up to 30 days following your plan effective date for your card to arrive. Your card will be delivered by mail in a plain white envelope. During this time you may use manual claim forms for eligible expenses. Please note that your debit card is good through the expiration date printed on the card.
- Elections made during this enrollment period **CANNOT BE CHANGED AFTER THE ENROLLMENT PERIOD** unless there is a family status change as defined by the Internal Revenue Code. Examples of a family status change are: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of a spouse's employment, or the transition of spouse's employment from full-time to part-time, or vice-versa.
- Once a family status change has occurred, an employee has 30 days to notify the North Carolina Service Center at 1-888-662-7500 to request a change in elections.
- Flexible Spending Account expenses must be incurred during the Plan Year in order to be eligible for reimbursement.
- An employee has 90 days after the plan year ends to submit claims for spending account expenses that were incurred during the plan year. **Please note that if employment terminates during the plan year, that employee's plan year ends the day employment ends.** The employee has 90 days after the termination date to submit claims.
- With Dependent Care Flexible Spending Accounts, the maximum reimbursement you can request is equal to the current account balance in your Dependent Care account. ***You cannot be reimbursed more than has actually been deducted from your pay.***
- The Colonial Cancer plan and the Health Screening Rider on the Colonial Accident and Colonial Medical Bridge plan have a 30-day waiting period for new enrollees. Coverage, therefore, will not begin until July 31, 2020.
- **Additionally, some policies may include a pre-existing condition clause. Please read your policy carefully for full details.**
- Please be aware there are certain coverages that may be subject to federal and state tax when premium is paid by pretax deduction or employee contribution.
- An employee taking a leave of absence, other than under the Family & Medical Leave Act, may not be eligible to re-enter the Flexible Benefits Program until the next plan year. Please contact your Benefit Administrator for more information.

EMPLOYEE BENEFITS GUIDE

COASTAL CAROLINA COMMUNITY COLLEGE

IN PERSON

During your open enrollment period, a Pierce Group Benefits representative will be available by appointment to answer any questions you may have and to assist you in the enrollment process.

ONLINE

You may enroll or make changes online to your flexible benefits plan. To enroll online, please visit **https://harmonyenroll.coloniallife.com**

ENROLLMENT PERIOD: MARCH 30, 2020 - APRIL 9, 2020

YOU CAN MAKE THE FOLLOWING BENEFIT ELECTIONS ONLINE DURING THE ENROLLMENT PERIOD:

- Sign up/re-enroll your Flexible Spending Account (Medical Reimbursement and Dependent Care).
- Enroll, change or cancel your Vision Insurance.
- Enroll, change or cancel your Dental Insurance.
- Enroll, change or cancel your Telemedicine coverage.
- Enroll, change or cancel your Colonial products (see the following pages for changes that can be completed online).

ACCESS YOUR BENEFITS ONLINE WHENEVER, WHEREVER.

Benefits Details | ***Educational Videos*** | ***Download Forms*** | ***Online Chat with Service Center***

To view your personalized benefits website, go to:

www.piercegroupbenefits.com/coastalcarolinacommunitycollege

or piercegroupbenefits.com and click "Find Your Benefits".

IMPORTANT NOTE & DISCLAIMER

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 quoted is subject to change. All policy descriptions are for information purposes only. Your actual policies may be different than those in this booklet.

HARMONY ONLINE ENROLLMENT:

COMPLETE THE STEPS BELOW TO BEGIN THE ONLINE ENROLLMENT PROCESS

HELPFUL TIPS:

- If you are a new employee and unable to log into the online system, please speak with the Benefits Representative assigned to your location, or contact Human Resources.
- If you are an existing employee and unable to log into the online system, please contact the Harmony Help Desk at 866-875-4772 between 8:30am and 6:00pm, or speak with the Benefits Representative assigned to your location.

1. Go to **https://harmonyenroll.coloniallife.com**

- **Enter your User Name: COA17-** *and then* **Last Name** *and then* **Last 4 of Social Security Number** (COA17-SMITH6789)
- **Enter your Password: Four digit Year of Birth** *and then* **Last 4 of Social Security Number** (19766789)

2. The screen prompts you to create a NEW password [_____].

3. Choose a security question and enter answer [_____].

4. Click on 'I Agree' and then "Enter My Enrollment".

5. The screen shows 'Me & My Family'. Verify that the information is correct and enter the additional required information (title, marital status, work phone, e-mail address). Click 'Save & Continue' twice.

6. The screen allows you to add family members. It is only necessary to enter family member information if adding or including family members in your coverage. Click 'Continue'.

7. The screen shows updated personal information. Verify that the information is correct and make changes if necessary. Click 'Continue'.

8. The screen shows 'My Benefits'. Review your current benefits and make changes/selections for the upcoming plan year.

- ***DENTAL*** (Choose one of the options and click 'Save & Continue'):

1. If you have existing coverage and would like to keep it without making changes, click 'Keep This Benefit';
2. If you would like to enroll in coverage, or change existing coverage, choose your plan in the Enroll section;
3. If you would like to decline coverage, click 'Decline/Cancel Coverage'

Select family members that you wish to cover by clicking 'Add a Family Member'.

- ***VISION*** (Choose one of the options and click 'Save & Continue'):

1. If you have existing coverage and would like to keep it without making changes, click 'Keep This Benefit';
2. If you would like to enroll in coverage, or change existing coverage, choose your plan in the Enroll section;
3. If you would like to decline coverage, click 'Decline/Cancel Coverage'

Select family members that you wish to cover by clicking 'Add a Family Member'.

- ***TELEMEDICINE*** (Choose one of the options and click 'Save & Continue'):

1. If you would like to enroll in coverage, choose your plan in the Enroll section;
2. If you would like to decline coverage, click 'Decline/Cancel Coverage'

<<< ***enrollment instructions continued on next page*** >>>

HARMONY ONLINE ENROLLMENT CONT.:

- ***HEALTH CARE FSA*** (Choose one of the options and click 'Save & Continue'):
  1. Enter annual amount. MAX $2,750/year

- ***DEPENDENT CARE FSA*** (Choose one of the options and click 'Save & Continue'):
  1. Enter annual amount. MAX $5,000/year

- ***CANCER ASSIST***
  You may enroll online in Cancer Assist coverage.

- ***DISABILITY – NCK1000***
  You may enroll online in NCK1000 – the North Carolina Educator Disability Plan.

- ***ACCIDENT 1.0***
  You may enroll online in Accident 1.0; however persons over age 64 applying for coverage and employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.

- ***MEDICAL BRIDGE***
  You may enroll online in Medical Bridge coverage.

- ***CRITICAL CARE***
  You may enroll online in Critical Care coverage.

- ***TERM LIFE 5000***
  You may enroll online in Term Life 5000; however, employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.

- ***WHOLE LIFE 5000***
  You may enroll online in Whole Life 5000; however, employees wishing to purchase an individual policy for their spouse should speak with the Benefits Representative.

9. Click 'Finish'.

10. Click 'I Agree' to electronically sign the authorization for your benefit elections.

11. Click 'Print a copy of your Elections' to print a copy of your elections, or download and save the document. **Please do not forget this important step!**

12. Click 'Log out & close your browser window' and click 'Log Out'.

Don't lose the chance to put up to $800 back into your pocket this year!

Participating in a healthcare flexible spending account (FSA) is like receiving a 30% discount from your medical providers.

How does a healthcare FSA work?

A healthcare FSA is a flexible spending account that allows you to set aside pre-tax dollars for eligible medical, dental, and vision expenses for you and your dependents, even if they are not covered under your primary health plan.

You choose an annual election amount. At the beginning of the plan year, your account is pre-funded and your full contribution is immediately available for use. Your election amount is then deducted from your paychecks in equal installments throughout the year.

Why should I enroll in a healthcare FSA?

Almost everyone has some level of predictable and non-reimbursable medical needs.

If you expect to incur medical expenses that won't be reimbursed by another plan, you'll want to take advantage of the savings this plan offers. Money contributed to a healthcare FSA is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $800 per year on healthcare expenses!

How do I use my FSA to pay for healthcare expenses?

You can use your Debit Card to pay your providers for eligible healthcare expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Healthcare FSA funds can cover costs for:

- Copays, deductible payments, coinsurance
- Doctor office visits, exams, lab work, x-rays
- Hospital charges
- Prescription drugs
- Dental exams, x-rays, fillings, crowns, orthodontia
- Vision exams, frames, contact lenses, contact lens solution, laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies and first aid kits
- Prescribed over-the-counter medications
- And much more…

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Cosmetic procedures or surgery
- Dental products for general health
- Hygiene products
- Insurance premiums
- Late payment fees charged by healthcare providers

A comprehensive list of eligible expenses can be found at www.healthierbenefits.com.

Online & mobile access

Get instant access to your account with the **IMS Flex Portal** and **IMS Flex Weathcare Mobile App**.

- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the IMS Flex Portal at www.healthierbenefits.com

Download the IMS Flex Weathcare Mobile App at www.healthierbenefits. com

Helpful hints

- Your full election amount is available on the first day of the plan year, which means you'll have access to the money you need, when you need it.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Save your receipts when you spend your healthcare FSA dollars. You may need itemized invoices to verify the eligibility of expenses or for reimbursement requests.
- The easiest way to manage your account is online at www.healthierbenefits.com or through the IMS Flex Weathcare Mobile App.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your healthcare FSA by the end of the plan year.

