PIERCE GROUP BENEFITS

EMPLOYEE BENEFITS GUIDE 2025

PLAN YEAR:
JULY 1, 2025 - JUNE 30, 2026

COASTAL CAROLINA COMMUNITY COLLEGE

EMPLOYEE BENEFITS GUIDE

TABLE OF CONTENTS

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

ENROLLMENT DATES:

March 31, 2025 - April 11, 2025

PLAN YEAR & EFFECTIVE DATES:

July 1, 2025 - June 30, 2026

Click on the video below to help you prepare for annual enrollment and learn about the benefits available to you!

COASTAL CAROLINA COMMUNITY COLLEGE

2025 Benefits Plan

July 1, 2025 - June 30, 2026

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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 guide, including premiums quoted, is subject to change.

All policy descriptions are for informational purposes only. Your actual policies may be different than those in this guide.

Rev: 3/6/2025

**For informational purposes only

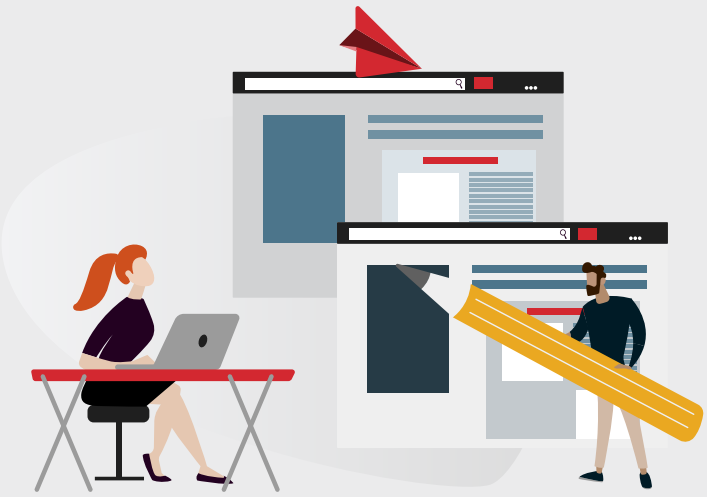
IMPORTANT CONTACT INFORMATION

	Carrier	Phone/Fax	Email	Website
Flexible Spending Accounts	IMS	P: 800-426-8739 F: 919-562-0021	-	www.ims-tpa.com
Dental Insurance	MetLife	P: 800-638-5433	-	www.metlife.com
Vision Insurance	Superior Vision	P: 800-507-3800 F: 410-752-8969	-	www.superiorvision.com
Telemedicine Benefits	Call A Doctor Plus	P: 800-835-2362	help@teladochealth.com	www.teladoc.com
Student Loan Assistance Program	GradFin	P: 844-472-3346	-	www.gradfin.com
North Carolina State Health Plan	SHPNC	P: 888-234-2416 F: 919-765-2322	-	www.shpnc.org
To View Your Benefits Online	Pierce Group Benefits	P: 1-888-662-7500 F: 984-225-2605	service@piercegroupbenefits.com	www.PierceGroupBenefits.com/CoastalCarolinaCommunityCollege
Supplemental Benefits	Colonial Life	Customer Service & Wellness Screenings 1-800-325-4368 F:1-800-880-9325 TDD For Hearing Impaired Customers 1-800-798-4040	-	www.coloniallife.com

NC State Health Plan: 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 1-877-679-6272.
If you are retiring, you must either log into www.myncretirement.com or call 1-877-679-6272.

ELIGIBILITY REQUIREMENTS

CURRENT EMPLOYEE?



ANNUAL ENROLLMENT DATES:

March 31, 2025 - April 11, 2025

PLAN YEAR & EFFECTIVE DATES:

July 1, 2025 - June 30, 2026

ELIGIBILITY

- **Permanent part-time and full-time employees working 30 or more hours per week are eligible for benefits.**

NEW HIRE?

Congratulations on your new employment! Your employment means more than just a paycheck. Your employer also provides eligible employees with a valuable benefits package. Above you will find eligibility requirements and below you will find information about how to enroll in these benefits as a new employee.

Flexible Spending Accounts and Colonial Life Insurance Products - Please call PGB's Employee Services within 30 days of your date of hire and a PGB Benefits Representative will help you enroll in benefits. The Employee Services number is located in the contact section of this guide.

All Other Benefits - Please reach out to your Benefits Department within 30 days of your date of hire.

Be sure to also review your group's custom benefits website, that allows for easy, year-round access to benefit information, live chat support, benefit explainer videos, plan certificates and documents, and carrier contacts and forms.

www.PierceGroupBenefits.com/CoastalCarolinaCommunityCollege

OVERVIEW OF BENEFITS

PRE – TAX BENEFITS

Flexible Spending Accounts
IMS

- Medical Reimbursement: $3,050/year Max
- Dependent Care Reimbursement: $5,000/year Max

***You will need to re-enroll in the Flexible Spending Accounts if you want them to continue next year.**

If you do not re-enroll, your contribution will stop effective June 30, 2025.

Dental Insurance
MetLife

Vision Insurance
Superior Vision

Cancer Benefits
Colonial Life

Accident Benefits
Colonial Life

Medical Bridge Benefits
Colonial Life

Disability Benefits*
Colonial Life

POST – TAX BENEFITS

Disability Benefits*
Colonial Life

Critical Illness Benefits
Colonial Life

Life Insurance
Colonial Life

- Term Life Insurance
- Whole Life Insurance

Telemedicine Benefits
Call A Doctor Plus

ADDITIONAL BENEFITS

Student Loan Assistance Program
GradFin

**Please note employees may choose to have Disability Benefit Premiums deducted with pre or post-tax funds.*

IMPORTANT NOTICES

When do my benefits start? The plan year for Colonial Life Insurance Products, IMS Flexible Spending Accounts, MetLife Dental, Superior Vision and Call A Doctor Plus Telemedicine runs from July 1, 2025, through June 30, 2026.

When do my deductions start? Deductions for Colonial Life Insurance Products, MetLife Dental, Superior Vision and Call A Doctor Plus Telemedicine start June 2025 for 12-month employees. Deductions for IMS Flexible Spending Accounts start July 2025 for 12-month employees.

Why have my Cancer, Accident, or Medical Bridge benefits not started yet? The Colonial Cancer plan and the Health Screening Rider on the Colonial Accident and Colonial Medical Bridge plan has a 30-day waiting period for new enrollees. Coverage, therefore, will not begin until July 31, 2025.

How do Flexible Spending Account (FSA) funds work, and do my FSA funds have to be used by a specific deadline? Flexible Spending Account expenses must be incurred during the plan year to be eligible for reimbursement. After the plan year ends, an employee has 90 days days to submit claims for incurred qualified spending account expenses (or 90 days days after employment termination date). If employment is terminated before the plan year ends, the spending account also ends. Failure to use all allotted funds in the FSA account will result in a "Use It or Lose It" scenario.

My spouse is enrolled in an Health Savings Account (HSA), am I eligible for an FSA? As a married couple, one spouse cannot be enrolled in a Medical Reimbursement FSA at the same time the other opens or contributes to an HSA.

How do Dependent Care Account (DCA) funds work and when do they need to be used? Dependent Care Accounts are like FSA accounts and allow you to request reimbursement up to your current balance. However, you cannot receive more reimbursement than what has been deducted from your pay. Any remaining funds in your DCA account must be utilized before the deadline. Failure to use all allotted funds in the DCA account will result in a "Use It or Lose It" scenario.

When will I get my card? 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.

I want to sign my family up for benefits as well, what information will I need? If signing up for any coverage on your spouse and/or children, please have their dates of birth and social security numbers available when speaking with the Benefits Representative.

What does Pre-Tax vs. Post-Tax Change? Pre-Tax benefits take funds directly from your paycheck to cover benefits before going through State and Federal taxing process. Post-Tax collects funds for benefits after taxes have been taken out. 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.

Can I change my benefit elections outside of the enrollment period? Elections made during this enrollment period CANNOT BE CHANGED AFTER THE ENROLLMENT PERIOD unless there is a family status change, otherwise known as a qualifying life event (QLE), as defined by the Internal Revenue Code. Examples of a QLE can be found in the chart on the next page. Once a QLE has occurred, an employee has 30 days to notify PGB's NC Employee Services at 1-888-662-7500 to request a change in elections.

I have a pre-existing condition. Will I still be covered? Some policies may include a pre-existing condition clause. Please read your policy carefully for full details.

QUALIFYING LIFE EVENTS

The benefit elections you make during Annual Enrollment or as a New Hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a Qualifying Life Event (status change) occurs. The summary of events that allow an employee to make benefit changes and instructions for processing those life event changes can be reviewed in the chart below.

Qualifying Life Event	Action Required	Result If Action Is Not Taken
New Hire	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next Annual Enrollment period.
Marriage	Add your new spouse to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next Annual Enrollment period.
Divorce	Remove the former spouse within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or Adoption of a Child	Enroll the new dependent in your elections within 30 days of the birth or adoption date, even if you already have family coverage. A copy of the birth certificate, mother's copy of birth certificate, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, don't forget to update your child's insurance information record.	The new dependent will not be covered until the next Annual Enrollment period.
Dependent Aging Out	Remove or update dependent elections within 30 days of the dependent aging out. For more information and assistance, please call PGB Employee Services at 888-662-7500.	Coverage for the dependent will end at the time of the dependent aging out and the policyholder must remove/update the dependent elections in order for the change to be reflected in the employee's deductions.
Death of a Spouse or Dependent	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage required.
Change in Spouse's Employment or Coverage	Add or drop benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You will not be able to make changes until the next Annual Enrollment period.

The examples included in this chart are not all-inclusive. Please speak to a Benefits Representative to learn more.

QUALIFYING LIFE EVENTS

Qualifying Life Event	Action Required	Result If Action Is Not Taken
Part-Time to Full-Time or Vice Versa	Change your elections within 30 days from the employment status change to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the next Annual Enrollment period.
Transferring Employers	If you are transferring from one PGB client to another, some benefits may be eligible for transfer. Please call PGB Employee Services at 888-662-7500 for more information and assistance.	You may lose the opportunity to transfer benefits.
Loss of Government or Education Sponsored Health Coverage	If you, your spouse, or a dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, you may be eligible to add additional coverage for eligible benefits.	You and your dependents are not eligible until the next Annual Enrollment period.
Entitlement to Medicare or Medicaid	If you, your spouse, or dependent becomes entitled to or loses coverage under Medicare or Medicaid, you may be able to change coverage under the accident or health plan.	You and your dependents are not eligible until the next Annual Enrollment period.
Non-FMLA Leave	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 next plan year. Please contact your Benefit Administrator for more information.	You and your dependents are not eligible until the next Annual Enrollment period.
Retiring	**Your individual supplemental/voluntary policies through Colonial Life are portable!** To move them from payroll deduction to direct billing, please complete and submit the Payment Method Change Form to Colonial Life within 30 days of retiring. You are also eligible for post-employment Dental, Vision, and Telemedicine benefits through PGB. Please visit: **www.piercegroupbenefits.com/individualcoverage** or call our Employee Services at 888-662-7500 for more information and assistance.	If you do not transfer your policies from payroll deduction to direct billing, Colonial Life will terminate your policies resulting in a loss of coverage.

