NCFLEX

STATE INSURANCE PLANS

NCFlex
State Insurance Plans

- Health Care Flexible Spending Account (HCFSA)
- Dependent Day Care Flexible Spending Account (DDCFSA)
- Dental Care
- Vision Care
- Critical Illness
- Cancer & Specified Disease
- Group Term Life Insurance
- Core Accidental Death & Dismemberment (AD&D)
- Voluntary Accidental Death & Dismemberment (AD&D)
- TRICARE Supplement

ncflex.org

NCFlex is administered through the North Carolina Office of State Human Resources

2017 Enrollment Guide

State Human Resources

WELLNESS TIP

Look for this icon throughout the guide to learn more about how your NCFlex benefits can help you get and stay well!

NCFLEX

STATE INSURANCE PLANS

Choose the NCFlex benefits that are right for you and your family

Watch videos to learn more about:

- *Each of the insurance plan options that NCFlex provides*
- *Pre-tax benefits and how they can help save you money*
- *Choosing the benefits that best meet the needs of you and your family*

Get answers to your questions:

- *When can I enroll?*
- *How does a Flexible Spending Account work?*
- *What is AD&D insurance, and do I need to enroll in my AD&D coverage?*
- *Why does my family need Critical Illness Insurance?*
- *And more!*

Learn more at www.ncflex.org

NCFlex Overview

The NCFlex Benefits Program provides a variety of plans to meet the needs of you and your family. You may enroll in any or all of the NCFlex benefits if you work for a state agency, university, select community college, or select charter school. You pay for the cost of coverage through payroll deductions before taxes are withheld. Paying for NCFlex benefits on a pre-tax basis reduces your taxable income, which reduces your state and federal income taxes and Federal Insurance Contributions Act (FICA).

NCFlex offers the following plans:

Why You Should Participate

Convenience and Tax Savings — Contributions for all NCFlex benefits are made through payroll deductions **before taxes** are withheld.

Flexibility — The choice to participate is yours. You can sign up for any or all of the benefits offered through NCFlex. Then, each year you will get to decide if you want to participate for the next year.

Two Ways to Save — First, we use the size of the state to our advantage to buy benefits at the lowest possible cost to save you money. Second, the cost for the insurance coverages and the two flexible spending accounts (FSAs) are deducted from your pay on a pre-tax basis. The amount of taxes you save (savings can be 25-40%) depends on your tax bracket.

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Certificate of Coverage by accessing our website at www.ncflex.org.

Enrolling for the First Time

What You Must Do

- Read this guide or go online to www.ncflex.org for detailed plan information.

NCFlex Benefits	If You Are Enrolling for the First Time
HCFSA	Enroll and designate annual contribution *(required each year)*
DDCFSA	Enroll and designate annual contribution *(required each year)*
Dental	Enroll and elect High Option PPO or Low Option PPO
Vision Care	Enroll and elect Basic or Enhanced Core Wellness Exam: Enroll for employee only; no cost coverage
Critical Illness	Enroll and elect coverage
Cancer and Specified Disease	Enroll and elect the Premium, High, or Low Option
Group Term Life	Enroll and elect coverage amount
Core AD&D	Enroll for employee-only, no-cost coverage
Voluntary AD&D	Enroll and elect coverage amount
TRICARE Supplement	Enroll and elect coverage amount

The State of North Carolina is the employer of this plan.

About This Guide

This guide describes benefits offered through NCFlex. In the event of any discrepancy between what is written here and what is written in the plan document and insurance certificates, the plan document and insurance certificates will govern. Changes in the tax laws or other requirements might cause changes in the plan. The State reserves the right to amend or terminate the plan or any benefits under the plan at any time.

Enrollment Reminders

At a Glance: Important Benefit Enrollment Reminders

Before making your 2017 benefit elections, be sure to review these reminders to help you correctly enroll in the coverage that is right for you and your family. Remember, if you work for a state agency, university, select community college, or select charter school your cost for coverage is deducted from your paycheck before taxes.

Benefit	Reminder	Page
Health Care FSA	• Re-enrollment required every year • Annual contribution limit is $2,550 per federal regulation • FSA reimbursements are made by direct deposit	7
NCFlex Convenience Card	• One card will be issued - no fee • Activation required • Additional cards must be requested - no fee	10
Dependent Day Care FSA	• Re-enrollment required every year • FSA reimbursements are made by direct deposit	11
Dental	• NCFlex is now offering MetLife Dental coverage. Be sure to visit www.metlife.com/dental, enter your zip code and select PDP Plus Network to find a list of participating in-network dentists near you. • Changing Dental Plan Options (High Option PPO or Low Option PPO) is only allowed during annual enrollment	15
Vision	• Two-year lockout period, if coverage is dropped - applies only to Basic Plan if coverage is dropped or dependent status is changed • No change in rates for 2017	19
Critical Illness	• No EOI (Evidence of Insurability) to enroll • Must elect coverage for yourself in order to cover dependents	23
Cancer	• Newly eligible — No EOI Low, High or Premium Options • After initial eligibility — EOI required • No EOI required during 2017 Annual Enrollment	25
Group Term Life	• Newly eligible • employee: No EOI up to $200,000 • After initial eligibility • employee: If enrolling for the first time, no EOI for $20,000 coverage election. • Annual Increase • employee: No EOI for $20,000 increase up to $200,000 Guarantee Issue Maximum during annual enrollment	28
Core AD&D	• Employee only coverage at no cost • You must elect coverage	30
Voluntary AD&D	• Many additional benefits, for you and eligible dependents, are included with election • Voya Travel Assistance: Worldwide Emergency Travel Assistance Services — provide coverage if a medical emergency occurs more than 100 miles away from home or in a foreign country	32
TRICARE Supplement	• Must have TRICARE Standard, Prime, Extra or be TRS • No deductible	34

Know Your Benefits

The State of North Carolina offers employees opportunities to participate in many benefits that can help you meet your health and financial goals. These include numerous pre-tax voluntary benefits under NCFlex, medical coverage through the State Health Plan, and retirement benefits, in addition to benefits your particular state agency, university, select community college, or select charter school may offer. It is important that you **carefully review your current elections each year** to ensure your choices meet your needs as your life changes. If you have any questions, you may contact eEnroll at 1-855-859-0966.

If you are enrolled in a Medical Plan that has a Health Care Reimbursement Account (HRA) and you are enrolled in a Health Care Spending Account (HCSA), you must use the HRA first. IRS regulations do not permit reimbursement under both plans for the same claims. If your spouse is enrolled in a Health Savings Account (HSA), you can not participate in the Health Care Spending Account (HCSA).

The NCFlex website (www.ncflex.org) provides you with an overview of available benefits. For a current NCFlex benefit statement, visit the online enrollment system.

To obtain information on your other benefits or for help in making your NCFlex elections, please visit the websites listed below. If you need assistance on information that is particular to your state agency, university, select community college, or select charter school, please contact your Health Benefit Representative (HBR) or benefit department.