Don't lose the chance to put up to $1,500 back into your pocket this year!

Participating in a dependent care flexible spending account (FSA) is like receiving a 30% discount from your care provider.

How does a dependent care FSA work?

A dependent care FSA is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses, such as daycare, that allow you to work or look for work.

You choose an annual election amount, up to $5,000 per family. The money is placed in your account via payroll deduction, in equal installments, and then used to pay for eligible dependent care expenses incurred during the plan year.

Why should I enroll in a dependent care FSA?

Child and dependent care is a large expense for many families. Millions of people rely on child care to be able to work, while others are responsible for older parents or disabled family members.

If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers. Money contributed to a dependent care account is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $1,500 per year on dependent care expenses!

How do I use my FSA to pay for dependent care expenses?

You can use your Debit Card to pay your provider for eligible dependent care expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Dependent care FSA funds can cover costs for:

- Before school or after school care for children 12 and younger
- Custodial care for dependent adults
- Licensed day care centers
- Nanny / Au Pair
- Nursery schools or preschools
- Late pick-up fees
- Summer or holiday day camps

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Expenses for non-disabled children 13 and older
- Educational expenses including kindergarten or private school tuition fees
- Food, clothing, sports lessons, field trips, and entertainment
- Overnight camp expenses
- Late payment fees for child care

A comprehensive list of eligible expenses can be found at www.healthierbenefits.com.

Online & mobile access

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- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the IMS Flex Portal at www.healthierbenefits.com

Download the IMS Flex Weathcare Mobile App at www.healthierbenefits.com or

Helpful hints

- You must have funds in your dependent care FSA before you can spend them.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Keep your receipts, you will need an itemized invoice for all reimbursement requests.
- The easiest way to manage your account is online at www.healthierbenefits.com or through the IMS Flex Weathcare Mobile App.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your dependent care FSA by the end of the plan year.

24/7 access to quality care... on your schedule!

Coastal Carolina Community College

	Complete
Teladoc Connect in under 10 minutes to US-based, board certified physicians who can answer questions, diagnose and even prescribe when necessary.	✓
Pharmacy Discount Card Save up to 75% on your prescription medication using our pharmacy discount card. It's easy to use and accepted at over 50,000 pharmacies nationwide!	✓
Life Assistance Access to professional Life Counselors and specialists who can help you achieve balance in your personal, family and work life is just a call away.	✓
Bill Saver Our Bill Saver program can help reduce the amount you owe for medical and dental bills over $400, often resulting in savings between 25-50%.	✓
Individual Rate PMPM Family Rate PFPM	$10.50 $13.50

For more information, please contact Pierce Group Benefits

Call A Doctor Plus
We Win When You Win.

Explanation of Benefits

The Call A Doctor Plus program provides your team with fast, convenient, 24/7 access to quality care by phone, video or mobile app. Here is more information about each service offered, including how to access the benefit.

Teladoc – Talk to a doctor in minutes

Teladoc provides your team with 24/7 phone or video access to doctors who can diagnose common medical conditions, provide treatment plans, and even write prescriptions when needed. Whether they're on vacation or it's 2 in the morning, your team can have access to the care they need, when they need it.

Key Benefits:

- → Talk to a doctor in 10 minutes on average
- → No co-pays, deductibles or per-call charges
- → 92% of issues are resolved on the first call
- → US-based, board-certified doctors
- → Connect 24/7/365 by phone, video or app
- → Get answers, prescriptions and treatment plans

Get Started in 3 Easy Steps!

1. Visit Teladoc.com or call (800) 835-2362 and select the option to 'set up your account'.
2. Be prepared to provide the following information
    a. First Name
    b. Last Name
    c. Date of Birth
    d. Zip Code
    e. Email Address: your primary email address
    f. Preferred Language
    g. Gender
    h. The name of your employer
3. Follow the rest of the steps, complete your medical history and you're all set!

Note: if trying to register online and your account cannot be found, please call (800) 835-2362 so that Teladoc's Client Service team can help you locate and set up your account.

Once you are finished, you can add dependents and download the mobile app.

Contact Teladoc

- → Phone: (800) 835-2362
- → Online: www.teladoc.com

Health Advocate – Help for life's challenges

Health Advocate gives your team 24/7 access to a Licensed Professional Counselor for help with personal, family, and work problems. They also have access to a work/life specialist who can help them find a wide range of support resources to help balance their work and life. All it takes is one phone call!

Key Benefits:

- → Support for stress, depression or anxiety
- → Help with work, marital or family issues
- → Network attorneys to assist with legal issues
- → Financial professionals for money matters
- → Childcare and Eldercare services
- → Thousands of online resources

Medical Bill Saver

Your team also has access to Health Advocates Medical Bill Saver program. Medical Bill Saver can help your team reduce the cost of uncovered medical and dental bills over $400. It's easy and can often result in 25 to 50% savings.

- → We work directly with doctors and other providers on your behalf
- → We have very high success rates of achieving significant savings
- → Our work often results in lower out-of-pocket costs
- → You become a savvier healthcare consumer through the process
- → Everyone in your immediate family can use the service.
- → ...and much more!

Contact Health Advocate

- → Phone: (877) 240-6863
- → Online: members.healthadvocate.com
  - o Select 'Complete Telehealth'

Pharmacy Discount Card – Save on prescription medication

Our FREE pharmacy discount card allows your employees to save up to 75% on your prescription medication using the pharmacy discount card. It's easy to use and accepted at over 50,000 pharmacies nationwide!

Key Benefits:

- → Save up to 75% on prescriptions
- → No claim forms to file
- → No deductibles
- → No limits or maximums
- → No pre-existing conditions

National Prescription Savings Network

Accessing the Discount Card

1. Register for a card at npsncard.com/teladoc
   a. Provide your personal information, including name, address, email and/or phone
   b. Click 'submit' and a card is sent to you by mail in 3 to 4 weeks
   c. If selected, your card will be immediately texted to your phone
2. Find a provider.
   a. Use searchrx.com to search local partners for the lowest possible price
   b. Search from over 50,000 pharmacies to find the best price
3. Go to your pharmacy of choice and present your card.
   a. You will pay the discounted rate at the time of purchase by showing your card.
   b. You will not have to fill out any reimbursement paperwork your savings are immediate!

Contact the Discount Card → Online: npsncard.com/teladoc

Dental Benefits from MetLife

Dental coverage designed for the real world.

MetLife®

Plan Design for: Coastal Carolina Community College

Choice, Service, Savings.
To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Coverage Type:	**In-Network[1]**	**Out-of-Network[1]**
Type A - Preventive	100% of PDP Fee[2]	100%of R&C Fee[4]
Type B - Basic Restorative	80% of PDP Fee[2]	80% of R&C Fee[4]
Type C - Major Restorative	50%of PDP Fee[2]	50% of R&C Fee[4]
Type D - Orthodontia	50% of PDP Fee	50% of R&C Fee
Deductible[3]		
Individual	$25	$25
Family	$75	$75
Annual Maximum Benefit:		
Per Person	$2000	$2000
Orthodontia Lifetime Max -- Adult and Child	$1000 per Person	

± Changes have been made to your Plan as of the Amendment Effective Date listed above. Please refer to your Certificate of Insurance/Certificate Rider for more details or contact your benefits administrator with any questions.ources.

1 "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP Provider. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a MetLife PDP Provider.

2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.

3 Applies to Type B and C services only.

4 Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Employee Only	**Employer Paid**
Employee + Spouse	**$42.24**
Employee + Child(ren)	**$40.54**
Employee + Family	**$94.73**

*List of Covered Services & Limitations**

Type A - Preventive	**How Many/How Often:**
Oral Examinations	• Oral exams but not more than once every 6 months.
X-rays	• Full mouth X-rays: once every 60 months.
Bitewing X-rays	• Not more than 1 set every 6 months for all Covered Persons.
Prophylaxis (cleanings)	• Cleaning of teeth (oral prophylaxis) but not more than once every 6 months.
Topical Fluoride Applications	• Topical fluoride treatment for a Dependent child under 19 years of age but not more than once in 12 months.
Sealants	• Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 14, but not more than once per tooth in a lifetime.
Space Maintainers	• Space Maintainers for dependent children to 19 years of age.
Periodontal Maintenance	• Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed four treatments in a calendar year.

Type B - Basic Restorative	**How Many/How Often:**
Fillings	• Amalgam and Resin-based Fillings.
Repairs of Dentures, Crowns, Inlays, and Onlays	• Simple Repairs of Cast Restorations.
Endodontics	• Root canal treatment.
Periodontal Surgery	
Periodontics	• Periodontal scaling and root planing.
Relining and Rebasing	• Relining and Rebasing of existing removable dentures.
Simple Extractions	
Oral Surgery	
Emergency palliative treatment	
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Consultations	
Injections of Antibiotic Drugs	

Type C - Major Restorative	**How Many/How Often:**
Crowns/Inlays/Onlays	• Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period.
Prefabricated Stainless Steel Crown	• Prefabricated stainless steel crowns but not more than once in any 60 month period.
Bridges and Dentures	• Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 Years prior to its replacement.