The examples included in this chart are not all-inclusive. Please speak to a Benefits Representative to learn more.

ENROLLMENT INFORMATION

IN-PERSON

During your annual enrollment period, a PGB Benefits Representative will be available by appointment to meet with you one-on-one to help you evaluate your benefits based on your individual and family needs, answer any questions you may have, and assist you in the enrollment process.

ANNUAL ENROLLMENT PERIOD:

MARCH 31, 2025 - APRIL 11, 2025

BENEFIT ELECTION OPTIONS

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

- Enroll/Re-Enroll in Flexible Spending Accounts.[+]
- Enroll in, change, or cancel Dental Insurance.
- Enroll in, change, or cancel Vision Insurance.
- Enroll in, change, or cancel Telemedicine coverage.
- Enroll in, change, or cancel Colonial coverage.

[+]You will need to re-enroll in the Flexible Spending Accounts if you want them to continue each year.

ACCESS YOUR BENEFIT OPTIONS WHENEVER, WHEREVER

You can view details about what benefits your employer offers, view educational videos about all of your benefits, download forms, chat with one of our knowledgeable Benefits Representatives, and more on your personalized benefits website. To view your custom benefits website, visit:

www.PierceGroupBenefits.com/CoastalCarolinaCommunityCollege

Click on the video below to learn more about Flexible Spending Accounts!

Don't lose the chance to put up to $960 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, up to $3,050. 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 $960 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
- 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.ims-tpa.com

Online & mobile access

Get instant access to your account with the **IMS Flex Portal** and **IMS Flex 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. ims-tpa.com

Download the IMS Flex Mobile App at the App Store or Google Play.

Helpful hints

- Your full election amount is available on the first day of the plan year, which means you'll have access toĂ 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 orĂ qualifying event.
- Save your receipts when you spend your healthcare FSA dollars. You may need itemized invoices to verifyĂ the eligibility of expenses or for reimbursement requests.
- The easiest way to manage your account is online at www.ims-tpa.com or through the IMS Flex MobileĂ App.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully andĂ use all the money in your healthcare FSA by the end of the plan year.

THE FSA STORE

Save even more with your FSA through our partnership.

Get $20 off any order of $150 with code **PBG20FSA**

Shop Now

Resources Available Through The FSA Store

- The largest selection of guaranteed FSA-eligible products
- Phone and live chat support available 24 hours a day / 7 days a week
- Fast and free shipping on orders over $50
- Use your FSA card or any other major credit card for purchases

Eligibility List

Search comprehensive list of eligible products and services.

FSA Calculator

Estimate how much you can save with an FSA.

Learning Center

Easy tips and resources for utilizing an FSA.

Savings Center

Your funds go further with the FSA Store rewards program.

Your Health, Your Funds, Your Choice

Take control of your health and wellness with guaranteed FSA-eligible essentials. Pierce Group Benefits partners with the FSA store to provide one convenient location for Flexible Spending Account holders.

Click or Scan to Shop Now

Click on the video below to learn more about Dependent Care Accounts!

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

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 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.

Click on the video below to learn more about Telemedicine Benefits!

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	$12.00 $15.00

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

How It Works

Discount Drug Network

How do the discounts work?

When people join together to purchase in large quantities, everyone saves! Discount Drug Network, provider of the Prescription Discount Card, covers millions of people and leverages the power of group purchasing to negotiate these discounts on behalf of our members. Just call or go online for help looking up drug pricing at your local pharmacy. The pricing tool on our website is incredibly easy to use and helps you price compare the prescription you need at all local participating pharmacies.

Who pays for this?

The pharmacies! The pharmacies agree to let our members get discount pricing (just like they do already for insurance customers) because they want our business! They not only give our members fantastic discounts, but they also pay us a small transaction fee each time we process a prescription through our network. This allows us to continue to operate, grow, and save our members money! For the first time, the individual consumer gets access to pricing typically reserved for the largest insurance companies.

Why do the pharmacies participate in this?

Simple! Because when you come to their store to fill a prescription you also typically buy personal care products and other miscellaneous items from their retail store. This is good business for them, good business for us, and big savings for you.

What drugs does it work for and how much will I save?

Any FDA-approved medications are available within our pricing network, but the savings we have access to are not the same for every drug. We find that our pricing is typically much less expensive than the insurance company pricing for generic drugs. For brand name drugs, the savings are usually less. The good news is, our online drug pricing tool suggests any and all alternative generic drugs for your prescription (when available) and helps you shop for the best price from all the participating pharmacies in your area.

What about my personal and medical information?

Is my privacy protected?

Of course! Your medical and prescription information is never shared with us by your pharmacy. HIPAA regulations carefully cover such sharing of information in order to protect the consumer. Discount Drug Network fully complies with HIPAA regulations. We won't ever see your name, contact info, or anything unless you call in or go on our website and decide to share that with us. If you do, we never sell that information to anyone. We simply use it to keep you up to date on any important industry news, tips for saving more money using our card, and ways to save on other healthcare products and services.

Pharmacy Discount Card – Save on prescription medication

Our FREE pharmacy discount card allows your employees to save an average of 47% on your prescription medication (up to 85%) using the pharmacy discount card. It's easy to use and accepted at over 66,000 pharmacies nationwide!

Key Benefits:

- → Save an average of 47% on prescriptions
- → Save at over 66,000 pharmacies
- → No claim forms to file
- → No deductibles
- → No limits or maximums
- → No pre-existing conditions

Accessing the Discount Card

1. Register for a card at discountdrugnetwork.com
    a. Click on 'Get Your Free Card'
    b. Provide your personal information, including name, address, email and/or phone
    c. Click 'submit' and a card is sent to you by mail in 3 to 4 weeks
    d. Once registered, you can also have your card immediately texted to your phone
2. Find a provider.
    a. Use discountdrugnetwork.com/rx-discount/ to search local partners for the lowest possible price
    b. Search from over 66,000 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: www.discountdrugnetwork.com

Click on the video below to learn more about Dental Insurance!

Dental

Metropolitan Life Insurance Company

Plan Design for: Coastal Carolina Community College

Effective Date: July 1, 2025

Amendment Effective Date±: March 1, 2024

Monthly Cost

Employee- $0
Employee Spouse- $43.93
Employee Children- $42.16
Employee Family- $98.52

Network:

The Preferred Dentist Program was designed to help you get the dental care you need and lower your costs. You get benefits for a wide range of covered services both in and out of the network. The goal is to deliver cost-effective protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network**[1] % of Negotiated Fee[2]	**Out-of-Network**[1] %of R&C Fee[4]
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible[3]		
Individual	$25	$25
Family	$75	$75
*Deductible applies to B&C services only		
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.

1. "In-Network Benefits" refer to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refer to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.
4. Reimbursement for out-of-network services is based on the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

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 Crowns	• 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. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

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 Implant Services.
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**.

Frequently Asked Questions

Average fees charged in a dentist's community for the same or substantially similar services.

How do I find a participating dentist? There are thousands of general dentists and specialists to choose from nationwide - so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

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.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist (out-of-network), your out-of-pocket costs may be higher.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[2] The website and phone number are for use by dental professionals only.

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, visit www.metlife.com/mybenefits or request one by calling 1-800-275-4638.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

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.

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)

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details. Metropolitan Life Insurance Company, New York, NY 10166

1. In-Network Benefits" refer to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refer to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Due to contractual requirements, MetLife is prevented from soliciting certain providers.

[3.] AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

[4.] Refer to your dental benefits plan summary for your out-of-network dental coverage.

Click on the video below to learn more about Vision Insurance!

SuperiorVision®

superiorvision.com | 1 (800) 507-3800

Vision Care Plan for Coastal Carolina Community College

Benefits through Superior National network

Frequency	
Exam	12 months (*Not applicable with materials only plan)
Frame	12 months
Contact lens fitting	12 months
Eyeglass lenses	12 months
Contact Lenses	12 months

(based on date of service)

Need help? Contact 1 (800) 507-3800 or visit superiorvision.com for assistance.

Exams

Eye exam copay*:
$10
(*Not applicable with materials only plan)

Contact lens fitting[2] copay (standard and specialty):
$25

Specialty In-network allowance:
$50

Materials[1]

Materials copay:
$10

Frames

In-network allowance:
$150

Contacts[4]

in lieu of glasses

In-network allowance:
$125

Monthly Premiums

	Full plan	Materials Only Plan
Employee only:	$7.39	$5.44
Employee + 1 dependent:	$12.63	$9.30
Employee + family:	$21.77	$16.03

Lenses (per pair)	In-Network Coverage	Out-of-Network Reimbursement
Single vision	Covered-in-full	Up to $29
Bifocal	Covered-in-full	Up to $43
Trifocal	Covered-in-full	Up to $53
Progressives	Covered at trifocal level[3]	Up to $53

Shop with convenience while using your benefits through these in-network online retailers.

1800contacts® GLASSES.COM contactsdirect befitting eyewear

Lens Add-On Discounts[5]	Your Cost
Anti-scratch coating	$15
Ultraviolet coating	$12
Tints – solid / gradient	$15 / $18
Polycarbonate lenses	$40
Blue light filtering	$15
Digital single vision	$30
Progressive lenses (standard / premium / ultra / ultimate)	$55 / $110 / $150 / $225
Anti-reflective coating (standard / premium / ultra / ultimate)	$50 / $70 / $85 / $120
Polarized lenses	$75
Plastic photochromic lenses	$80
Hi-index (1.67 / 1.75)	$80 / $120

Overage Discounts[5]	Amount
Frames	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contacts	10% off amount over allowance

Non-Covered Services Discounts[5]	Amount
Exams, frames, prescription lenses	30% off retail
Contacts, miscellaneous options	20% off retail
Disposable contact lenses	10% off retail
Retinal imaging	$39 cost

Additional Out-of-Network Reimbursements	Amount
Eye exam (MD) *Not applicable with materials only plan	Up to $34
Eye exam (OD)*Not applicable with materials only plan	Up to $26
Frame	Up to $74
Contact lens fitting (standard / specialty)[2]	Not covered
Contact lenses[5]	Up to $100

LASIK Discounts[5]

Multiple discounts on laser vision correction procedures may be available to you. To learn more, visit superiorvision.com or contact your benefits coordinator.

Hearing Aid Discounts[5]

Through Your Hearing Network, you have access to discounts on hearing services, devices, and accessories. To learn more, visit superiorvision.com or contact your benefits coordinator.

Free Mobile App

With the free Superior Vision app (available for Android and Apple devices), you can create an account, check your eligibility and benefits, find providers, and view your member ID card.

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Superior Vision Services, Inc. ("Superior Vision"), a Delaware corporation. Superior Vision is part of the MetLife family of companies. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.
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.
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. **5.** Not all providers support these discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if they offer the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all providers / all locations.

Click on the video below to learn more about Cancer Benefits!

Colonial Life
The benefits of good hard work.

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.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

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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).