Resource	Web Address
Benefits Resources	
NCFlex Pre-tax Benefits	www.ncflex.org
State Retirement Systems	www.myncretirement.com
ORBIT — State Retirement Account Access	orbit.myncretirement.com/Orbit
State Health Plan	www.shpnc.org
North Carolina Retirement Systems Supplemental Benefits	www.ncretiree.com
Financial & Wellness Resources	
State 401(k) and 457 Retirement Plans	www.ncplans.prudential.com
OSHR State Wellness Program	www.oshr.nc.gov/state-employee-resources/benefits/wellness
North Carolina State Employees Credit Union	www.ncsecu.org
Federal Government Finance	www.mymoney.gov

Benefits Enrollment

The state now offers an online enrollment system through eEnroll. You may login to eEnroll through www.ncflex.org. If you have any questions you may contact eEnroll at 1-855-859-0966.

Wellness Tip

Learn your health status today! Take a free, easy health assessment and receive a personalized health action plan. Go to the State Health Plan's website at www.shpnc.org and click on NC Health*Smart*. (*NC Health*Smart *is for members whose primary health coverage is through the State Health Plan.)*

Eligibility

Your Eligibility and Effective Date

You are eligible to participate in NCFlex if you are a state agency, university, select community college, or select charter school employee working 20 or more hours per week in a permanent, probationary, or time-limited position. You may check with your HBR concerning your benefit eligibility. If you enroll during annual enrollment, your participation is effective January 1, 2017. **If you are a newly eligible employee, you must enroll within 30 days of your employment date. Your participation begins the first day of the month following your date of hire.** Claims incurred prior to your effective date of coverage or after your plan termination date are not eligible for reimbursement.

Dependent Eligibility

Coverage for your eligible dependents is available for most NCFlex benefits (see the specific benefit section for details). Eligible dependents are generally:

- your legally married spouse;
- any unmarried child, including stepchild and foster child, who is dependent upon you for support and maintenance until the end of the month in which the child turns age 26;
- any unmarried child, including stepchild and foster child, of any age who remains dependent upon you for support and maintenance and who is unable to make a living because of a mental or physical handicap.*

For the accidental death and dismemberment, cancer, critical illness, dental, and vision plans, you may cover children who meet the above requirements.

For the HCFSA, you may also cover children under the age of 26, regardless of student, tax dependency, or marital status.

In addition, you may submit eligible expenses for a qualifying relative, which includes any individual who is not the tax dependent of another taxpayer, has the same principal residence as you, and for whom you provide more than half of the support for the calendar year.

The DDCFSA has additional eligibility rules. See the Dependent Day Care Flexible Spending Account section on page 11 for details.

Note: You should consult with your tax advisor if you have questions as to whether someone qualifies as your income tax dependent.

**Dependent child coverage may be extended beyond the 26th birthday under the following condition: The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the NCFlex plan you are wishing to keep them on.*

If Your Benefits Claim is Denied

If you have a benefits claim that is denied by the carrier, you have certain rights as a plan participant to appeal. For information on the appeals process for specific benefits, you may contact the individual benefit carriers. Please refer to the section of this guide (back cover) or contact your HBR. The steps to the appeals process is also located in the insurance certificates.

If You Have a Life Event

If you experience a life event (also referred to as a family or employment status change), it is your responsibility to log onto the eEnroll system and make appropriate changes. See the "Changing Your Elections During the Year" section for details. More detailed life events information is also available at www.ncflex.org.

Wellness Tip

Did you know that making healthy lifestyle choices, such as not smoking, staying active, and eating healthy foods, can not only make you feel well, it can also help prevent disease?

Changing Your Elections During the Year

Qualifying Life Events

Each year you can choose to participate in any or all of the NCFlex benefits. Once you have decided to participate, **you cannot change or cancel that decision during the year unless you have a life event — a change in family or employment status**.

These events include, but are not limited to:

- Marriage
- Divorce or legal separation
- Birth or adoption (or placement of adoption) of a child
- Death (yours or that of a covered dependent)
- Unpaid leave of absence
- Change in your spouse's employment, impacting his/her benefits eligibility
- Your dependent turns age 26

For more details about qualifying life events and the steps you need to take when one of them occurs, visit www.ncflex.org.

If you wish to change your elections, you must log onto the eEnroll system and make changes within **30 days** of the event. Valid changes to your elections are effective on the first day of the month following the date of your life event. **You may be required to provide documentation to verify the change.**

The changes you want to make to your benefits must be consistent with the life event. All benefits changes are subject to approval. Some plans are subject to waiting periods or require Evidence of Insurability (EOI). The Dental Plan, Cancer and Specified Disease Plan, and Vision Care Plan do not permit participants to change options during the plan year. (For example, Low Option to High Option or Basic to Enhanced, or vice versa.)

Non-Qualifying Life Events

If any events other than those listed above occur, check with your HBR to see if you may make changes to your NCFlex coverage during the year. Some examples of events that do not allow you to change your NCFlex elections are:

- re-hired within 30 days of termination date;
- the benefit cost is too high/you did not realize how much was going to come out of your paycheck;
- you decided you do not like the coverage; or
- you need more money in your paycheck.

Transfers

The State of North Carolina is the employer for the NCFlex benefits. When you transfer between a state agency, university, select community college, or select charter school, you can not make changes to your elections or elect new benefit options. You must transfer your existing NCFlex benefits to the new work location. **You must check the eEnroll system to ensure benefits have transferred.**

Note: If an employee transfers from an agency and is not enrolled in NCFlex Dental but is enrolled in an agency-specific post-tax dental plan, this does not qualify as a life event and the employee is not eligible to enroll in the NCFlex Dental due to a qualifying life event.

Limitation Affecting Increases to Spending Account Election

If you use an approved life event to increase your election amount to your HCFSA or DDCFSA, reimbursement of expenses incurred prior to the change date will be limited to your original account maximum and not the new maximum. For example, if you elect $1,000 for the plan year, then increase your plan-year maximum to $1,200 on July 1, you cannot be reimbursed more than $1,000 for expenses incurred prior to July 1.

IMPORTANT NOTES

- *Review your pay stub to make sure your deductions are correct. If deductions are incorrect on your pay stub, contact your HBR or benefits department immediately.*
- *If you change banks or bank accounts during the year, you will need to notify your HBR or benefits department if you participate in a FSA, so your reimbursements will be credited to the correct account.*

Health Care Flexible Spending Account

To participate, you MUST ENROLL in this plan each year.

The Health Care Flexible Spending Account (HCFSA) is simple to use. By participating you choose to contribute a set amount to your account through payroll deductions on a pre-tax basis. When you enroll in the HCFSA you will receive the NCFlex Convenience Card debit card to use for eligible expenses. There is no cost for the NCFlex Convenience Card. Cards are good for three years from the date of issue. If you are enrolled in the 2016 HCFSA and are re-enrolling in the account for 2017, your NCFlex Convenience Card will automatically be loaded with your new HCFSA election amount.

With this account you are reimbursed with the pre-tax dollars you set aside to pay for medical, dental, or other health care expenses not reimbursed by a health plan. This account can benefit almost all eligible employees, their spouses, children, and dependents who satisfy the "Dependent Eligibility" rules in the "NCFlex Program" section.

You never have to pay taxes on the money you receive from your spending account for qualified expenses. That means permanent tax savings, which helps your health care dollars go further.

How to Use Your HCFSA

To participate, you must enroll in this plan each year. FSA reimbursements are made by direct deposit.