Type D – Orthodontia

- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Benefit for initial placement of the appliance will be made representing 20% of the total benefit.
- Orthodontic benefits end at cancellation of coverage

Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

* The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

The MetLife® Preferred Dentist Program (PDP) Exclusions

The following expenses are not Covered Dental Expenses

x Services or Supplies…

— related to teeth lost before dental benefits began or for congenitally missing natural teeth;
— received by a covered person before the dental expense benefits start for that person;
— which are covered by any worker's compensation laws or occupational disease laws;
— which are covered by any employer's liability laws;
— which an employer is required by law to furnish in whole or in part;
— received through the medical department or similar facility which is maintained by the covered person's employer;
— received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;[2]
— for which a covered person is not required to pay;[1]
— which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
— which do not meet generally accepted dental standards, including experimental treatment;
— received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
— which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.[2]

x Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.
x Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.
x Replacement of a lost, missing or stolen crown, bridge or denture.
x Repair or replacement of an orthodontic appliance.
x Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.
x Any duplicate appliance or prosthetic device.
x Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.
x Instruction for oral care such as hygiene or diet.
x Periodontal splinting.
x Charges by a dentist for completing dental forms.[2]
x Charges for broken appointments.[3]
x Temporary or provisional restorations.
x Temporary or provisional appliances.
x Sterilization supplies.[3]
x Services or supplies furnished by a family member.[3]
x Treatment of temporomandibular joint disorders.
x Implantology.
x Myofunctional therapy or correction of harmful habits.
x Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

In Maryland:

x Services or supplies furnished as a result of a Referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited Referral is one in which a Health Care Practitioner:

a. refers a covered person to; or
b. directs an employee or a person under contract with the Health Care Practitioner to refer a covered person to a Health Care Entity in which:
   a. the Health Care Practitioner; or
   b. the Health Care Practitioner's immediate family; or
   c. both own a Beneficial Interest or have a Compensation Agreement.

For the purposes of this provision, the terms "Referral," "Health Care Practitioner," "Health Care Entity," "Beneficial Interest," and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations

[1] In policies sitused in **MD,** these exclusions do not apply to Medicaid.
[2] Not applicable in **MD**.
[3] Not applicable in **FL, MD, NJ** and **TN**.

MetLife Preferred Dentist Program (PDP) Overview

Frequently Asked Questions

Who is a participating Preferred Dentist Program (PDP) dentist?
A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 10-35%‡ below the average fees charged for the same services by dentists in the same geographic area.
‡ Based on internal analysis by MetLife

How do I find a MetLife PDP dentist?
There are over 120,000 participating PDP dentist locations nationwide, including over 29,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/dental or by calling 1-800-942-0854 to have a list faxed or mailed to you.
Please Note: Be sure to verify provider participation when you make your appointment.

What services are covered by my plan?
All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any negotiated fees on non-covered services?
Yes. PDP negotiated fees extend to non-covered services, such as cosmetic dentistry, providing plan participants with savings on these non-covered services as well.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation?
Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. MetLife strongly recommends that you have your dentist submit a pretreatment estimate to MetLife if the cost is expected to exceed $300. When your dentist suggests treatment, have him or her send a claim form, along with the proposed treatment plans and supporting documentation, to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Do I need an ID card?
No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice
Response system

Do my dependents have to visit the same dentist that I select?
No, you and your dependents each have the freedom to choose any dentist.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/dental or request one by calling 1-800-942-0854. MetLife will mail you a concise explanation of benefits (EOB) after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1- 800-942-0854 after your plan's effective date.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

Vision plan benefits for Coastal Carolina Community College

You may choose from two plans: exam & materials plan, or materials only plan

Benefits through Superior National network

	Exam & Materials Plan	Materials Only Plan
Copays		
Exam	$10	N/A
Materials[1]	$10	$10
Contact lens fitting	$25	$25
Monthly premiums		
Emp. only	$7.39	$5.44
Emp. + 1 dependent	$12.63	$9.30
Emp. +1 dependent		$9.30
Emp. + family	$21.77	$16.03
Services/frequency		
Exam	12 months	N/A
Frames	24 months	24 months
Contact lens fitting	12 months	12 months
Lenses	12 months	12 months
Contact lenses	12 months	12 months

Benefits	In-network	Out-of-network	In-network	Out-of-network
Exam (MD)	Covered in full	Up to $34	N/A	N/A
Exam (OD)	Covered in full	Up to $26	N/A	N/A
Frames	$150 retail allowance	Up to $74	$150 retail allowance	Up to $74
Contact lens fitting (standard[2])	Covered in full	Not covered	Covered in full	Not covered
Contact lens fitting (specialty[2])	$50 retail allowance	Not covered	$50 retail allowance	Not covered
Lenses (standard) per pair				
Single vision	Covered in full	Up to $29	Covered in full	Up to $29
Bifocal	Covered in full	Up to $43	Covered in full	Up to $43
Trifocal	Covered in full	Up to $53	Covered in full	Up to $53
Progressive lens upgrade	See description[3]	Up to $53	See description[3]	Up to $53
Contact lenses[4]	$125 retail allowance	Up to $100	$125 retail allowance	Up to $100

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses.*

[2] *Standard Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty Contact Lens Fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses.*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay.*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit.*

Discount features

Look for providers in the provider directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on covered materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options
Specialty contact lens fit:	10% off retail, then apply allowance

Maximum member out-of-pocket

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Single vision	Bifocal & trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

[5] *Discounts and maximums may vary by lens type. Please check with your provider.*

Discounts on non-covered exam, services and materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, miscellaneous options:	20% off retail
Disposable contact lenses:	10% off retail
Retinal imaging:	$39 maximum out-of-pocket

Refractive surgery

Superior Vision has a nationwide network of independent refractive surgeons and partnerships with leading LASIK networks who offer members a discount. These discounts range from 10%-50%, and are the best possible discounts available to Superior Vision.

North Carolina residents: Please contact our customer service department if you are unable to secure a timely (at least 30 days) appointment with your provider or need assistance finding a provider within a reasonable distance (30 miles) of your residence. Adjustments to your benefits may be available

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

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

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Cancer Insurance

Our Cancer Assist plan helps employees protect themselves and their loved ones through their diagnosis, treatment and recovery journey.

This individual voluntary policy pays benefits that can be used for both medical and/or out-of-pocket, non-medical expenses traditional health insurance may not cover. Available exclusively at the workplace, Cancer Assist is an attractive addition to any competitive benefits package that won't add costs to a company's bottom line.

Talk to your benefits representative today to learn more about this product and how it helps provide extra financial protection to employees who may be impacted by cancer.

Competitive advantages

- Composite rates.
- Four distinct plan levels, each featuring the same benefits with premiums and benefit amounts designed to meet a variety of budgets and coverage needs (benefits overview on reverse).
- Indemnity-based benefits pay exactly what's listed for the selected plan level.
- The plan's Family Care Benefit provides a daily benefit when a covered dependent child receives inpatient or outpatient cancer treatment.
- Employer-optional cancer wellness/health screening benefits available:
  - Part One covers 24 tests. If selected, the employer chooses one of four benefit amounts for employees: $25, $50, $75 or $100. This benefit is payable once per covered person per calendar year.
  - Part Two covers an invasive diagnostic test or surgical procedure if an abnormal result from a Part One test requires additional testing. This benefit is payable once per calendar year per covered person and matches the Part One benefit.

Flexible family coverage options

- Individual, Individual/Spouse, One-parent and Two-parent family policies.
- Family coverage includes eligible dependent children (to age 26) for the same rate, regardless of the number of children covered.

Attractive features

- Available for businesses with 3+ eligible employees.
- Broad range of policy issue ages, 17-75.
- Each plan level features full schedule of 30+ benefits and three optional riders (benefit amounts may vary based on plan level selected).
- Benefits don't coordinate with any other coverage from any other insurer.
- HSA compliant.
- Guaranteed renewable.
- Portable.
- Waiver of premium if named insured is disabled due to cancer for longer than 90 consecutive days and the date of diagnosis is after the waiting period and while the policy is in force.
- Form 1099s may not be issued in most states because all benefits require that a charge is incurred. Discuss details with your benefits representative, or consult your tax adviser if you have questions.

Optional riders (available at an additional cost/payable once per covered person)

- Initial Diagnosis of Cancer Rider pays a one-time benefit for the initial diagnosis of cancer. A benefit amount in $1,000 increments from $1,000-$10,000 may be chosen. The benefit for covered dependent children is two and a half times ($2,500-25,000) the chosen benefit amount.
- Initial Diagnosis of Cancer Progressive Payment Rider pays a $50 lump-sum payment for each month the rider has been in force, after the waiting period, once cancer is first diagnosed. The issue ages for this rider are 17-64.
- Specified Disease Hospital Confinement Rider pays $300 per day for confinement to a hospital for treatment of one of 34 specified diseases covered under the rider.

Cancer Assist Benefits Overview

This overview shows benefits available for all four plan levels and the range of benefit amounts payable for most common cancer treatments. Each benefit is payable for each covered person under the policy. Actual benefits vary based on the plan level selected.