Individual Cancer Insurance Description of Benefits

The policy and its riders may have additional 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. Coverage is dependent on answers to health questions. Applicable to policy forms CanAssist-NC and rider forms R-CanAssistIndx-NC, R-CanAssistProg-NC and R-CanAssistSpDis-NC.

Cancer Insurance Benefits	Level 1	Level 2	Level 3	Level 4
Air Ambulance, per trip	$2,000	$2,000	$2,000	$2,000
Maximum trips per confinement	*2*	*2*	*2*	*2*
Ambulance, per trip	$250	$250	$250	$250
Maximum trips per confinement	*2*	*2*	*2*	*2*
Anesthesia, General	25% of Surgical Procedures Benefit			
Anesthesia, Local, per procedure	$25	$30	$40	$50
Anti-Nausea Medication, per day	$25	$40	$50	$60
Maximum per month	*$100*	*$160*	*$200*	*$240*
Blood/Plasma/Platelets/Immunoglobulins, per day	$150	$150	$175	$250
Maximum per year	*$10,000*	*$10,000*	*$10,000*	*$10,000*
Bone Marrow or Peripheral Stem Cell Donation, per lifetime	$500	$500	$750	$1,000
Bone Marrow or Peripheral Stem Cell Transplant, per transplant	$3,500	$4,000	$7,000	$10,000
Maximum transplants per lifetime	*2*	*2*	*2*	*2*
Companion Transportation, per mile	$0.50	$0.50	$0.50	$0.50
Maximum per round trip	*$1,000*	*$1,000*	*$1,200*	*$1,500*
Egg(s) Extraction or Harvesting or Sperm Collection, per lifetime	$500	$700	$1,000	$1,500
Egg(s) or Sperm Storage, per lifetime	$175	$200	$350	$500
Experimental Treatment, per day	$200	$250	$300	$300
Maximum per lifetime	*$10,000*	*$12,500*	*$15,000*	*$15,000*
Family Care, per day	$30	$40	$50	$60
Maximum per year	*$1,500*	*$2,000*	*$2,500*	*$3,000*
Hair/External Breast/Voice Box Prosthesis, per year	$200	$200	$350	$500
Home Health Care Services, per day	$50	$75	$100	$150
Maximum per year	*30 days or twice the days confined*			
Hospice, Initial, per lifetime	$1,000	$1,000	$1,000	$1,000
Hospice, Daily	$50	$50	$50	$50
Maximum combined Initial and Daily per lifetime	*$15,000*	*$15,000*	*$15,000*	*$15,000*
Hospital Confinement, 30 days or less, per day	$100	$150	$250	$350
Hospital Confinement, 31 days or more, per day	$200	$300	$500	$700
Lodging, per day	$50	$50	$75	$80
Maximum days per year	*70*	*70*	*70*	*70*
Medical Imaging Studies, per study	$75	$125	$175	$225
Maximum per year	*$150*	*$250*	*$350*	*$450*
Outpatient Surgical Center, per day	$100	$200	$300	$400
Maximum per year	*$300*	*$600*	*$900*	*$1,200*
Private Full-time Nursing Services, per day	$50	$75	$125	$150
Prosthetic Device/Artificial Limb, per device or limb	$1,000	$1,500	$2,000	$3,000
Maximum per lifetime	*$2,000*	*$3,000*	*$4,000*	*$6,000*

Individual Cancer Insurance Description of Benefits

The policy and its riders may have additional 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. Coverage is dependent on answers to health questions. Applicable to policy forms CanAssist-NC and rider forms R-CanAssistIndx-NC, R-CanAssistProg-NC and R-CanAssistSpDis-NC.

Cancer Insurance Benefits	Level 1	Level 2	Level 3	Level 4
Radiation/Chemotherapy				
Injected chemotherapy by medical personnel, per week	$250	$500	$750	$1,000
Radiation delivered by medical personnel, per week	$250	$500	$750	$1,000
Self-Injected Chemotherapy, per month	$150	$200	$300	$400
Pump Chemotherapy, per month	$150	$200	$300	$400
Topical Chemotherapy, per month	$150	$200	$300	$400
Oral Hormonal Chemotherapy (1-24 months), per month	$150	$200	$300	$400
Oral Hormonal Chemotherapy (25+ months), per month	$75	$100	$150	$200
Oral Non-Hormonal Chemotherapy, per month	$150	$200	$300	$400
Reconstructive Surgery, per surgical unit	$40	$40	$60	$60
Maximum per procedure, including 25% for general	*$2,500*	*$2,500*	*$3,000*	*$3,000*
Second Medical Opinion, per lifetime	$150	$200	$300	$300
Skilled Nursing Care Facility, per day, up to days confined	$75	$100	$100	$150
Skin Cancer Initial Diagnosis, per lifetime	$300	$300	$400	$600
Supportive/Protective Care Drugs/Colony Stimulating Factors, per	$50	$100	$150	$200
Maximum per year	*$400*	*$800*	*$1,200*	*$1,600*
Surgical Procedures, per surgical unit	$40	$50	$60	$70
Maximum per procedure	*$2,500*	*$3,000*	*$5,000*	*$6,000*
Transportation, per mile	$0.50	$0.50	$0.50	$0.50
Maximum per round trip	*$1,000*	*$1,000*	*$1,200*	*$1,500*
Waiver of Premium	Yes	Yes	Yes	Yes
Policy-Wellness Benefits				
Bone Marrow Donor Screening, per lifetime	$50	$50	$50	$50
Cancer Vaccine, per lifetime	$50	$50	$50	$50
Part 1: Cancer Wellness/Health Screening, per year	One amount per account: $0, $25, $50, $75 or $100			
Part 2: Cancer Wellness/Health Screening, per year	Same as Part 1			

Additional Riders may be available at an additional cost				

WAITING PERIOD

The policy and its riders may have a waiting period. Waiting period means the first 30 days following the policy's coverage effective date during which no benefits are payable. If your cancer has a date of diagnosis before the end of the waiting period, coverage for that cancer will apply only to losses commencing after the policy has been in force for two years, unless it is excluded by name or specific description in the policy.

No recovery during the first 12 months of this policy for cancer with a date of diagnosis prior to 30 days after the effective date of coverage. If a covered person is 65 or older when this policy is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

EXCLUSIONS

We will not pay benefits for cancer or skin cancer:

■ If the diagnosis or treatment of cancer is received outside of the territorial limits of the United States and its possessions; or

■ For other conditions or diseases, except losses due directly from cancer.

CANCER BENEFIT PREMIUMS

LEVEL 1 - Composite Rates				
	Employee	Employee/Spouse	One-Parent Family	Two-Parent Family
Level 1 with $100 Cancer Wellness/Health Screening				
12-Pay Premium	$18.10	$28.60	$18.25	$28.75
LEVEL 2 - Composite Rates				
	Employee	Employee/Spouse	One-Parent Family	Two-Parent Family
Level 2 with $100 Cancer Wellness/Health Screening				
12-Pay Premium	$21.65	$33.85	$21.95	$34.15
LEVEL 3 - Composite Rates				
	Employee	Employee/Spouse	One-Parent Family	Two-Parent Family
Level 3 with $100 Cancer Wellness/Health Screening				
12-Pay Premium	$26.65	$44.40	$27.10	$44.85
LEVEL 4 - Composite Rates				
	Employee	Employee/Spouse	One-Parent Family	Two-Parent Family
Level 4 with $100 Cancer Wellness/Health Screening				
12-Pay Premium	$35.60	$59.40	$36.20	$60.00
OPTIONAL RIDERS				
	Employee	Employee/Spouse	One-Parent Family	Two-Parent Family
Specified Disease Hospital Confinement Rider				
12-Pay Premium	$1.25	$1.75	$1.25	$1.75
Initial Diagnosis of Cancer Rider (per $1,000)				
12-Pay Premium	$1.50	$2.50	$1.60	$2.60
Initial Diagnosis of Cancer Progressive Payment Rider				
12-Pay Premium	$7.80	$17.05	$7.80	$17.05

⚠ Sample rates only. Multiple choices and options available and rates may vary.

Click on the video below to learn more about Critical Illness Benefits!

Colonial Life

Group Critical Illness Insurance

Plan 1

When life takes an unexpected turn due to a critical illness diagnosis, your focus should be on recovery — not finances. Colonial Life's group critical illness insurance helps provide financial support by providing a lump-sum benefit payable directly to you for your greatest needs.

Coverage amount: _____

An unexpected moment changes life forever

Chris was mowing the lawn when he suffered a stroke. His recovery will be challenging and he's worried, since his family relies on his income.

HOW CHRIS'S COVERAGE HELPED

The lump-sum payment from his critical illness insurance helped pay for:

- *Co-payments and hospital bills not covered by his medical insurance*
- *Physical therapy to get back to doing what he loves*
- *Household expenses while he was unable to work*

For illustrative purposes only.

Critical illness benefit

COVERED CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Benign brain tumor	100%
Coma	100%
End stage renal (kidney) failure	100%
Heart attack (myocardial infarction)	100%
Loss of hearing	100%
Loss of sight	100%
Loss of speech	100%
Major organ failure requiring transplant	100%
Occupational infectious HIV or occupational infectious hepatitis B, C, or D	100%
Permanent paralysis due to a covered accident	100%
Stroke	100%
Sudden cardiac arrest	100%
Coronary artery disease	25%

KEY BENEFITS

- Available coverage for spouse and eligible dependent children at 50% of your coverage amount
- Cover your eligible dependent children at no additional cost
- Receive coverage regardless of medical history, within specified limits
- Works alongside your health savings account (HSA)
- Benefits payable regardless of other insurance

For more information, talk with your benefits counselor.

Colonial Life

ColonialLife.com

Subsequent diagnosis of a different critical illness[2]

If you receive a benefit for a critical illness, and are later diagnosed with a different critical illness, 100% of the coverage amount may be payable for that particular critical illness.

Subsequent diagnosis of the same critical illness[2]

If you receive a benefit for a critical illness, and are later diagnosed with the same critical illness,[3] 25% of the coverage amount may be payable for that critical illness.

Additional covered conditions for dependent children

COVERED CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Cerebral palsy	100%
Cleft lip or palate	100%
Cystic fibrosis	100%
Down syndrome	100%
Spina bifida	100%

Preparing for the unexpected is simpler than you think. With Colonial Life, you'll have the support you need to face life's toughest challenges.

1. Refer to the certificate for complete definitions of covered conditions.
2. Dates of diagnoses of a covered critical illness must be separated by more than 180 days.
3. Critical illnesses that do not qualify include: coronary artery disease, loss of hearing, loss of sight, loss of speech, and occupational infectious HIV or occupational infectious hepatitis B,C,or D.

THIS INSURANCE PROVIDES LIMITED BENEFITS
Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS
We will not pay the Critical Illness Benefit, Benefits Payable Upon Subsequent Diagnosis of a Critical Illness or Additional Critical Illness Benefit for Dependent Children that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; 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 critical illness.

PRE-EXISTING CONDITION LIMITATION
We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Colonial Life

Group Critical Illness Insurance

Plan 2

When life takes an unexpected turn, your focus should be on recovery — not finances. Colonial Life's group critical illness insurance helps relieve financial worries by providing a lump-sum benefit payable directly to you to use as needed.