If you participate in the HCFSA, you decide how much money you want to put into your account. Your annual contribution cannot be less than $120 a year. ***As part of the Health Care Reform Act, the maximum annual contribution amount is $2,550.*** When enrolling, please remember to elect your annual contribution amount.

When you enroll in the HCFSA, you will receive a claims kit containing a claim form and the procedures you need to follow when filing a claim. A list of eligible and ineligible expenses is available online. You may also visit www.ncflex.org for this information.

Electronic Claim Submission Options

There are two electronic claim submission options:

1. Electronic Claim Upload- submit a paperless claim. Log into your P&A Account at ncflex.padmin.com. Go to **Member Tools**–> **Upload Claim**–>**New Claim**.

2. Mobile Claim Submission- submit a claim directly from your smartphone!* First, capture a picture of your receipt or other documentation. Then, log into your account from your smartphone by going to ncflex.padmin.com. Select **Upload**, then select your claim type. Click **Continue**, then select your account and dollar amount. Next, select **Add File** and choose the image of your receipt from your image gallery.

*Not all mobile claim upload features are currently available on all mobile devices or with all operating systems. Wireless carrier fees may apply. Requires at least a two-megapixel camera.

Claim forms and supporting documentation can also be submitted via fax or mail. Go to ncflex.padmin.com to access the FSA claim form. When submitting a paper claim you must attach an itemized, third-party receipt or the insurance company EOB.

Fax: (877) 213-8917

Mail: (Attn: NC FSA Plan) 17 Court Street, Suite 500
Buffalo, NY 14202

If your claim is for a medical condition that is covered by a medical or dental plan, you will need to file your claim with that plan first. After that claim is processed, submit a copy of the EOB, which shows your out-of-pocket expenses, as part of your HCFSA claim. Under most circumstances, the State Health Plan no longer provides EOBs for PPO plan members for routine physician visits. A Claims Status Detail can be obtained on the State Health Plan's website.

Claim Reimbursements

Claims are processed every day (with the exception of holidays). Your reimbursement will be issued within one business day once your claim is fully processed. When the payment is issued, the reimbursement will be direct deposited into your account within two business days (on average), excluding holidays. If you provide P&A Group your e-mail address, they will automatically notify you when your claim is received and again when it is paid.

Another way you can be reimbursed is to pay for your eligible health care expenses using your NCFlex Convenience Card (see page 10 for details).

Claim reimbursement is based on the date you receive health care service, not the date you pay the invoice or the date you are billed, which must be between January 1, 2017, (or your plan effective date) and March 15, 2018, provided you remain in the plan for all of 2017. With the HCFSA, you can be reimbursed for your entire claim up to your plan-year election minus any previous claim reimbursements, even if that amount has not yet been deducted from your pay. This is a great advantage because you can take care of your immediate health care needs and then spread out your payments during the year through payroll deductions.

Take Action

Remember to complete all required information and sign your FSA claim form, if filing manually. Unsigned claim forms cannot be processed and will delay your reimbursement.

Direct Deposit

- *FSA reimbursements are made by direct deposit.*
- *If you change banks or switch accounts, please notify your HBR or benefits department to avoid payment delays.*

Eligible Health Care Expenses*

You may use your HCFSA for reimbursement of the following out-of-pocket health care expenses incurred during the plan year:

- deductible(s) and co-payments you have to pay under your health care plan or under your spouse's plan;
- the portion of covered expenses you have to pay (called a coinsurance) for any medical or dental bills after you have met your deductible;
- any amounts you are required to pay after reaching your maximum benefit under a medical or dental plan;
- over-the-counter medicines, vitamins, and supplements, **only with a physician's prescription**; and
- other allowable expenses including, but not limited to:
  - dental expenses
  - hearing aid and its batteries
  - infertility treatment
  - insulin and diabetic supplies
  - mileage ($0.19 per mile for 2016) to/from medical provider's office for treatment (**Note: IRS subject to change during the year)**
  - orthodontia
  - prescription drugs
  - refractive surgery (RK, PRK, LASIK)
  - smoking cessation programs
  - medical supplies
  - tuition at special school or specially trained tutor for disabled
  - vision expenses (exams, glasses, frames)
  - weight reduction program (prescribed by doctor to alleviate a diagnosed medical condition or obesity), but plan food is not covered

** Some health care expenses may require a letter of medical necessity written by an authorizing physician. There is a standard form available at www.ncflex.org that your physician can complete. Under the Health Care Reform Act, over-the-counter medications will not be eligible for reimbursement through the HCFSA unless you have a doctor's prescription for the expense.*

Eligible and Ineligible Expenses

Go to www.ncflex.org for a complete listing of eligible and ineligible expenses. To access the IRS list of expenses, visit www.irs.gov/publications/p502.

For an expense to be eligible, it must be incurred for medical care and not reimbursable by a health plan.

IMPORTANT NOTE:
Extension of FSA Expense Period

Expenses can be incurred between January 1, 2017, (or your plan effective date) and March 15, 2018, provided you remain active for all of 2017. (This is also known as the plan's grace period.) Claims for expenses incurred during this extension must be postmarked, faxed, or submitted electronically by April 30, 2018.

Ineligible Health Care Expenses

Medical, dental, and other premiums cannot be reimbursed through the HCFSA. In addition, elective cosmetic procedures and similar expenses are not allowable expenses according to the IRS. Visit **www.irs.gov/publications/p502/** for a more extensive list of eligible expenses. Common ineligible expenses include:

- over-the-counter medications, vitamins, and supplements, unless prescribed by a physician;
- cosmetic procedures that are not to correct a congenital deformity or disfigurement due to an accident or disease;
- dental procedures to whiten your teeth; and
- weight loss programs, unless prescribed by a doctor to alleviate a diagnosed medical condition or obesity.

Plan Carefully

Carefully consider your contributions to the HCFSA. **Under IRS regulations you will lose money remaining in your account after the deadline to submit eligible claims — April 30, 2018.** Therefore, you should estimate carefully and conservatively, only setting aside money you feel certain you will spend out of your own pocket for health care expenses during the plan year. **Remember, your NCFlex Convenience Card may not be used for all over-the-counter purchases.**

Termination of Employment

If you terminate employment or coverage during the plan year, you may submit claims for services incurred before your coverage termination date. **Services incurred after this date cannot be reimbursed unless you elect to continue coverage under COBRA.** In accordance with IRS regulation, any unused money in your account is forfeited and remains with the state.

HCFSA Worksheet

An important part of planning carefully is using the HCFSA worksheet below to identify you and your family members' out-of-pocket expenses for the upcoming plan year. The HCFSA worksheet is also available online by visiting www.ncflex.org.

This worksheet will help you calculate how much you may want to deposit in the HCFSA. Just follow the steps below.

Step 1: Based on your records for the past few years, fill in your anticipated eligible expenses.
- If the expense is paid by a health care plan, enter your copayment and any deductible.
- If the expense is not covered by the health care plan, enter the entire cost.

Step 2: Add up the total annual expenses for yourself and your family.

Step 3: Enter this amount in the Online Enrollment system.