Each benefit requires that charges are incurred for treatment. All benefits and riders are subject to a 30-day waiting period. Waiting period means the first 30 days following the policy's coverage effective date during which no benefits are payable. States without a waiting period will have a pre-existing condition limitation. Product has exclusions and limitations that may affect benefits payable. Benefits vary by state and may not be available in all states. See your Colonial Life benefits representative for complete details.

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Radiation/Chemotherapy

- Injected chemotherapy by medical personnel: $250-$1,000 once per calendar week
- Radiation delivered by medical personnel: $250-$1,000 once per calendar week
- Self-injected chemotherapy: $150-$400 once per calendar month
- Topical chemotherapy: $150-$400 once per calendar month
- Chemotherapy by pump: $150-$400 once per calendar month
- Oral hormonal chemotherapy (1-24 months): $150-$400 once per calendar month
- Oral hormonal chemotherapy (25+ months): $75-$200 once per calendar month
- Oral non-hormonal chemotherapy: $150-$400 once per calendar month

Anti-nausea Medication

$25-$60 per day, up to $100-$240 per calendar month

Medical Imaging Studies

$75-$225 per study, up to $150-$450 per calendar year

Outpatient Surgical Center

$100-$400 per day, up to $300-$1,200 per calendar year

Skin Cancer Initial Diagnosis

$300-$600 payable once per lifetime

Surgical Procedures

Inpatient and Outpatient Surgeries: $40-$70 per surgical unit, up to $2,500-$6,000 per procedure

Reconstructive Surgery

$40-$60 per surgical unit, up to $2,500-$3,000 per procedure including 25% for general anesthesia

Anesthesia

General: 25% of Surgical Procedures Benefit
Local: $25-$50 per procedure

Hospital Confinement

30 days or less: $100-$350 per day
31 days or more: $200-$700 per day

Family Care

Inpatient and outpatient treatment for a covered dependent child: $30-$60 per day, up to $1,500-$3,000 per calendar year

Second Medical Opinion on Surgery or Treatment

$150-$300 once per lifetime

Home Health Care Services

Examples include physical therapy, speech therapy, occupational therapy, prosthesis and orthopedic appliances, durable medical equipment: $50-$150 per day, up to the greater of 30 days per calendar year or twice the number of days hospitalized per calendar year

Hospice Care

Initial: $1,000 once per lifetime
Daily: $50 per day
$15,000 maximum for initial and daily hospice care per lifetime

Transportation and Lodging

- **Transportation** for treatment more than 50 miles from covered person's home: $0.50 per mile, up to $1,000-$1,500 per round trip
- **Companion Transportation** (for any companion, not just a family member) for commercial travel when treatment is more than 50 miles from covered person's home: $0.50 per mile, up to $1,000-$1,500 per round trip
- **Lodging** for the covered person or any one adult companion or family member when treatment is more than 50 miles from the covered person's home: $50-$80 per day, up to 70 days per calendar year

Benefits also included in each plan

Air Ambulance, Ambulance, Blood/Plasma/Platelets/Immunoglobulins, Bone Marrow or Peripheral Stem Cell Donation, Bone Marrow Donor Screening, Bone Marrow or Peripheral Stem Cell Transplant, Cancer Vaccine, Egg(s) Extraction or Harvesting/Sperm Collection and Storage (Cryopreservation), Experimental Treatment, Hair/External Breast/Voice Box Prosthesis, Private Full-time Nursing Services, Prosthetic Device/Artificial Limb, Skilled Nursing Facility, Supportive or Protective Care Drugs and Colony Stimulating Factors

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Cancer Insurance

Wellness Benefits

To encourage early detection, our cancer insurance offers benefits for wellness and health screening tests.

For more information, talk with your benefits counselor.

Part One: Cancer Wellness/Health Screening

Provided when one of the tests listed below is performed after the waiting period and while the policy is in force. Payable once per calendar year, per covered person.

Cancer Wellness Tests

- Bone marrow testing
- Breast ultrasound
- CA 15-3 *[blood test for breast cancer]*
- CA 125 *[blood test for ovarian cancer]*
- CEA *[blood test for colon cancer]*
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA *[blood test for prostate cancer]*
- Serum protein electrophoresis *[blood test for myeloma]*
- Skin biopsy
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

Health Screening Tests

- Blood test for triglycerides
- Carotid Doppler
- Echocardiogram *[ECHO]*
- Electrocardiogram *[EKG, ECG]*
- Fasting blood glucose test
- Serum cholesterol test for HDL and LDL levels
- Stress test on a bicycle or treadmill

Part Two: Cancer Wellness — Additional Invasive Diagnostic Test or Surgical Procedure

Provided when a doctor performs a diagnostic test or surgical procedure after the waiting period as the result of an abnormal result from one of the covered cancer wellness tests in Part One. We will pay the benefit regardless of the test results. Payable once per calendar year, per covered person.

Waiting period means the first 30 days following the policy's coverage effective date during which no benefits are payable.

The policy has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form CanAssist (and state abbreviations where applicable – for example: CanAssist-TX).

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Group Specified Disease Insurance
Plan 3 Full

For more information, talk with your benefits counselor.

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If you're diagnosed with a covered specified disease, group specified disease insurance* from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

*The policy name is Specified Disease Group Insurance.

Face amount: $_____

Plan features

- A lump-sum payment that can be used as you see fit
- Adjustable face amount to best meet your personal needs
- May pay multiple times for a covered specified disease
- Guaranteed renewable
- Portable

Specified disease benefit

For the diagnosis of this covered specified disease condition:[1]	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Coma	100%
Permanent paralysis due to a covered accident	100%
Blindness	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Coronary artery bypass graft surgery/disease[2]	25%

Subsequent diagnosis of a different specified disease[3]

If you receive a benefit for a specified disease, and later you are diagnosed with a different specified disease, the original percentage of the face amount is payable for that particular specified disease.

Subsequent diagnosis of the same specified disease[3]

If you receive a benefit for a specified disease, and later you are diagnosed with the same specified disease, 25% of the original face amount is payable. Specified disease conditions that do not qualify are: coronary artery bypass graft surgery/coronary artery disease[2] and occupational infectious HIV or occupational infectious hepatitis B, C or D.

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1 Please refer to the certificate for complete definitions of covered conditions.

2 Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

3 Dates of diagnoses of a covered specified disease must be separated by at least 180 days.

THIS POLICY PROVIDES LIMITED BENEFITS.

EXCLUSIONS AND LIMITATIONS FOR SPECIFIED DISEASE

We will not pay the Specified Disease Benefit or Benefit Payable Upon Subsequent Diagnosis of a Specified Disease that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a specified disease.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C-GR-NC. Please see your Colonial Life benefits counselor for details.

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Group Specified Disease Insurance

First Diagnosis Building Benefit Rider (Specified Disease)

A specified disease can have a big impact on your finances. To help protect your way of life, you can add the first diagnosis building benefit rider to your group specified disease coverage. Available at an additional cost, the rider provides a lump-sum benefit when a covered specified disease* is first diagnosed.

First diagnosis building benefit rider

Payable once per covered person per lifetime

- **Named insured** ..... **Accumulates $1,000 each year**
- **Covered spouse/dependent child** ..... **Accumulates $500 each year**

The rider covers the same family members as your group specified disease insurance. The benefit amount accumulates each year the rider is in force before a diagnosis is made, up to a maximum of 10 years.

If you are diagnosed with a covered specified disease before the end of the first rider year, the rider will pay one-half of the annual building benefit amount.

For more information, talk with your benefits counselor.

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* Conditions that do not apply to the rider include coronary artery bypass graft surgery/coronary artery disease. Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

The certificate to which the rider is attached has exclusions and limitations. This is not an insurance contract and only the actual certificate provisions will control. Applicable to rider form R-GCC1.0-BB-NC. Please see your Colonial Life benefits counselor for details.

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Specified Disease Insurance

Health Screening Benefit

For more information, talk with your benefits counselor.

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The optional health screening benefit can help you reduce the risk of serious illness through early detection.

Health screening benefit.....$_____

Maximum of one screening test per covered person per calendar year.

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Carotid Doppler
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

For cost and complete details, see your Colonial Life benefits counselor. Applicable to form CI-1.0-NC and GCC1.0-P-NC.

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To be eligible for Short-Term Disability benefits you must have at least one year of contributing membership service in the Retirement System earned within the 36 calendar months preceding your disability. To be eligible for Long-Term Disability benefits you must have at least five years of contributing membership service in the Retirement System earned within the 96 calendar months prior to becoming disabled or upon cessation of continuous salary continuation payments, whichever is later.

THE STATE OF NORTH CAROLINA

PROVIDES A DISABILITY INCOME PLAN FOR ITS PERMANENT, FULL-TIME TEACHERS AND STATE EMPLOYEES – AT NO COST TO THE INDIVIDUAL.

The State Plan is designed to provide for the continuation of a portion of your salary should you suffer the misfortune of an *accident* or *sickness* which disables you for longer than 60 days. HERE'S HOW IT WORKS…

1. **WHEN YOU ARE DISABLED:**

	First 12 Months of Disability	**Thereafter****
Percentage of Your Total Monthly Salary the State Pays You*	50%	65%
Maximum Total Benefit	$3,000	$3,900
Reduced By	Workers' Compensation	Workers' Compensation Social Security
Not Reduced By	Social Security	----------

* 1/12 of your total pay during the 12 months prior to your disability.
** you must have at least five years of contributing membership service in the Retirement System earned within the 96 calendar months prior to the end of the short-term disability period.