Coverage amount: _____

Preparing for a lifelong journey

Rebecca was born with Down syndrome. Her parents' critical illness coverage provided a benefit that can help cover expenses related to Rebecca's care and her changing needs.

HOW THEIR COVERAGE HELPED

The lump-sum amount from the family coverage benefit helped pay for:

- *A hospital stay and treatment for corrective heart surgery*
- *Physical therapy to build muscle strength*
- *Special needs daycare*

For illustrative purposes only.

Critical illness and cancer benefits

COVERED CRITICAL ILLNESS CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Benign brain tumor	100%
Coma	100%
End stage renal (kidney) failure	100%
Heart attack (myocardial infarction)	100%
Loss of hearing	100%
Loss of sight	100%
Loss of speech	100%
Major organ failure requiring transplant	100%
Occupational infectious HIV or occupational infectious hepatitis B, C, or D	100%
Permanent paralysis due to a covered accident	100%
Stroke	100%
Sudden cardiac arrest	100%
Coronary artery disease	25%
COVERED CANCER CONDITION[1]	**PERCENTAGE OF APPLICABLE COVERAGE AMOUNT**
Invasive cancer (including all breast cancer)	100%
Non-invasive cancer	25%
Skin cancer initial diagnosis	$400 per lifetime

KEY BENEFITS

- Available coverage for spouse and eligible dependent children at 50% of your coverage amount
- Cover your eligible dependent children at no additional cost
- Receive coverage regardless of medical history, within specified limits
- Works alongside your health savings account (HSA)
- Benefits payable regardless of other insurance

For more information, talk with your benefits counselor.

Colonial Life

ColonialLife.com

Subsequent diagnosis of a different critical illness[2]

If you receive a benefit for a critical illness, and are later diagnosed with a different critical illness, 100% of the coverage amount may be payable for that particular critical illness.

Subsequent diagnosis of the same critical illness[2]

If you receive a benefit for a critical illness, and are later diagnosed with the same critical illness,[3] 25% of the coverage amount is payable for that critical illness.

Reoccurrence of invasive cancer (including all breast cancer)

If you receive a benefit for invasive cancer and are later diagnosed with a reoccurrence of invasive cancer, 25% of the coverage amount is payable if treatment-free for at least 12 months and in complete remission prior to the date of reoccurrence; excludes non-invasive or skin cancer.

Additional covered conditions for dependent children

COVERED CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Cerebral palsy	100%
Cleft lip or palate	100%
Cystic fibrosis	100%
Down syndrome	100%
Spina bifida	100%

Preparing for the unexpected is simpler than you think. With Colonial Life, you'll have the support you need to face life's toughest challenges.

1. Refer to the certificate for complete definitions of covered conditions.
2. Dates of diagnoses of a covered critical illness must be separated by more than 180 days.
3. Critical illnesses that do not qualify include: coronary artery disease, loss of hearing, loss of sight, loss of speech, and occupational infectious HIV or occupational infectious hepatitis B,C,or D.

THIS INSURANCE PROVIDES LIMITED BENEFITS
Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS
We will not pay the Critical Illness Benefit, Benefits Payable Upon Subsequent Diagnosis of a Critical Illness or Additional Critical Illness Benefit for Dependent Children that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; 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 critical illness.

EXCLUSIONS AND LIMITATIONS FOR CANCER
We will not pay the Invasive Cancer (including all Breast Cancer) Benefit, Non-Invasive Cancer Benefit, Benefit Payable Upon Reoccurrence of Invasive Cancer (including all Breast Cancer) or Skin Cancer Initial Diagnosis Benefit for a covered person's invasive cancer or non-invasive cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a 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 initially diagnosed as having invasive or non-invasive cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while the named insured is covered under the certificate, and who are continuously covered from the date of birth or adoption.

PRE-EXISTING CONDITION LIMITATION
We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

Colonial Life

Group Critical Illness Insurance

First Diagnosis Building Benefit Rider

For more information, talk with your benefits counselor.

ColonialLife.com

The first diagnosis building benefit rider provides a lump-sum payment in addition to the coverage amount when you are diagnosed with a covered critical illness or invasive cancer (including all breast cancer). This benefit is for you and all your covered family members.

First diagnosis building benefit

Payable once per covered person per lifetime

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

The benefit amount accumulates each rider year the rider is in force before a diagnosis is made, up to a maximum of 10 years.

If diagnosed with a covered critical illness or invasive cancer (including all breast cancer) before the end of the first rider year, the rider will provide one-half of the annual building benefit amount.

Coronary artery disease is not a covered critical illness. Non-invasive and skin cancer are not covered cancer conditions.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX) and rider form R-GCI6000-BB. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Colonial Life

Group Critical Illness Insurance

Infectious Diseases Rider

For more information, talk with your benefits counselor.

ColonialLife.com

The sudden onset of an infectious or contagious disease can create unexpected circumstances for you or your family. The infectious diseases rider provides a lump sum which can be used toward health care expenses or meeting day-to-day needs. These benefits are for you as well as your covered family members.

Payable for each covered infectious disease once per covered person per lifetime

COVERED INFECTIOUS DISEASE[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Hospital confinement for seven or more consecutive days for treatment of the disease	
Antibiotic resistant bacteria (including MRSA)	50%
Cerebrospinal meningitis (bacterial)	50%
Diphtheria	50%
Encephalitis	50%
Legionnaires' disease	50%
Lyme disease	50%
Malaria	50%
Necrotizing fasciitis	50%
Osteomyelitis	50%
Poliomyelitis	50%
Rabies	50%
Sepsis	50%
Tetanus	50%
Tuberculosis	50%
Hospital confinement for 14 or more consecutive days for treatment of the disease	
Coronavirus disease 2019 (COVID-19)	25%

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1. Refer to the certificate for complete definitions of covered diseases.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

EXCLUSIONS AND LIMITATIONS FOR INFECTIOUS DISEASES RIDER

We will not pay benefits for a covered infectious disease that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; 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 covered infectious disease.

PRE-EXISTING CONDITION LIMITATION

We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX) and rider form R-GCI6000-INF. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Colonial Life

Group Critical Illness Insurance

Progressive Diseases Rider

For more information, talk with your benefits counselor.

ColonialLife.com

The debilitating effects of a progressive disease not only impact you physically, but financially as well. Changes in lifestyle may require home modification, additional medical treatment and other expenses. These benefits are for you as well as your covered family members.

Payable for each covered progressive disease once per covered person per lifetime

COVERED PROGRESSIVE DISEASE[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
This benefit is payable if the covered person is unable to perform two or more activities of daily living[2] and the 90-day elimination period has been met.	
Amyotrophic Lateral Sclerosis (ALS)	25%
Dementia (including Alzheimer's disease)	25%
Huntington's disease	25%
Lupus	25%
Multiple sclerosis (MS)	25%
Muscular dystrophy	25%
Myasthenia gravis (MG)	25%
Parkinson's disease	25%
Systemic sclerosis (scleroderma)	25%

1. Refer to the certificate for complete definitions of covered diseases.
2. Activities of daily living include bathing, continence, dressing, eating, toileting and transferring.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

EXCLUSIONS AND LIMITATIONS FOR PROGRESSIVE DISEASES RIDER

We will not pay benefits for a covered progressive disease that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; suicide or injuring oneself intentionally, whether sane or not; 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 covered progressive disease.

PRE-EXISTING CONDITION LIMITATION

We will not pay a benefit for a pre-existing condition that occurs during the 12-month period after the coverage effective date. Pre-existing condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

This information is not intended to be a complete description of the insurance coverage available. The insurance or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX) and rider form R-GCI6000-PD. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Colonial Life

Group Critical Illness Insurance

Exclusions and Limitations

STATE-SPECIFIC EXCLUSIONS

AK: Alcoholism or Drug Addiction Exclusion does not apply

CO: Suicide exclusion: whether sane or not replaced with while sane

CT: Alcoholism or Drug Addiction Exclusion replaced with Intoxication or Drug Addiction; Felonies or Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply

DE: Alcoholism or Drug Addiction Exclusion does not apply

IA: Exclusions and Limitations headers renamed to Exclusions and Limitations for Critical Illness Covered Conditions and Critical Illness Cancer Covered Conditions

ID: War or Armed Conflict Exclusion replaced with War; Felonies and Illegal Occupations Exclusion replaced with Felonies; Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse

IL: Alcoholism or Drug Addiction Exclusion replaced with Alcoholism or Substance Abuse Disorder

KS: Alcoholism or Drug Addiction Exclusion does not apply

KY: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion replaced with Intoxicants, Narcotics and Hallucinogenics.

LA: Alcoholism or Drug Addiction Exclusion does not apply; Domestic Partner added to Spouse

MA: Exclusions and Limitations headers renamed to Limitations and Exclusions for critical illness and cancer

MI: Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion does not apply

MN: Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion does not apply; Felonies and Illegal Occupations Exclusion replaced with Felonies or Illegal Jobs; Intoxicants and Narcotics Exclusion replaced with Narcotic Addiction

MS: Alcoholism or Drug Addiction Exclusion does not apply

ND: Alcoholism or Drug Addiction Exclusion does not apply

NV: Intoxicants and Narcotics Exclusion does not apply; Domestic Partner added to Spouse

PA: Alcoholism or Drug Addiction Exclusion does not apply; Suicide Exclusion: whether sane or not removed

SD: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply

TX: Alcoholism or Drug Addiction Exclusion does not apply; Doctor or Physician Relationship added as an additional exclusion

UT: Alcoholism or Drug Addiction Exclusion replaced with Alcoholism

VT: Alcoholism or Drug Addiction Exclusion does not apply; Intoxicants and Narcotics Exclusion does not apply; Suicide Exclusion: whether sane or not removed

STATE-SPECIFIC PRE-EXISTING CONDITION LIMITATIONS

FL: Pre-existing is 6/12; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date shown on the Certificate Schedule. Genetic information is not a pre-existing condition in the absence of a diagnosis of the condition related to such information.

GA: Pre-existing Condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received within 12 months preceding the coverage effective date.

ID: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition which caused a covered person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the coverage effective date shown on the Certificate Schedule.

IL: Pre-existing Condition means a sickness or physical condition for which a covered person was diagnosed, treated, had medical testing by a legally qualified physician, received medical advice, produced symptoms or had taken medication within 12 months before the coverage effective date shown on the Schedule of Benefits.

IN: Pre-existing is 6 months/12 months

MA: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.

ME: Pre-existing is 6 months/6 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, or received medical advice within six months before the coverage effective date shown on the Certificate Schedule.

MI: Pre-existing is 6 months/6 months

NC: Pre-existing Condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. If a covered person is 65 or older when this certificate is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated.

NV: Pre-existing is 6 months/12 months; Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within six months before the coverage effective date. Pre-existing Condition does not include genetic information in the absence of a diagnosis of the condition related to such information.

PA: Pre-existing is 90 days/12 months; Pre-existing Condition means a disease or physical condition for which you received medical advice or treatment within 90 days before the coverage effective date shown on the Certificate Schedule.

SD: Pre-existing is 6 months/12 months

TX: Pre-existing condition means a sickness or physical condition for which a covered person received medical advice or treatment within 12 months before the coverage effective date shown on the Certificate Schedule.