Cost For:	For You		For Your Spouse		For Your Children
Medical plan deductibles	$		$		$
Medical plan co-payments	$		$		$
Birth control pills or devices	$		$		$
Prescription drug co-payments	$		$		$
Routine physicals/exams	$		$		$
Dental care/orthodontia	$		$		$
Vision care	$		$		$
Hearing care	$		$		$
Health services/supplies	$		$		$
Other eligible expenses	$		$		$
Total Annual Health Care Expenses:	$	+	$	+	$

Your Annual Election:
(Enter this amount in eEnroll) = $

Tax Considerations

The HCFSA is based on current tax laws and gives you the advantage of those laws. Please keep in mind the following tax considerations before participating in the HCFSA:

- Plan participation may affect your future Social Security retirement benefits. This could happen if your taxable pay, after spending account contributions are taken out, is below the Social Security Taxable Wage Base. For most employees, the immediate tax savings is of far greater benefit than the long-term impact on Social Security benefits.
- Participation in the plan will not affect the amount you may contribute to a 401(k), 403(b), or 457 retirement plan.
- You cannot claim the same expenses through the HCFSA and on your tax return. Currently, only health care expenses over 10% of your adjusted gross income are deductible for income tax purposes. But with the HCFSA, you can save taxes immediately on the very first dollar not reimbursed by your health care plan.

Note: Check the IRS website for the latest information. You should consult with your tax advisor on these issues and whether someone qualifies as your income tax dependent.

NCFlex Convenience Card

When you enroll in the HCFSA you will automatically receive the NCFlex Convenience Card at no cost to you! Conveniently pay your eligible HCFSA expenses incurred by you and your dependents by swiping your card at the point-of-service. Purchases you make using the NCFlex Convenience Card are funded by the money in your HCFSA. If you are currently enrolled in the 2016 HCFSA and wish to re-enroll in the 2017 plan, your current NCFlex Convenience Card will automatically be loaded with the amount you elect for the 2017 plan year. If you are new to the plan and this is the first time you will receive a card, please note the card must be activated first.

How It Works

Your NCFlex Convenience Card automatically checks your account for available funds. Anytime you incur an eligible HCFSA expense with a vendor that accepts credit cards, simply swipe your NCFlex Convenience Card at the point-of-service and the expense will be deducted from your account. You have until March 15, 2017, to exhaust any remaining balance in your 2016 HCFSA. After that date, the NCFlex Convenience Card will deduct eligible expenses from your 2017 HCFSA.

- When swiping your NCFlex Convenience Card, you may choose "credit" or "debit." If you select "debit," you will be required to enter your PIN. Please note, the PIN is unique to your Convenience Card and can be retrieved by logging into your account at ncflex.padmin.com. Go to the Benefits Summary page, and select "New Debit Card Pin Information" from the drop down menu under "Choose an Action." Follow the prompts on your screen to access your secure PIN.
- As a reminder, the IRS may require a receipt or documentation to process certain convenience card transactions and to ensure your card is being used for eligible expenses only. In the event that you may be asked to provide additional documentation of your purchase, please keep your receipts.
- **If you do not submit requested receipts/documentation within 40 days of the transaction date, your card will be turned off (or blocked) automatically and future claims may be used to offset the transaction.**

Claim Submission Methods

If your provider doesn't accept debit or credit cards you can still be reimbursed for your HCFSA eligible expense. Pay out-of-pocket for your expense, and save a copy of your receipt. Submit an electronic or paper claim to P&A and include a copy of your receipt to receive reimbursement. Please see page 7 of this guide, *Electronic Claim Submission Options*, for more details.

How to Sign up

If this is your first time enrolling in the HCFSA, you will receive a card in the mail after you enroll. Your NCFlex Convenience Card can be activated by visiting padmin.com/activatecard or calling 1-888-879-4304 before use.

You may request an additional NCFlex Convenience Card at any time during the year by calling 1-866-916-3475 or going online to ncflex.padmin.com.

Remember, cards are good for three years from the date of issue and will NOT be automatically re-issued each January. If you already have an NCFlex Convenience Card, do not throw it away! Your 2017 HCFSA annual election amount will be loaded onto your existing card.

Additional Cards

You may order an additional card for your spouse or dependent (over 18 years of age) free of charge. To order additional cards, go online to ncflex.padmin.com and log into your account to request an additional card.

How to Check Your Account Balance

View your account balance directly from your smart phone - a great way to manage your account with on-the-go convenience! Visit ncflex.padmin.com on your mobile phone, and log into your account to access up-to-date account information.

You can also sign up to receive your account balance via text message. Simply update your online P&A Account profile at ncflex.padmin.com with your mobile number and carrier. Once your profile is updated, text the word BAL to the number 70626 and receive a text message with your account balance anytime, anywhere.

Lastly, you can also check your account balance by logging into your account from your computer, or give P&A's customer service team a call at 1-866-916-3475.

Dependent Day Care Flexible Spending Account

To participate, you MUST ENROLL in this plan each year.

The Dependent Day Care Flexible Spending Account (DDCFSA) is designed to benefit employees with young dependent children or disabled dependents of any age. Eligible day care expenses may be reimbursed for:

- your "qualifying child" (including a stepchild, foster child, child placed for adoption, or younger brother or sister) under age 13 who has the same principal residence as you for more than one-half of the year and does not provide more than one-half of his or her own support during the calendar year; or
- your qualifying child (as defined above) of any age, spouse, or other dependent who receives over one-half of his or her support from you (e.g., your disabled elderly parent), who is physically or mentally incapable of caring for himself or herself and has the same principal place of residence as you for more than one-half of the year. To reimburse day care received outside of your home, your disabled dependent must spend at least eight hours per day in your home.

Special rules apply for divorced or separated parents with dependent children. Generally, your child must be your dependent for whom you can claim an income tax exemption. In other words, you must have legal custody of your child for over one-half of the year for your day care expenses to be reimbursed through the DDCFSA.

Note: You should consult with your tax advisor if you have questions about whether someone qualifies as your income tax dependent.

When enrolling, you choose to contribute a set amount of money to your account through payroll deductions on a pre-tax basis. When you have an expense that qualifies for reimbursement, just submit a claim with any necessary documentation, and you will receive a tax-free reimbursement.

With this account, you are reimbursed with pre-tax dollars for child care or dependent adult care expenses you incur while working. If you are married, expenses are eligible expenses only if the expenses are necessary so that you and your spouse can work or attend school full-time. Your spouse may also be unemployed but actively looking for work.

To participate, you must enroll in this plan each year. DDCFSA reimbursements are made by direct deposit. This is a "pay-as-you-go" account; your entire election amount is not available January 1. You can only receive reimbursement up to the amount that has been payroll deducted to date.

How to Use Your DDCFSA

You decide in advance how much money you want to put into your account for the full year. If you participate in the DDCFSA, your annual contribution cannot be less than $120 a year. If you are single or if you are married and file a joint tax return, your annual maximum contribution is $5,000 a year. If you are married and file a separate tax return, your annual maximum contribution is $2,500 a year. These maximum limits comply with federal tax regulations. When enrolling, please remember to elect your annual contribution amount.

When filing a claim, attach a receipt that shows the amount of the charge and date of service with your dependent day care provider's tax identification number or Social Security Number.