2. Benefits under the State Plan are payable, for "Disability," which means that you are mentally or physically incapable of performing the duties of your usual occupation.

3. You become a member of the plan when you become a full-time, permanent employee of the State, and you are eligible to receive benefits from the Plan if you become disabled after you have completed one year's service. Your coverage under the Plan ends when your employment with the State terminates.

4. Benefits of the Plan are payable beginning **60 DAYS AFTER THE DATE OF YOUR DISABILITY** (60-day waiting period).

5. The Plan coordinates with other benefits related to your employment, so that *after* the amounts you are eligible to receive from Social Security (for the first six months only), Workers' Compensation, or State retirement plans, etc., the State pays you enough, in addition, to total a) 50% the first twelve months and b) 65% thereafter of your total salary, as explained in the chart above. **HOWEVER, ANY BENEFIT FROM A PLAN FOR WHICH *YOU* PAY THE ENTIRE COST YOURSELF DOES NOT AFFECT THE STATE PLAN IN ANY WAY.**

BENEFITS ARE SUBJECT TO NC STATE LAW

This information provided by Colonial Life Columbia, South Carolina 29202 www.coloniallife.com

Educator Income Protection Insurance

Colonial Life
Making benefits count.

How long could you afford to go without a paycheck?

Monthly Expenses:

$_____ Mortgage/rent	$_____ Groceries	$_____ Car
$_____ Medical bills	$_____ Utilities	$_____ Other

Total $_____

Colonial Life's Income Protection for School Personnel in North Carolina was designed especially to supplement existing state plans in North Carolina and help protect your paycheck.

My Coverage Worksheet (For use with your Colonial Life Benefits Counselor)

Employee Coverage (includes both on- and off-job benefits)

How much coverage do I need?

On-Job Accident/On-Job Sickness $_____ Off-Job Accident/Off-Job Sickness $_____

	On-Job	Off-Job
Total Disability		
First 3 months	$_____/month	$_____/month
Next 9 months	$_____/month	$_____/month
Partial Disability		
Up to 3 months	$_____/month	$_____/month

When will my benefits start?

After an Accident: _____ days After a Sickness: _____ day

What additional features are available?

- Normal pregnancy is covered the same as any other covered sickness.
- Waiver of Premium.
- You're eligible for most benefits from the first day of your covered accident – including weekends, holidays and summer vacation – with no waiting period. Disability benefits may have an elimination period.

How much will it cost?

Your cost will vary based on the level of coverage you select.

NCK 1000

Employee Coverage

In addition to disability coverage, this plan also provides employees with benefits for medical fees related to accidents, hospital confinement, accidental death and dismemberment, as well as fractures and dislocations. Even if you're not disabled, the following benefits are payable for covered accidental injuries:

Even if you're not disabled, the following benefits are payable for covered accidental injuries:

Medical Fees for Accidents Only

Medical Fees are for doctor office visits, X-rays, and hospital emergency room expenses, including supplies used.

Up to $350

Hospital Confinement Benefit for Accident or Sickness

Pays in addition to disability benefit.

- Benefits begin on the first day of confinement in a hospital for a covered accident or covered sickness.
  Up to 3 months $1,200/month ($40/day)
  The Hospital Confinement benefit increases to $6,200/month when the Total Disability benefit ends at age 70.

Accidental Death and Dismemberment Benefits

Benefits payable for death or dismemberment occurring within 90 days from date of accident.

- Accidental Death $10,000
- Loss of a Finger or Toe
  Single Dismemberment $750
  Double Dismemberment $1,500
- Loss of a Hand, Foot or Sight of an Eye
  Single Dismemberment $5,000
  Double Dismemberment $10,000
- Common Carrier Death (includes school bus for school activities) $20,000

Complete Fractures

Complete Fractures requiring closed reduction

Hip, Thigh	$1,500
Vertebrae	1,350
Pelvis	1,200
Skull (depressed)	1,125
Leg	900
Foot, Ankle, Kneecap	750
Forearm, Hand, Wrist	750
Lower Jaw	600
Shoulder Blade, Collarbone	600
Skull (simple)	525
Upper Arm, Upper Jaw	525
Facial Bones	450
Vertebral Processes	300
Coccyx, Rib, Finger, Toe	120

Complete Dislocations

Complete Dislocations requiring closed reduction with anesthesia

Hip	$1,350
Knee	975
Shoulder	750
Collarbone	675
Ankle, Foot	600
Hand	525
Lower Jaw	450
Wrist	375
Elbow	300
One Finger, Toe	120

- **For a fracture or dislocation** requiring an open operation, your benefit would be 1½ times the amount shown.
- **For a chip fracture**, your benefit would be 25% of the amount shown. Chip fractures are those in which a fragment of bone is broken off near a joint at a point where a ligament is attached.
- **For multiple fractures or dislocations**, you would receive each amount, up to a total of 1½ times the highest amount.
- **For your first dislocation**, you would receive the amount shown; however, recurrent dislocations of the same joint are not covered.

Optional Spouse and Dependent Coverage

You may cover one or all of the eligible dependent members of your family for an additional premium. Eligible dependents include your spouse and ALL dependent children who are younger than age 26.

Medical Fees for Accidents Only

Medical Fees are for doctor office visits, X-rays, and hospital emergency room expenses, including supplies used.

Up to	$350

Hospital Confinement Benefit for Accident or Sickness

• Up to 3 months	$1,200/month ($40/day)

Accidental Death and Dismemberment Benefits

• Accidental Death	$1,000
• Loss of a Finger or Toe	
Single Dismemberment	$75
Double Dismemberment	$150
• Loss of a Hand, Foot or Sight of an Eye	
Single Dismemberment	$500
Double Dismemberment	$1,000
• Common Carrier Death (includes school bus for school activities)	$2,000

Here are some frequently asked questions about Colonial Life's Educator Income Protection insurance:

Will my disability income payment be reduced if I have other insurance?

You're paid regardless of workers' compensation or any other insurance you may have with other insurance companies. Benefits are paid directly to you (unless you specify otherwise).

When am I considered totally disabled?

Totally disabled means you are:

- Unable to perform the material and substantial duties of your job;
- Not, in fact, working at any job; and
- Under the regular and appropriate care of a doctor.

What if I want to return to work part-time after I am totally disabled?

You may be able to return to work part-time and still receive benefits. We call this "Partial Disability." This means you may be eligible for coverage if:

- You are unable to perform the material and substantial duties of your job for 20 hours or more per week,
- You are able to work at your job or your place of employment for less than 20 hours per week,
- Your employer will allow you to return to your job or place of employment for less than 20 hours per week; and
- You are under the regular and appropriate care of a doctor.

The total disability benefit must have been paid for at least one full month immediately prior to your being partially disabled.

When do disability benefits end?

The Total Disability Benefit will end on the policy anniversary date on or next following your 70th birthday.
The Hospital Confinement benefit increases when the Total Disability Benefit ends.

What if I change employers or retire?

If you change jobs or retire, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable for life as long as you pay your premiums when they are due or within the grace period.

How do I file a claim

Visit coloniallife.com or call our Policyholder Service Center at 1.800.325.4368 for additional information.

What is a pre-existing condition?

A pre-existing condition means a sickness or physical condition for which any covered person was treated, received medical advice, or had taken medication within 12 months before the effective date of the policy. If you are age 65 or older when the policy is issued, pre-existing conditions include only conditions specifically excluded from coverage by the rider.

If you become disabled due to a pre-existing condition, we will not pay for any disability period if it begins during the first 12 months the policy is in force.

What is a covered accident or a covered sickness?

A covered accident is an accident. A covered sickness means an illness, infection, disease or any other abnormal physical condition.

A covered accident or covered sickness:

- Occurs after the effective date of the policy;
- Occurs while the policy is in force; and
- Is of a type listed on the Policy Schedule; and
- Is not excluded by name or specific description in the policy.

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of: alcoholism or drug addiction; flying; hazardous avocations; felonies or illegal occupations; having a pre-existing condition as defined and limited by the policy; psychiatric or psychological condition; racing; semi-professional or professional sports; suicide or self-inflicted injury, war or armed conflict.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form NCK1000-NC. This is not an insurance contract and only the actual policy provisions will control.

NCK 1000

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1200 Colonial Life Boulevard
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Accident Insurance

Colonial Life®

Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they're unexpected. How you care for them shouldn't be.

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries
- Car accidents
- Falls & spills
- Dislocation
- Accidental injuries that send you to the Emergency Room, Urgent Care or doctor's office

Colonial Life's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Plus you'll feel better knowing you can have greater financial security.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Healthcare Spending Account (HSA) guidelines

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable as long as you pay your premiums when they are due or within the grace period.

Can my premium change?

Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

Accident 1.0-Preferred with Health Screening Benefit

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment..... $150
- X-ray Benefit.....$50
- Ambulance $400
- Air Ambulance..... $2,000

Common Accidental Injuries

Dislocations (Separated Joint)	Non-Surgical	Surgical
Hip	$6,600	$13,200
Knee (except patella)	$3,300	$6,600
Ankle – Bone or Bones of the Foot (other than Toes)	$2,640	$5,280
Collarbone (Sternoclavicular)	$1,650	$3,300
Lower Jaw, Shoulder, Elbow, Wrist	$990	$1,980
Bone or Bones of the Hand	$990	$1,980
Collarbone (Acromioclavicular and Separation)	$330	$660
One Toe or Finger	$330	$660

Fractures	Non-Surgical	Surgical
Depressed Skull	$5,500	$11,000
Non-Depressed Skull	$2,200	$4,400
Hip, Thigh	$3,300	$6,600
Body of Vertebrae, Pelvis, Leg	$1,650	$3,300
Bones of Face or Nose (except mandible or maxilla)	$770	$1,540
Upper Jaw, Maxilla	$770	$1,540
Upper Arm between Elbow and Shoulder	$770	$1,540
Lower Jaw, Mandible, Kneecap, Ankle, Foot	$660	$1,320
Shoulder Blade, Collarbone, Vertebral Process	$660	$1,320
Forearm, Wrist, Hand	$660	$1,320
Rib	$550	$1,100
Coccyx	$440	$880
Finger, Toe	$220	$440

Your Colonial Life policy also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) .....$1,000 to $12,000
- Coma.....$10,000
- Concussion $150
- Emergency Dental Work .....$75 Extraction, $300 Crown, Implant, or Denture
- Lacerations (based on size).....$50 to $800

Requires Surgery

- Eye Injury.....$300
- Tendon/Ligament/Rotator Cuff.....$500 - one, $1,000 - two or more
- Ruptured Disc $500
- Torn Knee Cartilage $500

Surgical Care

- Surgery (cranial, open abdominal or thoracic).....$1,500
- Surgery (hernia) $150
- Surgery (arthroscopic or exploratory) $250
- Blood/Plasma/Platelets $300

Transportation/Lodging Assistance

If injured, covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Transportation ..... $500 per round trip up to 3 round trips
- Lodging (family member or companion) ..... $125 per night up to 30 days for a hotel/motel lodging costs

Accident Hospital Care

- Hospital Admission* ..... $1,500 per accident
- Hospital ICU Admission* ..... $3,000 per accident

** We will pay either the Hospital Admission or Hospital Intensive Care Unit (ICU) Admission, but not both.*

- Hospital Confinement ..... $250 per day up to 365 days per accident
- Hospital ICU Confinement ..... $500 per day up to 15 days per accident

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit ..... $50 (up to 3 visits per accident)
- Medical Imaging Study ..... $250 per accident (limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy ..... $35 per treatment up to 10 days
- Appliances ..... $125 (such as wheelchair, crutches)
- Prosthetic Devices/Artificial Limb ..... $500 - one, $1,000 - more than 1
- Rehabilitation Unit ..... $100 per day up to 15 days per covered accident, and 30 days per calendar year. Maximum of 30 days per calendar year

Accidental Dismemberment

- Loss of Finger/Toe ..... $750 – one, $1,500 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye ..... $7,500 – one, $15,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

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

Named Insured ..... $25,000 Spouse ..... $25,000 Child(ren) $12,500

365-day elimination period. Amounts reduced for covered persons age 65 and over. Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	$25,000	$100,000
• Spouse	$25,000	$100,000
• Child(ren)	$5,000	$20,000

Health Screening Benefit

- **$50 per covered person per calendar year**

Provides a benefit if the covered person has one of the health screening tests performed.
This benefit is payable once per calendar year per person and is subject to a 30-day waiting period.

Tests include:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid doppler
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult 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)
- Stress test on a bicycle or treadmill
- Skin cancer biopsy
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

My Coverage Worksheet (For use with your Colonial Life benefits counselor)

Who will be covered? (check one)

○ Employee Only ○ Spouse Only ○ One Child Only ○ Employee & Spouse

○ One-Parent Family, with Employee ○ One-Parent Family, with Spouse ○ Two-Parent Family

When are covered accident benefits available? (check one)

○ On and Off -Job Benefits ○ Off -Job Only Benefits

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of: hazardous avocations; felonies or illegal occupations; racing; semi-professional or professional sports; sickness; suicide or self-inflicted injuries; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of: birth; intoxication.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form Accident 1.0-HS-NC. This is not an insurance contract and only the actual policy provisions will control.

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1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

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The following summary is included in this booklet for informational purposes only. Open Enrollment for the State of North Carolina Teachers' and State Employees' Health Plan is not part of this benefits plan open enrollment period. Pierce Group Representatives are not authorized to assist employees with their SHP enrollment or make SHP enrollment elections on an employee's behalf.

2020 STATE HEALTH PLAN COMPARISON

Active and Non-Medicare Subscribers

PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,250 Individual $3,750 Family	$2,500 Individual $7,500 Family	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Coinsurance	20% of eligible expenses after deductible is met	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible is met	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	$4,890 Individual $14,670 Family	$9,780 Individual $29,340 Family	$5,900 Individual $16,300 Family	$11,800 Individual $32,600 Family
Preventive Services	$0 (covered at 100%)	N/A	$0 (covered at 100%)	N/A
Office Visits	$25 for PCP; $10 if you use PCP on ID card; $80 Specialist	40% after deductible is met	$45 for PCP; $30 if you use PCP on ID card; $94 for Specialist	50% after deductible is met
Urgent Care	$70		$100	

PCP: Primary Care Provider

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

DALE R. FOLWELL, CPA
STATE TREASURER OF NORTH CAROLINA

PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Copay waived w/admission or observation stay)	$300 copay, then 20% after deductible is met		$337 copay, then 30% after deductible is met	
Inpatient Hospital	$300 copay, then 20% after deductible is met	$300 copay, then 40% after deductible is met	$337 copay, then 30% after deductible is met	$337 copay, then 50% after deductible is met
PHARMACY BENEFITS				
Tier 1 (Generic)	$5 copay per 30-day supply		$16 copay per 30-day supply	
Tier 2 (Preferred Brand & High-Cost Generic)	$30 copay per 30-day supply		$47 copay per 30-day supply	
Tier 3 (Non-preferred Brand)	Deductible/coinsurance		Deductible/coinsurance	
Tier 4 (Low-Cost Generic Specialty)	$100 copay per 30-day supply		$200 copay per 30-day supply	
Tier 5 (Preferred Specialty)	$250 copay per 30-day supply		$350 copay per 30-day supply	
Tier 6 (Non-preferred Specialty)	Deductible/coinsurance		Deductible/coninsurance	
Preferred Diabetic Testing Supplies**	$5 copay per 30-day supply		$10 copay per 30-day supply	

** Preferred Brand is the OneTouch Test Strips. Non-preferred diabetic testing supplies are considered a Tier 3 member copay.

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Hospital Confinement Indemnity Insurance
Plan 3

For more information, talk with your benefits counselor.

Our Individual Medical Bridge℠ insurance can help with medical costs that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement ..... $_____
Maximum of one benefit per covered person per calendar year

Observation room ..... **$100 per visit**
Maximum of two visits per covered person per calendar year

Rehabilitation unit confinement ..... **$100 per day**
Maximum of 15 days per confinement with a 30-day maximum per covered person per calendar year

Waiver of premium
Available after 30 continuous days of a covered hospital confinement of the named insured

Diagnostic procedure

- **Tier 1** **$250**
- **Tier 2** **$500**

Maximum of $500 per covered person per calendar year for all covered diagnostic procedures combined

Outpatient surgical procedure

- **Tier 1** ..... $_____
- **Tier 2** ..... $_____

Maximum of $_____ per covered person per calendar year for all covered outpatient surgical procedures combined

The following is a list of common diagnostic procedures that may be covered.

Tier 1 diagnostic procedures

- **Breast**
  - Biopsy (incisional, needle, stereotactic)
- **Diagnostic radiology**
  - Nuclear medicine test
- **Digestive**
  - Barium enema/lower GI series
  - Barium swallow/upper GI series
  - Esophagogastroduodenoscopy (EGD)
- **Ear, nose, throat, mouth**
  - Laryngoscopy
- **Gynecological**
  - Amniocentesis
  - Cervical biopsy
  - Cone biopsy
  - Endometrial biopsy
  - Hysteroscopy
  - Loop electrosurgical excisional procedure (LEEP)
- **Liver** – biopsy
- **Lymphatic** – biopsy
- **Miscellaneous**
  - Bone marrow aspiration/biopsy
- **Renal** – biopsy
- **Respiratory**
  - Biopsy
  - Bronchoscopy
  - Pulmonary function test (PFT)
- **Skin**
  - Biopsy
  - Excision of lesion
- **Thyroid** – biopsy
- **Urologic**
  - Cystoscopy

Tier 2 diagnostic procedures

- **Cardiac**
  - Angiogram
  - Arteriogram
  - Thallium stress test
  - Transesophageal echocardiogram (TEE)
- **Diagnostic radiology**
  - Computerized tomography scan (CT scan)
  - Electroencephalogram (EEG)
  - Magnetic resonance imaging (MRI)
  - Myelogram
  - Positron emission tomography scan (PET scan)

The surgeries listed below are only a sampling of the surgeries that may be covered. Surgeries must be performed by a doctor in a hospital or ambulatory surgical center. For complete details and definitions, please refer to your policy.