UT: Pre-existing is 6 months/6 months

This information is not intended to be a complete description of the insurance coverage available. The insurance, its name or its provisions may vary or be unavailable in some states. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form GCI6000-P and certificate form GCI6000-C (including state abbreviations where used, for example: GCI6000-C-TX). For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company. This form is not complete without base form 385403, 387100, 387169, 402383, 402558 or 387238, and rider form 387307, 387381, 387452, 387523, 387594, 387665, 402605 or 402671.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

CRITICAL ILLNESS BENEFIT PREMIUMS

Plan 1 - Critical Illness Rates illustrated per unit. Named Insured unit value = $1000					
Issue Age	**Deduction**	**Named Insured**	**Employee & Spouse**	**One-Parent Family**	**Two Parent Family**
Non-Tobacco					
17-24	**12-Pay Premium**	$0.22	$0.31	$0.22	$0.31
25-29	**12-Pay Premium**	$0.30	$0.43	$0.30	$0.43
30-34	**12-Pay Premium**	$0.38	$0.55	$0.38	$0.55
35-39	**12-Pay Premium**	$0.57	$0.85	$0.57	$0.85
40-44	**12-Pay Premium**	$0.77	$1.14	$0.77	$1.14
45-49	**12-Pay Premium**	$1.08	$1.65	$1.08	$1.65
50-54	**12-Pay Premium**	$1.44	$2.23	$1.44	$2.23
55-59	**12-Pay Premium**	$1.90	$2.94	$1.90	$2.94
60-64	**12-Pay Premium**	$2.60	$4.02	$2.60	$4.02
65-69	**12-Pay Premium**	$2.84	$4.38	$2.84	$4.38
70-74	**12-Pay Premium**	$3.27	$5.04	$3.27	$5.04
Wellbeing Assistance Benefit **Rates by wellbeing amount = 1 unit**					
Wellbeing Amount		**Named Insured**	**Employee & Spouse**	**One-Parent Family**	**Two Parent Family**
$100	12-Pay Premium	$6.65	$10.35	$6.65	$10.35

⚠ Sample rates only. Multiple choices and options available and rates may vary.

CRITICAL ILLNESS BENEFIT PREMIUMS

Plan 2 - Critical Illness & Cancer Benefits Rates illustrated per unit. Named Insured unit value = $1000					
Issue Age	**Deduction**	**Named Insured**	**Employee & Spouse**	**One-Parent Family**	**Two Parent Family**
Non-Tobacco					
17-24	**12-Pay Premium**	$0.40	$0.57	$0.40	$0.57
25-29	**12-Pay Premium**	$0.57	$0.83	$0.57	$0.83
30-34	**12-Pay Premium**	$0.75	$1.09	$0.75	$1.09
35-39	**12-Pay Premium**	$1.15	$1.70	$1.15	$1.70
40-44	**12-Pay Premium**	$1.55	$2.30	$1.55	$2.30
45-49	**12-Pay Premium**	$2.21	$3.32	$2.21	$3.32
50-54	**12-Pay Premium**	$2.86	$4.34	$2.86	$4.34
55-59	**12-Pay Premium**	$3.76	$5.71	$3.76	$5.71
60-64	**12-Pay Premium**	$5.13	$7.79	$5.13	$7.79
65-69	**12-Pay Premium**	$6.29	$9.57	$6.29	$9.57
70-74	**12-Pay Premium**	$6.29	$9.57	$6.29	$9.57
Wellbeing Assistance Benefit **Rates by wellbeing amount = 1 unit**					
Wellbeing Amount		**Named Insured**	**Employee & Spouse**	**One-Parent Family**	**Two Parent Family**
$100	12-Pay Premium	$6.65	$10.35	$6.65	$10.35

⚠ Sample rates only. Multiple choices and options available and rates may vary.

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

Click on the video below to learn more about Disability Benefits!

Educator Disability Advantage Short-Term Disability

Educator Disability Advantage insurance[1] from Colonial Life is designed to provide financial protection for all education workers with plans that can help supplement and/or complement the Disability Income Plan of North Carolina. Educator Disability Advantage insurance provides flexible options for disability coverage and accidental injury benefits to help protect your income and maintain lifestyle needs if you become disabled due to a covered accident or sickness.

My Disability 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/Sickness	Off-Job Accident/Sickness
• **Total Disability**		
First three months	$_____/month	$_____/month
Next nine months	$_____/month	$_____/month
• **Partial Disability**		
Up to three months	$_____/month	$_____/month

When will my benefits start?

After an accident: _____ days After a sickness: _____ days

What additional features or benefits are included?

- Normal pregnancy is covered the same as any other covered sickness.
- Waiver of Premium: We will waive your premium payments after 90 consecutive days of a covered disability.
- Goodwill Child Benefit: $1,000, up to two benefits per year for adoption or ward of a guardian
- Mental or Nervous Disorders Benefit

How much will it cost?

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

How long could you afford to go without a paycheck?

Monthly Expenses:

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

Disability benefits and more

Anita teaches at a local community college and enjoys spending time on active hobbies and volunteering with non-profits. When she was injured in a mountain biking accident, she worried that she might not be able to make ends meet for a while.

How Anita's coverage helped*

With her coverage, she received benefits for:

- Accident emergency treatment $400
- X-ray $150
- Collarbone fracture requiring surgery .. $1,200
- Elbow dislocation (nonsurgical) $400
- Hospital stay of three nights $150
- Short-term disability benefits $1,400

Total amount: **$3,700**

**For illustrative purposes only. Coverage amounts may vary based on injury, treatment, income and more.*

Additional Employee Coverage

In addition to disability coverage, this plan also provides employees with benefits related to accidental injuries, their treatment and more. Even if you're not disabled, the following benefits are payable for covered accidental injuries or sickness:

ACCIDENTAL INJURIES BENEFITS

- **Accident emergency treatment** **$400**
- **X-ray** **$150**
- **Accident follow-up treatment (including transportation)/Telemedicine** **$75**
  (up to six benefits per accident per person, up to twelve a year per person)

HOSPITAL CONFINEMENT BENEFIT FOR ACCIDENT OR SICKNESS

Pays in addition to disability benefit. Benefits begin on the first day of confinement in a hospital.

Up to three months ..... **$1,500/month ($50/day)**
The Hospital Confinement benefit increases to $7,500/month when the Total Disability benefit ends at age 70.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

- **Accidental death** **$25,000**
- **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**
  Dismemberment **$10,000**
- **Common carrier death (includes school bus for school activities)** **$50,000**

COMPLETE FRACTURES	Nonsurgical	Surgical
Hip, thigh	$1,500	$3,000
Vertebrae	$1,350	$2,700
Pelvis	$1,200	$2,400
Skull (depressed)	$1,500	$3,000
Leg	$900	$1,800
Foot, ankle, kneecap	$750	$1,500
Forearm, hand, wrist	$750	$1,500
Lower jaw	$600	$1,200
Shoulder blade, collarbone	$600	$1,200
Skull (simple)	$525	$1,050
Upper arm, upper jaw	$525	$1,050
Facial bones	$450	$900
Vertebral processes	$300	$600
Rib	$300	$600
Finger, toe	$175	$350
Coccyx	$125	$250

COMPLETE DISLOCATIONS	Nonsurgical	Surgical
• Hip	$1,500	$3,000
• Knee	$975	$1,950
• Shoulder	$750	$1,500
• Collarbone (sternoclavicular)	$750	$1,500
• Ankle, foot	$750	$1,500
• Collarbone (acromioclavicular and separation)	$675	$1,350
• Hand	$525	$1,050
• Lower jaw	$450	$900
• Wrist	$400	$800
• Elbow	$400	$800
• One finger, toe	$125	$250

- 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, we will pay for both, up to two 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 Child(ren) 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.

ACCIDENTAL INJURIES BENEFITS

- **Accident emergency treatment** $400
- **X-ray** $150
- **Accident follow-up treatment (including transportation)/Telemedicine** $75
  (up to six benefits per accident per person, up to twelve a year per person)

HOSPITAL CONFINEMENT BENEFIT FOR ACCIDENT OR SICKNESS

Up to three months ..... **$1,500/month ($50/day)**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

- **Accidental death** $5,000
- **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)** $10,000

More than 1 in 4 of 20-year-olds become disabled before retirement age.[2]

Frequently Asked Questions

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

Benefits are payable regardless of workers' compensation or any other insurance you may have with other insurance companies. Benefits are payable 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 occupation;
- Not, in fact, working at any occupation; 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 more than half of your normally weekly scheduled hours;
- You are able to work at your job or your place of employment for less than half of your normally weekly scheduled hours;
- Your employer will allow you to return to your job or place of employment for less than half of your normally weekly scheduled hours; and
- You are under the regular and appropriate care of a doctor.

The total disability benefit must have been paid for at least fourteen days 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, or when you are no longer considered disabled as defined in the policy, whichever comes first.

The Hospital Confinement benefit increases when the Total Disability Benefit ends.

Can I keep my coverage if I change jobs?

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 twelve 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 twelve months the policy is in force.

What is the Mental or Nervous Disorder benefit?

This benefit provides coverage for a disability due to a mental or nervous condition. Coverage provides a benefit up to three months per occurrence, with a cumulative lifetime maximum benefit of 24 months.

For more information, talk with your Colonial Life benefits counselor.

1. Educator Disability Advantage is the marketing name of the insurance product filed as "Disability Income Insurance Policy."
2. U.S. Social Security Administration, The Faces and Facts of Disability. https://www.ssa.gov/disabilityfacts/facts.html. Accessed April 2021.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for losses that are caused by or are the result of: Cosmetic Surgery, Felonies and Illegal Occupations, Flying, Hazardous Avocations, Intoxicants and Narcotics, Racing, Semiprofessional or Professional Sports, Substance Abuse, Suicide or Self-Inflicted Injuries, and War or Armed Conflict.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Applicable to policy form NCK1100. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Colonial Life®

Pregnancy and having a baby

Disability Insurance

For more information, talk with your benefits counselor.

ColonialLife.com

A baby changes everything – even your financial situation.

Disability insurance can help you pay for everyday living expenses and keep you focused on taking care of the new addition to your family.

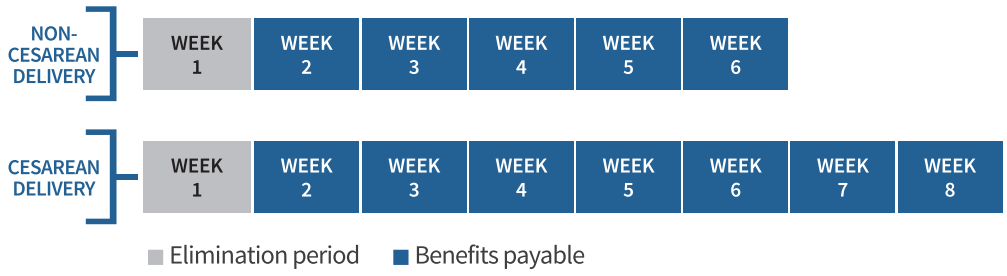
How disability insurance can help

- The usual recovery period is six weeks (non-cesarean delivery) or eight weeks (cesarean delivery). If your claim is approved, your benefits will start after you satisfy your elimination period (waiting period).
- Benefits are paid directly to you to use as you see fit.
- Your disability benefits are not affected by your employer's leave of absence program, the Family Medical Leave Act (FMLA), your sick leave or paid time off/vacation time.
- If you were not pregnant before your coverage effective date, pregnancy complications, such as pre-term labor, gestational diabetes and pre-eclampsia, are treated just like any other covered sickness.