Claims are processed each day (with the exception of holidays). Your reimbursement will be issued within one business day once your claim is fully processed and adjudicated. When the payment is issued, the reimbursement will be direct deposited into your account within two business days (on average), excluding holidays. If you provide P&A Group your email address, they will automatically notify you when your claim is received and again when it is paid.

Claim reimbursement is based on the date you receive the dependent day care service, not the date you pay the invoice or the date you are billed, which must be between January 1, 2017, (or your plan effective date) and March 15, 2018, provided you remain active through December 31, 2017. **You will be reimbursed up to the available balance in your DDCFSA on the processing date.**

When you enroll in the DDCFSA, you will receive a claims kit containing a claim form and the procedures you need to follow when filing a claim. A list of eligible expenses is available online. You may also visit www.ncflex.org for this information.

Take Action

Remember to complete and sign your FSA claim form, if filing manually. Unsigned claim forms cannot be processed and will delay your reimbursement.

Direct Deposit

- *DDCFSA reimbursements are made by direct deposit.*
- *If you change banks or switch accounts, please notify your HBR or benefits department to avoid payment delays.*

Eligible Dependent Day Care Expenses

Under tax laws, dependent day care expenses are eligible only if the expenses are necessary so that you and your spouse can work or attend school full-time. In addition, your spouse may also be unemployed but actively looking for work. If your spouse works part-time, your election may not exceed the lesser of your annual income or your spouse's annual income.

You can be reimbursed through your DDCFSA for:

- payments to nursery schools, day care centers, or individuals who satisfy all state and local laws and regulations;
- payments for before-school care and after-school care beginning with kindergarten and higher grades;
- payments to relatives for care of a qualifying dependent(s); however, the relative cannot be your tax dependent or your child if under age 19 as of the end of the calendar year; and
- payments (in lieu of regular day care) to day camp (e.g., soccer, computers, etc.), but not overnight camps.

Eligible and Ineligible Expenses

Go to www.ncflex.org for a complete listing of eligible and ineligible DDCFSA expenses, which can be found under the Flexible Spending Account section.

Ineligible Dependent Day Care Expenses

Some common ineligible expenses include:

- tuition expenses for education of a qualified dependent beginning with kindergarten and higher grades;
- expenses incurred while you and/or your spouse are not working (except for short temporary absences like vacation and minor illnesses);
- expenses for overnight camps;
- transportation fees;
- prepayment for services not received while covered; and
- late payment fees.

IMPORTANT NOTE: Extension of FSA Expense Period

Expenses can be incurred between January 1, 2017, (or your plan effective date) and March 15, 2018, provided you remain active for all of 2017. Prior year claims must be postmarked, faxed, or submitted electronically by April 30, 2018.

Plan Carefully

Carefully consider your contributions to the DDCFSA. **Under IRS regulations, you will lose money remaining in your account after the deadline to submit eligible claims — April 30, 2018.** Therefore, you should estimate carefully and conservatively, only setting aside money you feel certain you will spend out of your own pocket for dependent day care expenses during the plan year.

Termination of Employment

If you terminate employment or coverage during the plan year, you may submit claims for services incurred on or before your coverage termination date. Services incurred after your termination date will be reimbursed up to your available balance*. In accordance with IRS regulation, any unused money in your account is forfeited and remains with the state.

Only pertains to the Dependent Day Care FSA.

Important Issues

If both you and your spouse contribute to this plan or to a similar plan where he or she works, the IRS only allows a maximum family contribution of $5,000 per calendar year.

Keep in mind your annual election cannot be greater than either your annual income or your spouse's annual income, whichever is lower.

Certain IRS rules also affect the amount you may elect on a pre-tax basis:

- If your spouse is a full-time student or totally disabled, your spouse is treated as having income of $250 a month ($500 a month if two or more dependents receive dependent day care). If your spouse is actively looking for work, your spouse's income for the year must exceed your DDCFSA annual election.
- If you are considered highly paid by the IRS (earning over $120,000 in the previous plan year of 2016 and indexed for inflation in future years), your pre-tax dependent day care election may need to be adjusted based on the results of IRS discrimination tests. If you are affected, you will be notified.
- If you are divorced or legally separated, you must have legal custody of your child for over half the year to participate in the DDCFSA.

Note: The NCFlex Convenience Card is no longer available for Dependent Day Care participants.

DDCFSA or Tax Credit: What Combination Is Right for You?

Both the DDCFSA and the tax credit are designed to save you money on your dependent care expenses by reducing your taxes. But which is the best option to choose? In general:

DDCFSA vs. Dependent Care Credit: Married Filing Jointly. *The following is a comparison for a married couple filing a joint return. They have one qualifying individual for the DDCFSA/Dependent Care Tax Credit, EIC, Child Tax Credit, and ACTC, and $5,000 of dependent care expenses, taking the standard deduction and claiming three exemptions. We also show results with two qualifying individuals and the couple claiming four exemptions. The couple's wages are their only income (both spouses work, earning equal wages), and they claim no tax credits other than those listed. Only federal tax savings are considered (not state tax or credits). The figures below are for the 2016 tax year. Some numbers have been rounded.*

Participating in the DDCFSA on a salary reduction basis is better (or worse) than claiming the Dependent Care Tax Credit by this amount (if negative, the Dependent Care Tax Credit is better).			Participating in the DDCFSA on a salary reduction basis is better (or worse) than claiming the Dependent Care Tax Credit by this amount (if negative, the Dependent Care Tax Credit is better).		
Gross wages of employee and spouse	1 qualifying individual	2 qualifying individuals	Gross wages of employee and spouse	1 qualifying individual	2 qualifying individuals
$10,000	($1,990)	($2,368)	$70,000	$533	$133
$15,000	$383	($1,940)	$80,000	$533	$133
$20,000	$383	$183	$90,000	$533	$133
$25,000	$584	$648	$100,000	$533	$133
$30,000	$1,157	$1,436	$125,000	$1,283	$883
$35,000	$932	$1,316	$150,000	$1,033	$883
$40,000	$1,022	$836	$175,000	$1,033	$633
$45,000	$1,142	$936	$200,000	$1,183	$783
$50,000	$533	$1,068	$225,000	$1,183	$783
$60,000	$533	$133	$250,000	$873	$473

DDCFSA vs. Dependent Care Credit: Head of Household. *The following is a comparison for a taxpayer filing as head of household with one qualifying individual for the DDCFSA/Dependent Care Tax Credit, EIC, Child Tax Credit, and ACTC, and $5,000 of dependent care expenses, taking the standard deduction and claiming two exemptions. We also show results with two qualifying individuals and the couple claiming three exemptions. The taxpayer has no income other than wages and claims no tax credits other than those listed. Only federal tax savings are considered (not state tax or credits). The figures below are for the 2016 tax year. Some numbers have been rounded.*