Tier 1 outpatient surgical procedures

- **Breast**
  - Axillary node dissection
  - Breast capsulotomy
  - Lumpectomy
- **Cardiac**
  - Pacemaker insertion
- **Digestive**
  - Colonoscopy
  - Fistulotomy
  - Hemorrhoidectomy
  - Lysis of adhesions
- **Skin**
  - Laparoscopic hernia repair
  - Skin grafting
- **Ear, nose, throat, mouth**
  - Adenoidectomy
  - Removal of oral lesions
  - Myringotomy
  - Tonsillectomy
  - Tracheostomy
  - Tympanotomy
- **Gynecological**
  - Dilation and curettage (D&C)
  - Endometrial ablation
  - Lysis of adhesions
- **Liver**
  - Paracentesis
- **Musculoskeletal system**
  - Carpal/cubital repair or release
  - Foot surgery (bunionectomy, exostectomy, arthroplasty, hammertoe repair)
  - Removal of orthopedic hardware
  - Removal of tendon lesion

Tier 2 outpatient surgical procedures

- **Breast**
  - Breast reconstruction
  - Breast reduction
- **Cardiac**
  - Angioplasty
  - Cardiac catheterization
- **Digestive**
  - Exploratory laparoscopy
  - Laparoscopic appendectomy
  - Laparoscopic cholecystectomy
- **Ear, nose, throat, mouth**
  - Ethmoidectomy
  - Mastoidectomy
  - Septoplasty
  - Stapedectomy
  - Tympanoplasty
- **Eye**
  - Cataract surgery
  - Corneal surgery (penetrating keratoplasty)
  - Glaucoma surgery (trabeculectomy)
  - Vitrectomy
- **Gynecological**
  - Hysterectomy
  - Myomectomy
- **Musculoskeletal system**
  - Arthroscopic knee surgery with meniscectomy (knee cartilage repair)
  - Arthroscopic shoulder surgery
  - Clavicle resection
  - Dislocations (open reduction with internal fixation)
  - Fracture (open reduction with internal fixation)
  - Removal or implantation of cartilage
  - Tendon/ligament repair
- **Thyroid**
  - Excision of a mass
- **Urologic**
  - Lithotripsy

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EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, or war. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition. Pre-exisiting conditions are those conditions whether diagnosed or not, for which a covered person received medical advice, diagnosis or care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the policy. If a covered person is 65 or older when the policy is issued, pre-existing conditions will include only conditions specifically eliminated by rider.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000-NC. This is not an insurance contract and only the actual policy provisions will control.

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Hospital Confinement Indemnity Insurance

Health Screening

For more information, talk with your benefits counselor.

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Individual Medical Bridge℠ insurance's health screening benefit can help pay for health and wellness tests you have each year.

Health screening ..... $_____

Maximum of one health screening test per covered person per calendar year; subject to a 30-day waiting period

- 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)
- Carotid Doppler
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

Waiting period means the first 30 days following any covered person's policy coverage effective date, during which no benefits are payable. For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number IMB7000 (including state abbreviations where used, for example: IMB7000-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

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Hospital Confinement Indemnity Insurance

Medical Treatment Package

For more information, talk with your benefits counselor.

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The medical treatment package for Individual Medical Bridge℠ coverage can help pay for deductibles, co-payments and other out-of-pocket expenses related to a covered accident or covered sickness.

The medical treatment package paired with Plan 3 provides the following benefits:

Air ambulance **$1,000**
Maximum of one benefit per covered person per calendar year

Ambulance **$100**
Maximum of one benefit per covered person per calendar year

Appliance **$100**
Maximum of one benefit per covered person per calendar year

Doctor's office visit ..... **$25 per visit**
Maximum of three visits per calendar year for named insured coverage or maximum of five visits per calendar year for all covered persons combined

Emergency room visit ..... **$100 per visit**
Maximum of two visits per covered person per calendar year

X-ray ..... **$25 per benefit**
Maximum of two benefits per covered person per calendar year

THIS POLICY PROVIDES LIMITED BENEFITS.

EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, or war.

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IMB7000-MEDICAL TREATMENT PACKAGE NORTH CAROLINA EDUCATORS | 1-16 | NS-15014-NC

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Hospital Confinement Indemnity Insurance

Optional Riders

For more information, talk with your benefits counselor.

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Individual Medical Bridge℠ offers two optional benefit riders – the daily hospital confinement rider and the enhanced intensive care unit confinement rider. For an additional cost, these riders can help provide extra financial protection to help with out-of-pocket medical expenses.

Daily hospital confinement rider ..... **$100 per day**
Per covered person per day of hospital confinement
Maximum of 365 days per covered person per confinement

Enhanced intensive care unit confinement rider ..... **$500 per day**
Per covered person per day of intensive care unit confinement
Maximum of 30 days per covered person per confinement

Re-confinement for the same or related condition within 90 days of discharge is considered a continuation of a previous confinement.

EXCLUSIONS

We will not pay benefits for losses which are caused by: alcoholism or drug addiction, dental procedures, elective procedures and cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide or injuries which any covered person intentionally does to himself or herself, or war. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition. Pre-exisiting conditions are those conditions whether diagnosed or not, for which a covered person received medical advice, diagnosis or care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the policy. If a covered person is 65 or older when the policy is issued, pre-existing conditions will include only conditions specifically eliminated by rider.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to rider numbers R-DHC7000-NC and R-EIC7000-NC. This is not an insurance contract and only the actual policy or rider provisions will control.

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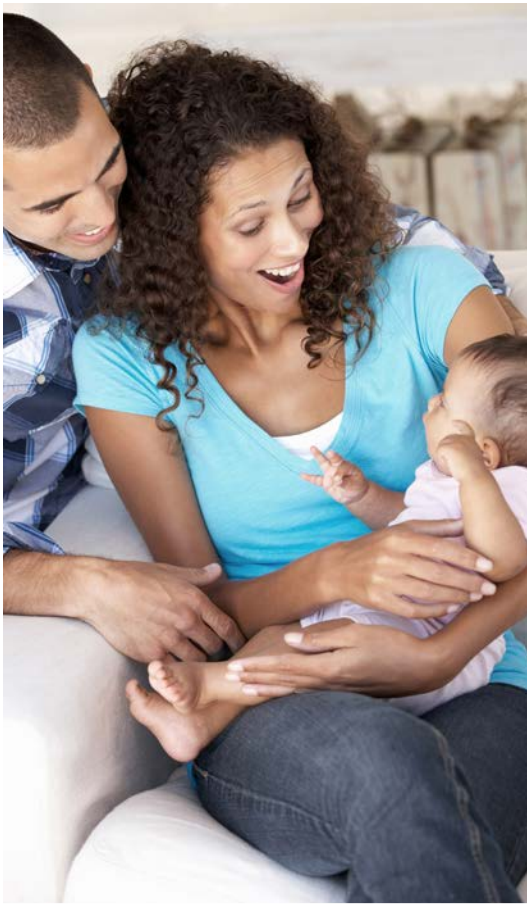
Colonial Life

Term Life Insurance



Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Life insurance protection when you need it most

Life insurance needs change as life circumstances change. You may need different coverage if you're getting married, buying a home or having a child.

Term life insurance from Colonial Life provides protection for a specified period of time, typically offering the greatest amount of coverage for the lowest initial premium. This fact makes term life insurance a good choice for supplementing cash value coverage during life stages when obligations are higher, such as while children are younger. It's also a good option for families on a tight budget — especially since you can convert it to a permanent cash value plan later.

With this coverage:

- A beneficiary can receive a benefit that is typically free from income tax.
- The policy's accelerated death benefit can pay a percentage of the death benefit if the covered person is diagnosed with a terminal illness.
- You can convert it to a Colonial Life cash value insurance plan, with no proof of good health, to age 75.
- Coverage is guaranteed renewable up to age 95 as long as premiums are paid when due.
- Portability allows you to take it with you if you change jobs or retire.

Spouse coverage options	Dependent coverage options
Two options are available for spouse coverage at an additional cost:	You may add a Children's Term Life Rider to cover all of your eligible dependent children with up to $20,000 in coverage each for one premium.
1. Spouse Term Life Policy: Offers guaranteed premiums and level death benefits equivalent to those available to you –whether or not you buy a policy for yourself.	
2. Spouse Term Life Rider: Add a term rider for your spouse to your policy, up to a maximum death benefit of $50,000; 10-year and 20-year are available (20-year rider only available with a 20- or 30-year term policy).	The Children's Term Life Rider may be added to either the primary or spouse policy, not both.

If the insured dies by suicide, whether sane or insane, within two years (one year in ND) from the coverage effective date or the date of reinstatement, we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. Product may vary by state. For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

Colonial Life insurance products are underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

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Colonial Life

Whole Life Insurance

Talk with your Colonial Life benefits counselor to learn more.

ColonialLife.com

Life insurance that comes with guarantees – because life doesn't

You can't predict the future, but you can rest easier knowing you have life insurance with lifelong guarantees.