Your disability policy may have a giving birth limitation. If so, this means Colonial Life will not pay disability benefits if you give birth within the first nine months after your coverage effective date. If the pregnancy is considered a pre-existing condition, any dates missed from work due to pregnancy, delivery, or associated complications may not be covered. Please refer to your disablity sales brochure.

Understanding your elimination period (waiting period)

If your claim is approved, your benefits will start after you have satisfied the elimination period, which is the period of time that no benefits are payable. Your elimination period may vary based on the plan you select.



For illustrative purposes only. Example based on a seven-day elimination period.

Although the above example shows benefits payable for five or seven weeks after the elimination period, the policy provides a monthly benefit. After deducting the elimination period and paying any full months of disability, the remaining dates will be paid using the daily rate.

Filing your disability claim

If there are no complications, you should file your claim after delivery. For complications before delivery, you should file your claim as soon as the doctor indicates you are unable to continue working.

This information is not intended to be a complete description of the insurance coverage available. The insurance has exclusions and limitations which may affect any benefits payable. Coverage type and benefits may vary by state and may not be available in all states. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

Applicable to policy forms ISTD3000 and rider form ISTD3000-ADIB (including state abbreviations where used, for example: ISTD3000-TX and ISTD3000-ADIB-TX). Applicable to policy form DIS1000 including state abbreviations where used. Applicable to ED DIS1.0 including state abbreviations where used. Applicable to policy form ICC21-DIP3000 and ICC21-DIP3000-R-DIS. Applicable to policy forms GDIS-P and certificate form GDIS-C (including state abbreviations where used, for example: GDIS-P-EE-TX and GDIS-C-EE-TX). Applicable to policy form VSTDMP and certificate form VSTDC including state abbreviations where used. For cost and complete details of coverage, call or write your Colonial Life benefits representative or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

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SHORT-TERM DISABILITY PREMIUMS

On/Off-Job Accident and On/Off-Job Sickness with Mental or Nervous Benefit						
Monthly Benefit Amount			Pay Premium	Elimination Period		
First 3 Months	Next 9 Months	Units		0/7	0/14	14/14
$400.00	$200.00	4	12-Pay Premium	$22.70	$19.50	$18.70
$600.00	$300.00	6	12-Pay Premium	$29.10	$24.30	$23.10
$800.00	$400.00	8	12-Pay Premium	$35.50	$29.10	$27.50
$1,000.00	$500.00	10	12-Pay Premium	$41.90	$33.90	$31.90
$1,500.00	$750.00	15	12-Pay Premium	$57.90	$45.90	$42.90
$2,000.00	$1,000.00	20	12-Pay Premium	$73.90	$57.90	$53.90
$2,500.00	$1,250.00	25	12-Pay Premium	$89.90	$69.90	$64.90
$3,000.00	$1,500.00	30	12-Pay Premium	$105.90	$81.90	$75.90
$3,500.00	$1,750.00	35	12-Pay Premium	$121.90	$93.90	$86.90
$3,900.00	$1,950.00	39	12-Pay Premium	$134.70	$103.50	$95.70

Monthly Disability Benefit	To Provide 60% Monthly Disability Benefit	Percent of Income Coverage
$400.00	$8,000 - $9,999.99	60%
$600.00	$12,000 - $13,999.99	60%
$800.00	$16,000 - $17,999.99	60%
$1,000.00	$20,000 - $21,999.99	60%
$1,200.00	$24,000 - $25,999.99	60%
$1,500.00	$30,000 - $31,999.99	60%
$2,000.00	$40,000 - $41,999.99	60%
$2,500.00	$50,000 - $51,999.99	60%
$3,000.00	$60,000 - $61,999.99	60%
$3,500.00	$78,000 - $82,799.99	53.85%
$4,000.00	$102,000 - $106,799.99	47.06%
$4,500.00	$126,000 - $130,799.99	42.86%
$5,000.00	$150,000 and above	40%

⚠ Sample rates only. Multiple choices and options available and rates may vary.

Click on the video below to learn more about Accident Benefits!

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.

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

ACCIDENT BENEFIT PREMIUMS

Preferred with HealthScreening - On/Off-Job Accident Coverage

	12-Pay Premium
Named Insured	$21.15
Employee & Spouse	$28.97
One-Parent Family	$32.67
Two-Parent Family	$40.48

Preferred with HealthScreening - Off-Job Only Accident Coverage

	12-Pay Premium
Named Insured	$17.92
Employee & Spouse	$23.96
One-Parent Family	$26.56
Two-Parent Family	$32.61

⚠ Sample rates only. Multiple choices and options available and rates may vary.

2025 STATE HEALTH PLAN COMPARISON

Active and Non-Medicare Subscribers

PLAN DESIGN FEATURES	Enhanced PPO Plan (80/20)		Base PPO Plan (70/30)	
	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	$0 for CPP PCP on ID card; $10 for non-CPP PCP on ID card; $25 for any other PCP	40% after deductible is met	$0 for CPP PCP on ID card; $30 for non-CPP PCP on ID card; $45 for any other PCP	50% after deductible is met
Teladoc	$25		$45	
Specialist Visits	$40 for CPP Specialist; $80 for other Specialists	40% after deductible is met	$47 for CPP Specialist; $94 for other Specialists	50% after deductible is met
Speech/Occu/Chiro/PT	$26 for CPP Provider; $52 for other Providers	40% after deductible is met	$36 for CPP Provider; $72 for other Providers	50% after deductible is met
Urgent Care	$70		$100	

PCP: Primary Care Provider, CPP: Clear Pricing Project

To find a CPP Provider, visit www.shpnc.org and click Find a Doctor.

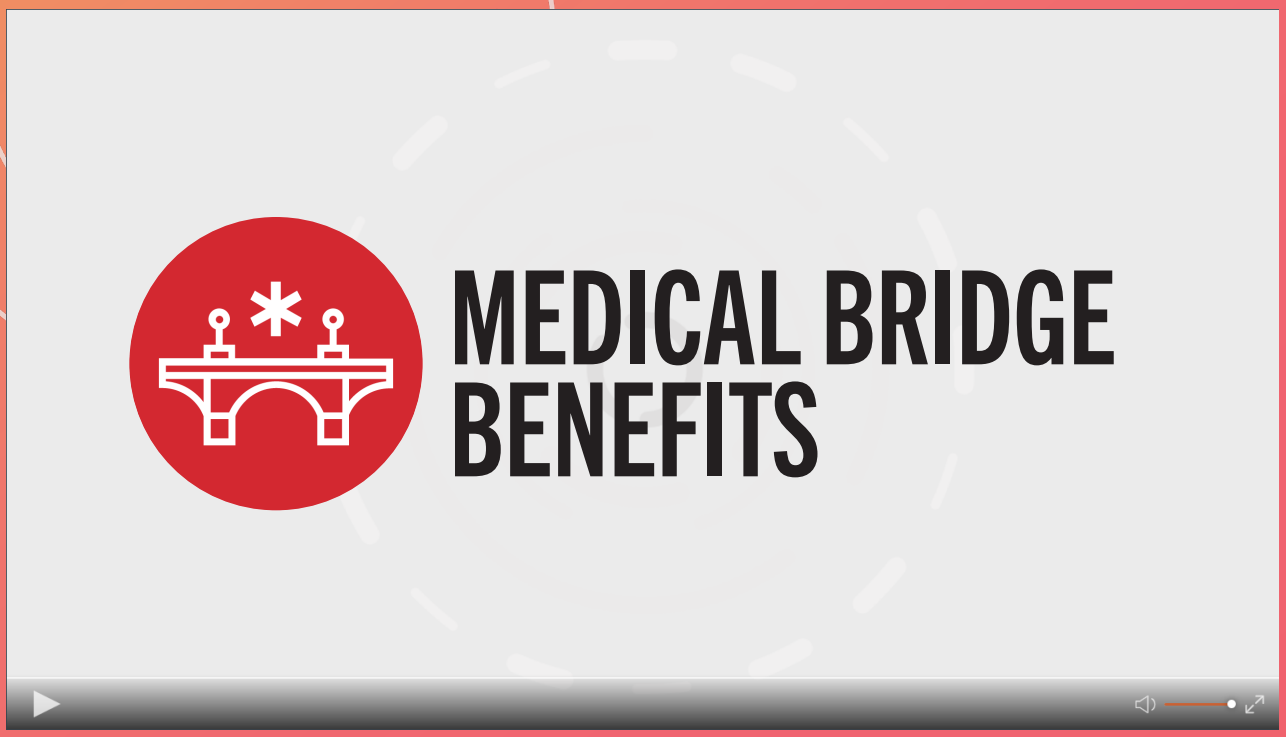
North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA

PLAN DESIGN FEATURES	Enhanced PPO Plan (80/20)		Base PPO Plan (70/30)	
	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	$5 copay per 30-day supply		$16 copay per 30-day supply	
Tier 2	$30 copay per 30-day supply		$47 copay per 30-day supply	
Tier 3	Deductible/coinsurance		Deductible/coinsurance	
Tier 4	$100 copay per 30-day supply		$200 copay per 30-day supply	
Tier 5	$250 copay per 30-day supply		$350 copay per 30-day supply	
Tier 6	Deductible/coinsurance		Deductible/coinsurance	
Preferred Blood Glucose Meters (BGM) and Supplies*	$5 copay per 30-day supply		$10 copay per 30-day supply	
Preferred and Non-Preferred Insulin	$0 copay per 30-day supply		$0 copay per 30-day supply	
Preventive Medications	$0 (covered by the Plan at 100%)		$0 (covered by the Plan at 100%)	

* This does not include Continuous Glucose Monitoring Systems or associated supplies. Preferred Continuous Glucose Monitoring Systems and associated supplies are considered a Tier 2 member copay.

Click on the video below to learn more about Medical Bridge Benefits!



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Hospital Confinement Indemnity Insurance

Plan 2

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

Outpatient surgical procedure

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

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

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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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. 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.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

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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.

This information is not intended to be a complete description of the insurance coverage available. The insurance has exclusions and limitations which may affect any benefits payable. Applicable to policy form IMB7000-NC. For cost and complete details of coverage, call or write your Colonial Life benefits counselor or the company.

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Hospital Confinement Indemnity Insurance

Optional Riders

For more information, talk with your benefits counselor.

ColonialLife.com

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.