Participating in the DDCFSA on a salary reduction basis is better (or worse) than claiming the Dependent Care Tax Credit by this amount (if negative, the Dependent Care Tax Credit is better).			Participating in the DDCFSA on a salary reduction basis is better (or worse) than claiming the Dependent Care Tax Credit by this amount (if negative, the Dependent Care Tax Credit is better).		
Gross wages of employee and spouse	1 qualifying individual	2 qualifying individuals	Gross wages of employee and spouse	1 qualifying individual	2 qualifying individuals
$10,000	($1,990)	($2,368)	$70,000	$753	$133
$15,000	$383	($1,940)	$80,000	$1,283	$883
$20,000	$672	$564	$90,000	$1,283	$883
$25,000	$922	$1,436	$100,000	$1,033	$883
$30,000	$872	$1,081	$125,000	$723	$323
$35,000	$1,149	$701	$150,000	$796	$323
$40,000	$1,159	$1,086	$175,000	$873	$473
$45,000	$533	$1,111	$200,000	$873	$473
$50,000	$533	$133	$225,000	$873	$473
$60,000	$533	$133	$250,000	$1,123	$723

Tax Considerations

The DDCFSA is based on current tax laws and gives you the advantage of those laws. Please keep in mind the following tax considerations before participating in the DDCFSA: You may prefer to use your dependent day care expenses to claim a Child Care Credit when you file your federal and state income tax returns. The law permits you to use the Child Care Credit or the DDCFSA but not for the same expense. (Your Child Care Credit is reduced dollar-for-dollar by any amount you claim through the DDCFSA.) The spending account is an alternative way to save taxes for those employees who may prefer not to file for the Child Care Credit or who would receive greater tax savings through the DDCFSA.

DDCFSA Worksheet

An important part of planning carefully is using a worksheet to identify your dependent day care out-of-pocket expenses for the upcoming plan year. The DDCFSA worksheet is also available online at www.ncflex.org.

To get an idea of your dependent day care expenses, take a look at your records for the past few years. Using this information, add any new types of expenses you anticipate and complete the following worksheet:

Upcoming Plan Year

Child care (children under age 13)	$
Dependent adult day care	$
FICA and other taxes you pay for the above care providers	$
Day camp (not overnight camp)	$
Cost for preschool (prior to kindergarten)	$
Total Annual Expenses:	= $
Your Annual Election:	= $ (Enter this amount in eEnroll)

Remember…

If you are single or married and filing jointly, the most you can deposit in the DDCFSA is $5,000 in a calendar year. If you are married and filing separately, the maximum is $2,500 a year. If both you and your spouse can contribute to this plan or to a similar plan where he or she works, the maximum family contribution is $5,000.

Keep in mind your annual election cannot be greater than either your annual income or your spouse's annual income, whichever is lower.

Ultimately, it is up to each employee to determine which approach is better based on their individual tax situation. Each employee should consult with their individual tax advisor to help in choosing the right approach to their unique circumstances.

Certain IRS rules also affect the amount you may elect on a pre-tax basis:

- If your spouse is a full-time student or totally disabled, your spouse is treated as having income of $250 a month ($500 a month if two or more dependents receive dependent day care). If your spouse is actively looking for work, your spouse's income for the year must exceed your DDCFSA annual election.
- If you are considered highly paid by the IRS (earning over $120,000 in the previous plan year of 2016 and indexed for inflation in future years), your pre-tax dependent day care election may need to be adjusted based on the results of IRS discrimination tests. If you are affected, you will be notified.
- If you are divorced or legally separated, you must have legal custody of your child for over half the year to participate in the DDCFSA.

This benefit does not require annual enrollment

Dental

Why You Should Consider Dental Coverage

Taking care of your teeth and gums benefits more than your smile. Did you know that maintaining good dental health can mean better overall health? That's why having a good dental plan is so important. The right dental coverage makes it easier to visit the dentist, and staying on top of your care is key to preventing costly problems that can add up.

Affordable Plan Options

The average family of four spends $1,824 a year on dental services, not including the costs of braces.

With a MetLife Dental High Option PPO Plan or Low Option PPO Plan, you can visit any licensed dentist, in or out of the Preferred Dental Provider (PDP) Plus Network, and still receive benefits. The right coverage makes it easier to visit the dentist and helps lower your costs. When you choose a participating dentist you could save even more since dentists in network accept negotiated fees that are typically 15-45% less than the average charges in the same area.

Refer to the "Summary of Benefits" section on page 16 to review the services covered under each plan. To find a participating dentist, go to www.metlife.com/dental, enter your zip code, and select the PDP Plus Network. You can also call 1-855-676-9441 to request that a copy be sent to you.

Enrolling in an NCFlex Dental Plan

If you are currently enrolled in the NCFlex Dental Plan, you are not required to re-enroll. **Your current dental plan election will carry over, unless you make a change during annual enrollment.**

Enrolling within 30 days of your employment hire date allows you to utilize your benefits on either the High Option PPO Plan or Low Option PPO Plan with no waiting period.

Changing Dental Plan Options

Once you select your dental plan option (High Option PPO or Low Option PPO) you must keep that option for the entire plan year, even if you have a qualified life event. You may only change your dental plan option during the annual enrollment period (for example, Low Option PPO to High Option PPO, or High Option PPO to Low Option PPO).

The Dental Plan is administered and underwritten by Metropolitan Life Insurance Company. For information regarding claim payment, refer to the Certificate of Coverage found at www.ncflex.org.

Monthly Cost

Rate Tier	High Option PPO	Low Option PPO
Employee Only	$ 36.10	$ 21.22
Employee and Spouse	$ 72.40	$ 42.78
Employee and Child(ren)	$ 78.20	$ 45.94
Family	$123.70	$ 73.22

Dental Claims Processing

MetLife encourages you to discuss your treatment plan with your provider and submit a pre-estimate **before the work begins** if the estimated charge for a particular dental service is expected to be $300 or more.

To submit a pre-estimate, simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. The dentist will need to provide the proposed treatment plan, applicable x-rays, supporting documents, and estimated charges to MetLife. This provides an opportunity to review the proposed course of treatment and estimated fees.

Need More Information?

Visit...	And look under...	To find...
www.ncflex.org	Dental	• *MetLife My Benefits* website link • Dental Forms • Online Tools
www.metlife.com/mybenefits	You will need to add "NCFlex" as the company name so that you can create your own unique User ID and password. Click on the Register Now button to provide your first name, last name, date of birth, SSN, and e-mail address.	• Dental Benefits information, claims history, etc. • *Find a Dentist* • Oral Health Library • Mobile Application

Summary of Dental Benefits

Important Note: This is only a summary of the benefits under the dental plans. You may review and/or obtain a copy of the Certificate of Coverage on the NCFlex website at www.ncflex.org. You may register on ***My Benefits*** at www.metlife.com/mybenefits to get information about what is and is not covered on your dental plan. Payments for services are subject to **maximum amounts allowed** by the plan.