Whole life insurance provides guaranteed features – cash value accumulation, premium rates and a death benefit (minus any loans and loan interest) – that help ensure those benefits will be there to help protect your family's way of life.

With this coverage:

- Life insurance benefits for the beneficiary are typically tax-free.
- You have three opportunities to purchase additional coverage with no proof of good health required if you are 50 or younger with the Guaranteed Purchase Option Rider.
- The policy's built-in terminal illness accelerated death benefit provides up to 75% of the policy's death benefit (up to $150,000) if you're diagnosed with a terminal illness.[1]
- A $3,000 immediate claim payment that can help your designated beneficiary pay for funeral costs or other expenses.
- You can take the policy with you even if you change jobs or retire; with no increase in premium.
- Paid-Up at Age 70 or Paid-Up at Age 100
  These two plan options allow you to select what age your premium payments will end. You can choose to have your policy paid up when you reach age 70 or 100.

1 Any payout would reduce the death benefit. Benefits may be taxable as income. Individuals should consult with their legal or tax counsel when deciding to apply for accelerated benefits.

If the insured dies by suicide, whether sane or insane, within two years (one year in ND) from the coverage effective date or the date of reinstatement, we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. Product may vary by state. For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

Colonial Life insurance products are underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.
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PIERCE GROUP BENEFITS
ADDITIONAL BENEFITS

THE FSA STORE
FLEX SPENDING WITH ZERO GUESSWORK

Pierce Group Benefits partners with the FSA Store to provide one convenient location for all your FSA-eligible purchases. Through our partnership, Pierce Group Benefits and FSA Store can help you shop for FSA eligible items and answer the many questions that come along with having a Flexible Spending Account.

FSA store®
Everything Flex Spending.

- **The largest selection of guaranteed FSA-eligible products**
- **24/7 support, FREE shipping on orders over $50**
- **Are your health needs eligible? Easily check with our expansive Eligibility List**
- **Need an Rx? We'll work with you to make getting one easier**
- **Learning Center - Get daily money-saving info**
- **Use your FSA Card or any major credit card**

Accessing FSA Store is easy. Simply visit FSAstore.com/PGBFL for the largest selection of guaranteed FSA-eligible products with zero guesswork. Get $20 off $200+ with code PGBF20. One use per customer.

General Notice of COBRA Continuation Coverage Rights
**** Continuation Coverage Rights Under COBRA****

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

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

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

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Coastal Carolina Community College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Coastal Carolina Community College. Applicable documentation will be required i.e. court order, certificate of coverage etc.

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

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

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

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

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

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

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

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

Plan contact information
Coastal Carolina Community College
Attn: Cindy Burkhart Woolridge
444 Western Boulevard
Jacksonville, NC 28546
burkhartc@coastalcarolina.edu

COBRA Administrator for Dental Coverage
Interactive Medical Systems
PO Box 1349
Wake Forest, NC 27588

Physical Address:
11635 Northpark Drive
Suite 330
Wake Forest, NC 27588

(800) 426-8739

COBRA Administrator for Vision Coverage
Superior Vision
Attn: COBRA
11101 White Rock Road
Rancho Cordova, CA 95670

(800) 507-3800 ext. 2232

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my application(s) for insurance submitted during the current enrollment and eligibility for benefits under any insurance issued including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application(s), I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Non-health information including earnings or employment history deemed appropriate by Colonial to evaluate my application may be disclosed by any person or organization that has these records about me, including my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial obtains pursuant to this authorization will be used for the purpose of evaluating my application(s) for insurance or eligibility for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution and a copy is as valid as the original. A copy will be included with my contract(s) and I or my authorized representative may request access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract(s) or the contract itself. If revoked, Colonial may not be able to evaluate my application(s) for insurance or eligibility for benefits as necessary to issue my contract(s). I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Underwriting Department, P.O. Box 1365, Columbia, SC 29202.

You may refuse to sign this form; however, Colonial may not be able to issue your coverage. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, or Conservator.

_____	_____	_____	_____
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the proposed insured as _____ (indicate relationship). If legal Guardian, Power or Attorney Designee, or Conservator.

_____	_____	_____
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)

Notice of Insurance Information Practices
We collect Non Public Information (NPI) about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) will affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Our affiliated companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs. This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

If you believe NPI we have about you is incorrect, please write us. You letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

If we decide not issued coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

To receive our complete privacy notice, including more information about our information-sharing, access and correction practices, write to our parent company: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. For additional information about our commitment to privacy, visit www.coloniallife.com.
NIP

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU.

Information regarding your insurability will be treated as confidential. Colonial or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (617) 426-3660.

Colonial or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

I'm Leaving, Now What?

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Health Insurance
Under certain qualifying events, employees and dependents have the opportunity to continue coverage for 18-36 months under the COBRA Act. Please contact the State Health Plan at 1-888-234-2416.

If you are retiring, you must either log in to www.myncretirement.com or call 1-888-234-2416.

Other Benefits
If you wish to continue coverage of any of the following benefits, Pierce Group Benefits will be happy to serve you:

PIERCE GROUP BENEFITS

- ***Dental and Vision Insurance***
- ***Supplemental/Voluntary Insurances - Cancer, Disability, Life, etc.***
- ***Flexible Spending Accounts***

Please visit **www.piercegroupbenefits.com/individualfamily**
or call **888-662-7500** for more information on these policies, as well as to enroll/continue your benefits. You may also click on the "Individual & Family" button on the Pierce Group Benefits homepage, www.piercegroupbenefits.com to access this information.

Transferring from one Employer to Another?
If you are transferring from a current PGB client to another, some benefits may be eligible for transfer. Please call 888-662-7500 and a Service Specialist will be glad to help you.

CONTACT INFORMATION:

FLEXIBLE SPENDING ACCOUNTS INTERACTIVE MEDICAL SYSTEMS

- ***Mailing Address:*** P.O Box 1349, Wake Forest, NC 27588
- ***Website:*** www.healthierbenefits.com
- ***Medical or Dependent Care Customer Service:*** 800-426-8739
- ***Fax Claims:*** 919-562-0021

- ***Direction for checking Flexible Spending Account balance and history online***:
  1. Go to www.healthierbenefits.com
  2. Select the "Register" button
  3. Follow the instructions filling in the required fields and submit the registration information.
- Once registered you can enter your login and password to access your account and check balances, transaction history, etc.

- ***Directions for filing manual claims for Flexible Spending Accounts online:***
  1. Scan your claim receipts
  2. Login to your user account at www.healthierbenefits.com
  3. Click on "Request Reimbursement"
  4. Acknowledge terms
  5. Complete the requested form information
  6. Click on the "Upload File" and attach claim receipts

- ***Directions for accessing a manual claim form for Flexible Spending Accounts:***
  1. Go to www.healthierbenefits.com
  2. Click on "Flex Forms"
  3. Complete the form and mail or fax to Interactive Medical Systems along with copies of your receipts

METLIFE - DENTAL INSURANCE

- ***Customer Service:*** 1-800-942-0854
- ***Website:*** www.metlife.com/mybenefits

SUPERIOR - VISION INSURANCE

- ***Customer Service:*** 1-800-507-3800
- ***Website:*** www.superiorvision.com

NORTH CAROLINA STATE HEALTH PLAN

- ***Customer Service:*** 1-888-234-2416
- ***Website:*** http://shpnc.org

CALL A DOCTOR PLUS - TELEMEDICINE

See the inside of your benefit booklet for information on how to set up your account and contact Call A Doctor Plus!

HARMONY ONLINE ENROLLMENT

- See pages 5-6 for online enrollment instructions
- ***Technical Help Desk***: 1-866-875-4772

COLONIAL LIFE

VISIT COLONIALLIFE.COM TO SET UP YOUR PERSONAL ACCOUNT

- ***Website:*** www.coloniallife.com
- ***Claims Fax***: 1-800-880-9325
- ***Customer Service & Wellness Screenings:*** 1-800-325-4368
- ***TDD for hearing impaired customers call:*** 1-800-798-4040

If you wish to file a Wellness/Cancer Screening claim for a test performed within the past 18 months, you need the name and date of the test performed as well as your doctor's name and phone number. Colonial also needs to know if this is for you or another covered individual and their name and social security number. You may:

- FILE BY PHONE! Call 1-800-325-4368 and provide the information requested by Colonial's Automated Voice Response System, 24 hours per day, 7 days a week, or
- SUBMIT ON THE INTERNET using the Wellness Claim Form at www.coloniallife.com, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "Wellness Test." Fax this to Colonial at 1-800-880-9325 or MAIL to PO Box 100195, Columbia, SC 29202

If your Wellness/Cancer Screening test was more than 18 months ago, you must fax or mail Colonial a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.
Please Note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

When you terminate employment, you have the opportunity to continue your Colonial coverage either through direct billing or automatic payment through your bank account. Please contact Colonial at 1-800-325-4368 to request the continuation of benefits form.

TO VIEW YOUR BENEFITS ONLINE

Visit **www.piercegroupbenefits.com/coastalcarolinacommunitycollege**

For additional information concerning plans offered to employees of Coastal Carolina Community College, please contact our North Carolina Service Center at 1-888-662-7500, ext. 100