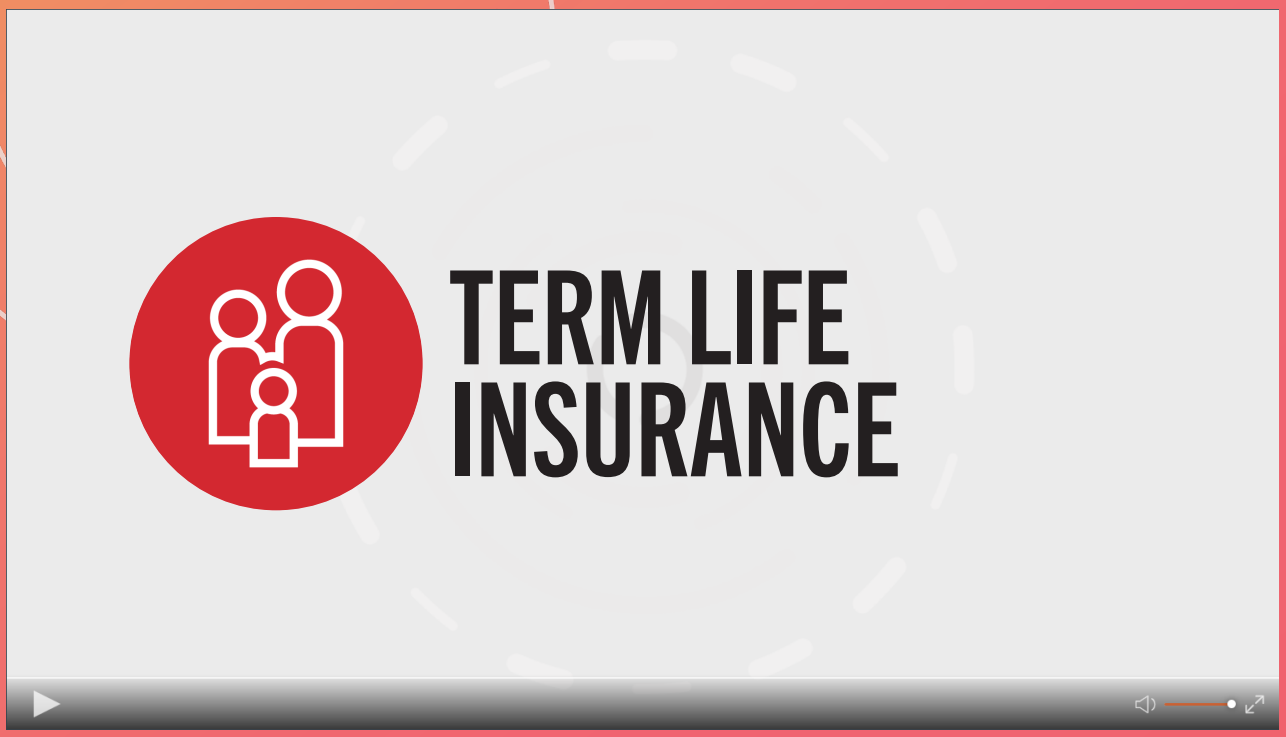
For cost and complete details, see your Colonial Life benefits counselor. Applicable to rider numbers R-DHC7000-NC and R-EIC7000-NC. This is not an insurance contract and only the actual policy or rider provisions will control.

MEDICAL BRIDGE BENEFIT PREMIUMS

INDIVIDUAL MEDICAL BRIDGE Plan 2 Named Insured		Level 3	Level 4
Hospital Confinement Medical Treatment Pkg $100 Health Screening		$1,500.00	$2,000.00
Outpatient Surgical Procedure		Option 2 Tier 1 $750 Tier 2 $1,500 CY Max $2,500	Option 2 Tier 1 $750 Tier 2 $1,500 CY Max $2,500
Ages 17-49	12-Pay Premium	$38.35	$46.45
Ages 50-59	12-Pay Premium	$50.25	$61.30
Ages 60-64	12-Pay Premium	$63.90	$78.90
Ages 65-75	12-Pay Premium	$90.40	$112.45

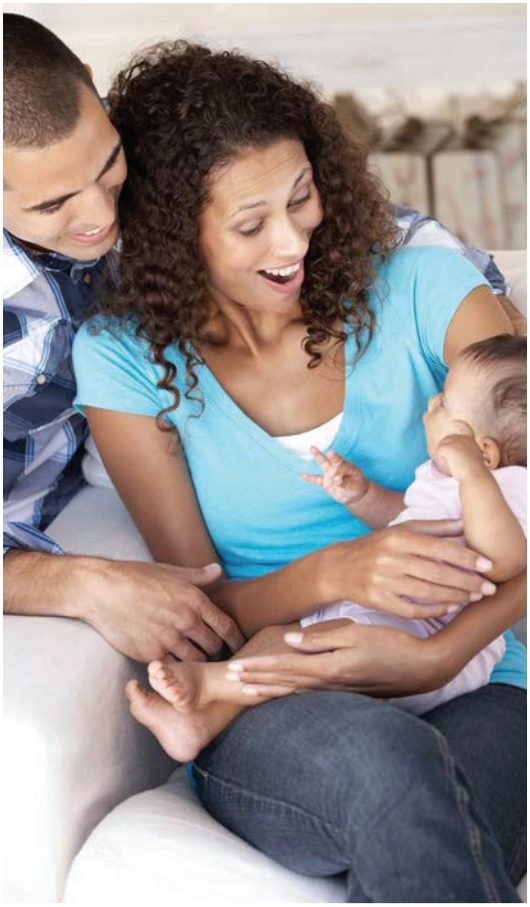
⚠ Sample rates only. Multiple choices and options available and rates may vary.

Click on the video below to learn more about Term Life Insurance!



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.

7-19 | NS-16570-1

How much coverage do you need?

☐ **YOU** $ _____

Select the term period:

☐ 10-year
☐ 15-year
☐ 20-year
☐ 30-year

☐ **SPOUSE** $ _____

Select the term period:

☐ 10-year
☐ 15-year
☐ 20-year
☐ 30-year

Select any optional riders:

☐ Spouse term life rider
$ _____ face amount
for _____-year term period

☐ Children's term life rider
$ _____ face amount

☐ Accidental death benefit rider

☐ Chronic care accelerated death benefit rider

☐ Critical illness accelerated death benefit rider

☐ Waiver of premium benefit rider

To learn more, talk with your Colonial Life benefits counselor.

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Optional riders

At an additional cost, you can purchase the following riders for even more financial protection.

Spouse term life rider

Your spouse may receive a maximum death benefit of $50,000; 10-year and 20-year spouse term riders are available.

Children's term life rider

You can purchase up to $20,000 in term life coverage for all of your eligible dependent children and pay one premium. The children's term life rider may be added to either your policy or your spouse's policy – not both.

Accidental death benefit rider

The beneficiary may receive an additional benefit if the covered person dies as a result of an accident before age 70. The benefit doubles if the accidental bodily injury occurs while riding as a fare-paying passenger using public transportation, such as ride-sharing services. An additional 25% will be payable if the injury is sustained while driving or riding in a private passenger vehicle and wearing a seatbelt.

Chronic care accelerated death benefit rider

If a licensed health care practitioner certifies that you have a chronic illness, you may receive an advance on all or a portion of the death benefit, available in a one-time lump sum or monthly payments.[1] A chronic illness means you require substantial supervision due to a severe cognitive impairment or you may be unable to perform at least two of the six Activities of Daily Living.[2] Premiums are waived during the benefit period.

Critical illness accelerated death benefit rider

If you suffer a heart attack (myocardial infarction), stroke or end-stage renal (kidney) failure, a $5,000 benefit is payable.[1] A subsequent diagnosis benefit is included.

Waiver of premium benefit rider

Premiums are waived (for the policy and riders) if you become totally disabled before the policy anniversary following your 65th birthday and you satisfy the six-month elimination period.[3]

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.
2 Activities of daily living are bathing, continence, dressing, eating, toileting and transferring.
3 You must resume premium payments once you are no longer disabled.

EXCLUSIONS AND LIMITATIONS

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, minus any loans and loan interest to you.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Applicable to policy forms ICC18-ITL5000/ITL5000 and rider forms ICC18-R-ITL5000-STR/R-ITL5000- STR, ICC18-R-ITL5000-CTR/R-ITL5000-CTR, ICC18-R-ITL5000-WP/R-ITL5000-WP, ICC18-R-ITL5000-ACCD/R-ITL5000- ACCD, ICC18-R-ITL5000-CI/R-ITL5000-CI, ICC18-R-ITL5000-CC/R-ITL5000-CC. For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

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TERM LIFE INSURANCE PREMIUMS

10-Year Term Base Plan Monthly Non-Tobacco Rates					
Issue Age	**Pay Premium**	**$10,000.00**	**$25,000.00**	**$50,000.00**	**$100,000.00**
25	12-Pay Premium	$6.64	$10.60	$10.21	$16.42
30	12-Pay Premium	$7.06	$11.65	$10.21	$16.42
35	12-Pay Premium	$7.57	$12.94	$11.25	$18.50
40	12-Pay Premium	$7.98	$13.96	$14.04	$24.08
45	12-Pay Premium	$9.17	$16.92	$18.62	$33.25
50	12-Pay Premium	$11.72	$23.29	$25.58	$47.16
55	12-Pay Premium	$16.17	$34.44	$36.37	$68.75
60	12-Pay Premium	$23.36	$52.39	$53.96	$103.91

20-Year Term Base Plan Monthly Non-Tobacco Rates					
Issue Age	**Pay Premium**	**$10,000.00**	**$25,000.00**	**$50,000.00**	**$100,000.00**
25	12-Pay Premium	$6.71	$10.77	$10.54	$17.08
30	12-Pay Premium	$7.12	$11.81	$10.54	$17.08
35	12-Pay Premium	$7.69	$13.23	$11.58	$19.17
40	12-Pay Premium	$8.23	$14.58	$15.42	$26.83
45	12-Pay Premium	$9.68	$18.21	$21.79	$39.58
50	12-Pay Premium	$12.67	$25.69	$31.58	$59.16
55	12-Pay Premium	$18.06	$39.14	$46.33	$88.66
60	12-Pay Premium	$26.84	$61.10	$72.00	$139.99

⚠ Sample rates only. Multiple choices and options available and rates may vary.

Click on the video below to learn more about Whole Life Insurance!

Colonial Life

Whole Life Plus Insurance*

You can't predict your family's future, but you can prepare for it.

Help give your family more peace of mind and coverage for final expenses with Colonial Life Individual Whole Life Plus insurance.

Benefits and features

- Choose the age when your premium payments end — Paid-Up at Age 70 or Paid-Up at Age 100
- Stand-alone spouse policy available even without buying a policy for yourself
- Ability to keep the policy if you change jobs or retire
- Built-in terminal illness accelerated death benefit that provides up to 75% of the policy's death benefit (up to $150,000) if you're diagnosed with a terminal illness[1]
- Immediate $3,000 claim payment that can help your designated beneficiary pay for funeral costs or other expenses
- Provides cash surrender value at age 100 (when the policy endows)

Additional coverage options

Spouse term rider

Cover your spouse with a death benefit up to $50,000, for 10 or 20 years.

Juvenile Whole Life Plus policy

Purchase a policy (Paid-Up at Age 70) while children are young and premiums are low — whether or not you buy a policy for yourself. You may also increase the coverage when the child is 18, 21 and 24 without proof of good health.