Benefit Category	High Option PPO Plan Pays	Low Option PPO Plan Pays
Type I — Diagnostic and Preventive		
Oral Examination (two per calendar year)	100%	100%
Cleaning (two per calendar year)		
X-rays (bitewing x-rays — one per calendar year; full-mouth radiograph series or panoramic series — one every five years)		
Topical Fluoride (two per calendar year under age 19)		
Sealants for Permanent First and Second Molars (under age 16; see Certificate for frequencies)		
Space Maintainers (under age 19)		
Type II — Basic Services		
Fillings (amalgam, synthetic, or composite; replacements limited to once every 24 months)	80%	50%
Simple Extractions		
Endodontics (root canal treatment)		
Re-Cement Crowns, Inlays, Bridges		
Repair of Removable Dentures		
Periodontal Services (gingivectomy, gingivoplasty, osseous surgery, scaling, and root planing)	50%	
Periodontal Maintenance after Therapy (two per consecutive 12 months)		
Oral Surgery (wisdom teeth extractions)		
General Anesthesia		
Type III — Major Services (Not covered under the Low Option PPO Plan)		
Crowns, including Single Implant Crowns (Not eligible for dependent children under age 14; replacements limited to every seven years. Single prosthetic procedures are considered completed on the date they are inserted, not the date of impression.)	50%	Not Covered
Dentures (replacements limited to every seven years)		
Bridges (replacements limited to every seven years)		
Fixed Bridge Repairs		
Denture Adjustments/Relining (within six months of initial denture placement)		
Implants		
Type IV — Orthodontics (High Option PPO Plan only - Dependent Children up to age 19)		
Orthodontic Treatment in Progress (treatment plans not started under the MetLife Dental High Option PPO Plan will be prorated based on the date the benefit is eligible on the MetLife Dental PPO Plans. Reimbursement will not be paid beyond the date the child turns the age of 19).	50%	Not Covered
Maximums/Deductibles		
Calendar-Year Maximum (per covered person; excludes orthodontic services under the High Option PPO Plan) *NEW!*	$5,000	$1,000
Lifetime Orthodontic Maximum (per covered person) **The lifetime maximum will include any reimbursement received from the prior carrier.**	$1,500	N/A
Calendar-Year Deductible (per person/per family)	$50/$150 for Types II and III only	$25/$75 for Types I and II

Dental Benefit Waiting Periods

Enrolling for the First Time

State- or Employer-Sponsored Plan Type	And You are Enrolling in the NCFlex:	Waiting Period
New Hire (Enrollment must be within 30 days of hire)	High Option PPO Plan	**NO** waiting period for covered services
	Low Option PPO Plan	**NO** waiting period for covered services
Late Entrant (Not enrolled in any Dental Plan Option prior to January 1, 2017)	High Option PPO Plan	**NO** waiting period for covered services
	Low Option PPO Plan	**NO** waiting period for covered services

Enrolling from a State- or Employer-Sponsored Plan at Annual Enrollment or due to a Qualifying Life Event*

State- or Employer-Sponsored Plan Type	And You are Enrolling in the NCFlex:	Waiting Period
Low Option (without Orthodontics)	Low Option PPO Plan	**NO** waiting period for covered services
Low Option (without Orthodontics)	High Option PPO Plan	**NO** waiting period for covered services
High Option (with Orthodontics)	Low Option PPO Plan	**NO** waiting period for covered services
High Option (with Orthodontics)	High Option PPO Plan	**NO** waiting period for covered services

Changing Your Dental Option at Annual Enrollment

Note: Changing from High Option to Low Option or vice versa is permitted at Annual Enrollment.	Change	Waiting Period
Enrolled in Low Option PPO Plan	High Option PPO Plan	**NO** waiting period for covered services
Enrolled in High Option PPO Plan	Low Option PPO Plan	**NO** waiting period for covered services

Adding Dependents at Annual Enrollment or due to a Qualifying Life Event

Enrolled in either High Option PPO Plan or Low Option PPO Plan	**NO** waiting period for covered services

*** Dependent children, up to age 19, participating in the High Option PPO Plan are eligible for orthodontic benefits. Orthodontic treatment in progress (treatment plans not started under the MetLife Dental High Option PPO Plan or started when a member was establishing a waiting period) will be prorated based on the date the benefit is eligible in the MetLife Dental High Option PPO Plan. The lifetime maximum will include any reimbursement received from the prior carrier.*

Exclusions and Limitations

This is a partial listing of the exclusions listed with the plan policy. Please refer to your plan certificate for a complete listing. If there are any discrepancies, the plan policy certificate and/or contract shall govern. The policy will not pay for the following dental expenses and services:

- crowns, inlays, cast restorations, or other laboratory-prepared restorations on a tooth that is not extensively decayed and/or has a complete cusp fracture and can successfully be restored with an amalgam or composite resin filling;
- procedures, services, or supplies which: (a) are not included in the policy's list of covered dental services; (b) have been rendered before the insured's insurance begins; or (c) have been rendered after the insured's insurance ends, except as defined under the plan policy;
- any procedure, service, or appliance which relates to: (a) the change in bite; (b) the alteration of the bite with the exception of periodontal surgery; (c) bite registration; (d) bite analysis; or (e) occlusal guard;
- pulp caps, adult fluoride treatments, athletic mouth guards, replacement of lost or stolen appliances, myofunctional therapy, infection control, oral hygiene instruction, separate charges for acid etch, treatment of jaw fractures, orthognathic surgery, personal supplies, broken appointments, completion of claim forms, exams required by a third party, travel time, transportation costs, or professional advice given on the phone;
- chemotherapeutic agents that are provided on the same day or within 45 days following periodontal scaling, root planing, or periodontal surgical procedures;
- procedures, services, or supplies which do not have a reasonably favorable prognosis, as determined by MetLife;
- any procedure, service, or supply provided primarily for cosmetic purposes;
- services or supplies received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection or committing or attempting to commit an assault or felony; or
- treatment performed outside of the United States of America, other than emergency treatment. For such emergency treatment, the maximum allowable charge shall not exceed the plan's allowable charge.

Review your Certificate, which can be found on the NCFlex website at www.ncflex.org.

Eligible Dependents

Include your spouse or unmarried dependent child(ren) up to age 26, regardless of student status.

Wellness Tip

- Don't rush! Brush 2-3 times a day for at least 2-3 minutes
- Be gentle – harder is not better
- Reach for the back
- Soft bristled brushes are recommended

Vision Care

NCFlex offers an excellent Vision Care Plan. The plan is administered by Superior Vision Services (SVS) and underwritten by National Guardian Life Insurance Company. It offers two schedules of benefits – both provide a comprehensive eye exam and benefits for vision materials. You may receive either eyeglasses or contact lenses in a benefit period but not both. You have the following options:

Core Wellness Exam
Available to employees at no cost. An annual comprehensive eye exam for a $20 co-pay. If vision materials are needed, discounts are available from select providers in the SVS network. Please check the Superior Vision website for the most current provider information.

Basic Plan Exam and Materials
A plan that provides an annual comprehensive eye exam and your choice of glasses or contact lenses.

Enhanced Plan Enhanced Exam and Materials
A plan that provides an annual comprehensive eye exam and your choice of glasses or contact lenses with increased frequency, frame allowance, and contact lens allowance.

The Core, Basic, and Enhanced plans offer in-network and non-network benefits. Using an in-network provider will result in less expense for you. Remember, you are responsible for paying any charges in excess of your covered benefit. When using a non-network provider, you pay the provider in full and submit an itemized bill to SVS. You will be reimbursed the non-network allowance.

You have a choice of over 2,800 vision providers in the SVS network that includes ophthalmologists, optometrists, and optical companies. Providers in the SVS network also include many optical chains, plus one-hour and same-day locations throughout the state. If your vision care provider is not part of the SVS network, you or your provider may contact SVS with the provider's name, address, and telephone number to begin the provider nomination process.

Cost

The monthly premium you pay for vision coverage is based on the plan you choose and whether you choose to cover yourself only, or yourself and your family. If you wish to participate in the Wellness Core Exam, you must enroll.