Children's term rider

You may purchase up to $20,000 in term life insurance coverage for all of your eligible dependent children and pay one premium. The children's term rider may be added to either your policy or your spouse's policy — not both.

Advantages of Whole Life Plus insurance

- Permanent life insurance coverage that stays the same through the life of the policy
- Premiums will not increase due to changes in health or age.
- Accumulates cash value based on a nonforfeiture interest rate of 3.75%[2]
- Policy loans available, which can be used for emergencies
- Benefit for the beneficiary that is typically tax-free

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

Benefits worksheet

For use with your benefits counselor

How much coverage do you need?

☐ YOU $_____

Select the option:

☐ Paid-Up at Age 70

☐ Paid-Up at Age 100

☐ SPOUSE $ _____

Select the option:

☐ Paid-Up at Age 70

☐ Paid-Up at Age 100

☐ DEPENDENT STUDENT $ _____

Select the option:

☐ Paid-Up at Age 70

☐ Paid-Up at Age 100

Select any optional riders:

☐ Spouse term rider $ _____face amount for _____-year term period

☐ Children's term rider $ _____face amount

☐ Accelerated death benefit for long term care services rider

☐ Accidental death benefit rider

☐ Chronic care accelerated death benefit rider

☐ Critical illness accelerated death benefit rider

☐ Guaranteed purchase option rider

☐ Waiver of premium benefit rider

To learn more, talk with your benefits counselor.

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Additional coverage options (Continued)

Accelerated death benefit for long term care services rider[3]

Talk with your benefits counselor for more details.

Accidental death benefit rider

An additional benefit may be payable if the covered person dies as a result of an accident before age 70, and doubles if the injury occurs while riding as a fare-paying passenger using public transportation. An additional 25% is payable if the injury occurs while driving or riding in a private passenger vehicle and wearing a seatbelt.

Chronic care accelerated death benefit rider

If a licensed health care practitioner certifies that you have a chronic illness, you may receive an advance on all or a portion of the death benefit, available in a one-time lump sum or monthly payments.[1] Talk with your benefits counselor for more details.

Critical illness accelerated death benefit rider

If you suffer a heart attack, stroke or end-stage renal (kidney) failure, a $5,000 benefit is payable.[1] A subsequent diagnosis benefit is included.

Guaranteed purchase option rider

This rider allows you to purchase additional whole life coverage — without having to answer health questions — at three different points in the future. The rider may only be added if you are age 50 or younger when you purchase the policy. You may purchase up to your initial face amount, not to exceed a total combined maximum of $100,000 for all options.

Waiver of premium benefit rider

Policy and rider premiums are waived if you become totally disabled before the policy anniversary following your 65th birthday and you satisfy the six-month elimination period. Once you are no longer disabled, premiums will resume.

* Whole Life Plus is a marketing name of the insurance policy filed as "Whole Life Insurance" in most states.

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.

2 Accessing the accumulated cash value reduces the death benefit by the amount accessed, unless the loan is repaid. Cash value will be reduced by any outstanding loans against the policy.

3 The rider is not available in all states.

This life insurance does not specifically cover funeral goods or services and may not cover the entire cost of your funeral at the time of your death. The beneficiary of this life insurance may use the proceeds for any purpose, unless otherwise directed.

EXCLUSIONS AND LIMITATIONS: 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, minus any loans and loan interest to you.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Applicable to policy forms ICC19-IWL5000-70/IWL5000-70, ICC19-IWL5000-100/IWL5000-100, ICC19-IWL5000J/IWL5000J and rider forms ICC23-IWL5000-LTC/IWL5000-LTC, ICC19-R-IWL5000-STR/R-IWL5000-STR, ICC19-R-IWL5000-CTR/R-IWL5000-CTR, ICC19-R-IWL5000-WP/R-IWL5000-WP, ICC19-R-IWL5000-ACCD/R-IWL5000-ACCD, ICC19-R-IWL5000-CI/R-IWL5000-CI, ICC19-R-IWL5000-CC/R-IWL5000-CC, ICC19-R-IWL5000-GPO/R-IWL5000-GPO (including state abbreviations where applicable). For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

WHOLE LIFE INSURANCE PREMIUMS

Adult Base Plan Paid-up to Age 70 Non-Tobacco Rates						
Issue Age	Pay Premium	$10,000.00	$25,000.00	$50,000.00	$100,000.00	$200,000.00
25	12-Pay Premium	$9.87	$24.69	$49.37	$98.75	$197.49
30	12-Pay Premium	$11.92	$29.79	$59.58	$119.16	$238.32
35	12-Pay Premium	$14.96	$37.39	$74.79	$149.58	$299.15
40	12-Pay Premium	$19.35	$48.37	$96.75	$193.49	$386.98
45	12-Pay Premium	$25.57	$63.93	$127.87	$255.74	$511.48
50	12-Pay Premium	$34.87	$87.18	$174.37	$348.74	$697.47

Adult Base Plan Paid-up to Age 100 Non-Tobacco Rates						
Issue Age	Pay Premium	$10,000.00	$25,000.00	$50,000.00	$100,000.00	$200,000.00
25	12-Pay Premium	$9.20	$23.00	$46.00	$92.00	$183.99
30	12-Pay Premium	$10.46	$26.14	$52.29	$104.58	$209.16
35	12-Pay Premium	$12.52	$31.29	$62.58	$125.16	$250.32
40	12-Pay Premium	$15.51	$38.77	$77.54	$155.08	$310.15
45	12-Pay Premium	$19.88	$49.71	$99.41	$198.83	$397.65
50	12-Pay Premium	$25.10	$62.75	$125.49	$250.99	$501.98
55	12-Pay Premium	$32.45	$81.12	$162.24	$324.49	$648.97
60	12-Pay Premium	$42.96	$107.39	$214.78	$429.57	$859.13

⚠ Sample rates only. Multiple choices and options available and rates may vary.

Colonial Life

Customer Service Guide

Getting started

The easiest way to manage your business with us is through ColonialLife.com. To sign up for the website, click Register at the top right of the home page and follow the instructions.

Contact us

Online

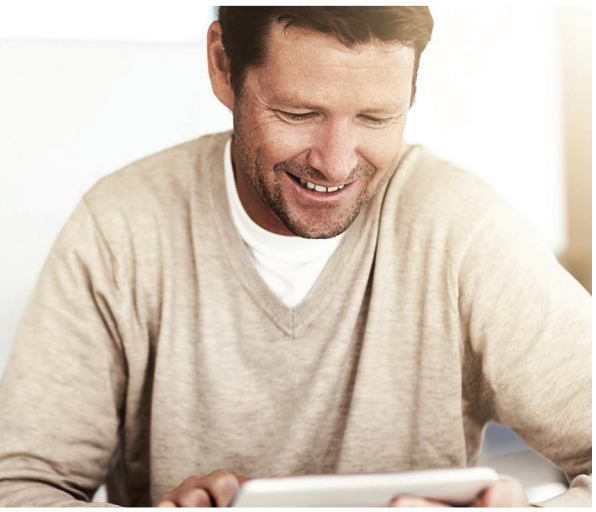
ColonialLife.com
Log in and click on
Contact Us

Telephone

1-800-325-4368

Hearing-impaired customers

Please contact the National Relay service at 711 for assistance.



ColonialLife.com

Consider your options

At Colonial Life, our goal is to give you an excellent customer experience that is simple, modern and personal. For your convenience, you can choose how you interact with us. For the quickest service, we recommend using our website, which lets you do the following:

- Review, print or download a copy of your policy/certificate by clicking on the **My Correspondence tab.**
- Update contact information or add family member profile information for use when filing online claims.
- Access service forms to make changes to your policy, such as a beneficiary change.
- Submit your claim using our eClaims system.
- Check the status of your claim and view claims correspondence.
- Access claim forms.

eClaims are quick and easy

With the eClaims feature on ColonialLife.com, you can file most claims online by simply answering a few questions and uploading your supporting documentation. You're able to spend less time on paperwork, and we're able to process your claim faster.

- From ColonialLife.com, file claims from any device. It's fast, easy and available 24/7.
- Select direct deposit to receive your benefit payment faster.
- Easily submit additional documents.

Paper claims

- If you don't want to file online, download the form you need by visiting the File a Claim page on ColonialLife.com and clicking on claim and service forms.
- You may fax your claim to 1-800-880-9325.
- Follow the instructions, tips and videos to complete and submit your claim.

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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)

COBRA CONTINUATION OF COVERAGE

INTRODUCTION: You're getting this notice because you recently gained coverage under a group 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 [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to 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;
- 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,

COBRA CONTINUATION OF COVERAGE

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?: In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 knowabout 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: Sabrina Adalin
444 Western Boulevard
Jacksonville, NC 28546
adalins@coastalcarolina.edu

Dental COBRA Administrator:

Interactive Medical Systems
PO Box 1349
Wake Forest, NC 27588
(800) 426-8739

Vision COBRA Administrator:

Superior Vision
ATTN: COBRA
11090 White Rock Road, Ste 175
Rancho Cordova, CA 95670
(800) 507-3800

PRIVACY NOTICES

Non Public Information (NPI)

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 policy holders 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 legal 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 institution 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, 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 tor 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. Your 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 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 reasons(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 your if we may have disclosed the disputed NPI to that person int he past two years.

Disclosure Notice Concerning The Medical Information Bureau

Information regarding your insurability will be treated as confidential. Colonial or its reinsure(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 reinsure 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.

CONTINUATION OF COVERAGE

We are committed to being there for you and your family at every stage of life. Pierce Group Benefits makes it easy to stay protected!

The following benefits can be self-enrolled online or by contacting PGB Employee Services, with Individual and Family coverage options available for most plans. You are eligible to sign-up the first day after the end date of your employer-sponsored plan.

DENTAL BENEFITS

VISION BENEFITS

TELEMEDICINE BENEFITS

SUPPLEMENTAL/VOLUNTARY POLICIES

Your individual supplemental/voluntary policies through Colonial Life are portable! To transfer your benefits from payroll deduction to direct billing or automatic bank draft, please call Employee Services at 888-662-7500 within 30 days of becoming unemployed, switching careers, or retiring.

TRANSFERRING EMPLOYERS?

If you are transferring from a current PGB client to another, some benefits may be eligible for transfer. Please call Employee Services at 888-662-7500 for assistance.

Please visit **www.piercegroupbenefits.com/individualcoverage** or call **888-662-7500** for more information on these policies, as well as to enroll/continue your benefits.

NORTH CAROLINA STATE HEALTH PLAN 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 North Carolina State Health Plan at 1-877-679-6272.

If you are retiring, you must either log into www.myncretirement.com or call 1-877-679-6272.

PIERCE GROUP BENEFITS

ABOUT PIERCE GROUP BENEFITS

Pierce Group Benefits is a leading full-service employee benefits administration and consulting agency serving employer groups across the Southeast. By leveraging market strength, exclusive partnerships, and industry expertise, we deliver trusted advice, products, and solutions that benefit employers and employees alike; delivered by one team and driven by one purpose — together we can do more.

SCAN TO VIEW YOUR CUSTOM BENEFITS MICROSITE