Cost	Employee Only	Employee and Family
Core Wellness Exam	No charge	N/A
Basic Plan	$ 5.56	$ 15.46
Enhanced Plan	$ 8.58	$ 22.88

Cancellation of Coverage

If you elect coverage in the Basic plan this year and drop coverage or change coverage status the following year, you will have to wait an additional two years ("lockout" period) before you can re-enroll in the Basic plan. For example, if you enrolled for 2016 and drop coverage for 2017, you cannot participate in the Basic plan until 2019. The lockout period does not apply if you move from Basic to Enhanced, Basic or Enhanced to Core Wellness, or Core Wellness to Basic or Enhanced. The two year lockout will apply at any time the employee is in the first year of participation in the Basic Plan and coverage is dropped the next open enrollment period with no further coverage elected.

Changing Between Plans

During annual enrollment, you may change between the Core, Basic, and Enhanced plans. The frame amount, if applicable, will change each calendar year depending on what plan you are enrolled in. You may enroll in only one of the three benefit plans. If you need family coverage, you must enroll in the Basic or Enhanced plans.

Refractive Surgery Discount (All Plans)

Ophthalmology surgeons are being contracted to provide refractive surgery (RK, PRK, and LASIK) at a 20% discount off their usual and customary surgical fees or a 10% to 15% discount off their total fees. Contact SVS at 1-800-507-3800 for information on this discount.

Coordination with the Health Care Flexible Spending Account (HCFSA)

Even if you do not elect vision coverage, you can still set aside money from your pay on a pre-tax basis and be reimbursed for out-of-pocket vision expenses under the HCFSA. See page 7 for more information.

The Superior Vision Services Plan is underwritten by National Guardian Life Insurance Company.

List of Providers

For a list of vision care providers, you may call the SVS toll-free number at 1-800-507-3800 or visit www.ncflex.org.

Using SVS Benefits with In-Store Discounts

SVS recognizes you may take advantage of the in-store promotions or coupons offered by some of our "in-network" providers. Your SVS benefits are not intended for use in conjunction with these types of offers, nor are the providers contractually obligated to provide discounts in addition to the insured benefit. The provider will allow one discount only:

- the discount to the insurance company (SVS); or
- the discount to you (the sale or coupon).

The choice you make is important. If you go through SVS, you become a beneficiary of the stated coverage. If you choose to utilize the sale or coupon, you pay for all charges in full and submit the receipts to SVS. The SVS reimbursement will be based on the "non-network" rates in your policy. The "in-network" status applies only to the provider when you utilize the insurance, not as a "cash" customer. This is why the "non-network" rates are applied to your reimbursement. Please contact SVS at 1-800-507-3800 for more information before making your purchase.

IMPORTANT NOTE:
This is only a summary of the benefit plan. All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Coverage. You may review and/or obtain a copy of the Certificate of Coverage by visiting www.ncflex.org.

Eligible Dependents

Eligible dependents include your spouse or unmarried dependent child(ren) up to age 26, regardless of student status.

Services Available Under Your Insured Benefit at Additional Cost

- No-line bifocal lenses
- Progressive power lenses
- Slab-off lenses
- Polished bevels or faceted lenses
- Polycarbonate, polaroid, photochromic lenses
- Oversized lenses (larger than 62mm)
- Prism lenses
- Cosmetic lenses
- Tints on lenses (except Rose or
- Pink #1 or #2)
- Frames priced higher than the contracted retail allowance
- Scratch coating, UV coating,
- anti-reflective coating

Available Discounts for Additional Purchases/ Services from Selected In-Network Providers

The discount benefit is available under all three plans and now provides discounts on the covered pair of frames and lenses.

Discounts are available on additional purchases of eyeglasses and contact lenses, ranging from 10% up to 30% off retail prices. Keep in mind, this additional materials discount will apply to any subsequent purchases of materials after you make your first insured purchase.

Wellness Tip

Protecting your eyes from harmful UV rays is as important as protecting your skin. Wear sunglasses and hats when out in the sun and glare!

Core Wellness Exam

- Comprehensive eye exam covered in full after $20 co-pay
- Frequency- once every calendar year
- See page 22 for discount features for materials
- Out-of-Network reimbursement: $19 - $24

Summary of Benefits

	Basic Plan (Exam & Materials)		Enhanced Plan (Exam & Materials- increased benefits)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Vision Exam	$20 Co-pay	Up to $44 Ophthalmologist $39 Optometrist	$20 Co-pay	Up to $44 Ophthalmologist; $39 Optometrist
Frames	Up to $125 retail, plus 20% discount on overages*	Up to $50	Up to $175 retail, plus 20% discount on overages*	Up to $81
Contact Lens Exam/Fitting	*Standard:* Covered in full after $20 co-pay *Specialty:* Covered up to $50 after $20 co-pay	Not Covered	*Standard:* Covered in full after $20 co-pay *Specialty:* Covered up to $50 after $20 co-pay	Not Covered
Single Vision	Covered in Full	$34	Covered in Full	$34
Bifocal		$48		$48
Trifocal		$64		$64
Lenticular		$88		$88
Lens Options/Upgrades*	**In-Network**		**In-Network**	
Standard Single Vision Lenses	20% off retail; out-of-pocket not to exceed:		20% off retail; out-of-pocket not to exceed:	
Scratch Coat (factory)	$13		$13	
UV Coating	$15		$15	
Standard Anti-Reflective Coat	$50		$50	
High Index 1.6	$55		$55	
Photochromic	$80		$80	
Polycarbonate	$40		$40	
Standard Lined Bifocal & Trifocal Lenses				
Scratch Coat (factory)	$13		$13	
UV Coating	$15		$15	
Standard Anti-Reflective Coat	$50		$50	
High Index 1.6	20% off retail		20% off retail	
Photochromic	20% off retail		20% off retail	
Polycarbonate	20% off retail		20% off retail	
Additional Services Available on Any Lens*	**In-Network**		**In-Network**	
Progressive	20% off difference between retail for desired lens and standard, lined, trifocal lens		20% off difference between retail for desired lens and standard, lined, trifocal lens	
Plastic Tints; Solid or Gradient	$25		$25	
Glass Coloring	$35		$35	
Power Over 4.00 D Sphere, 2.00 D Cylinder & 5.00 D Prism	20% off retail		20% off retail	
Cosmetic Finishing, Beveling, Edging, & Mounting	20% off retail		20% off retail	
Miscellaneous Options	20% off retail		20% off retail	
Contact Lenses- In Lieu of Eyeglasses and Frames	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Elective	Up to $120 retail	$100	Up to $150 retail	$100
Medically Necessary	Covered in Full	$210	Covered in Full	$210
Frequency of Services				
Vision Exam	Calendar Year		Calendar Year	
Contact Lens Fitting Exam	Calendar Year		Calendar Year	
Lenses	Calendar Year		Calendar Year	
Frames	Every Two Calendar Years		Calendar Year	
Contact Lenses	Calendar Year		Calendar Year	
LASIK Discount	Varies by in-network provider: flat/fixed fee, 20% discount off surgical fees, or 10% to 15% discount off total fees	None	Varies by in-network provider: flat/fixed fee, 20% discount off surgical fees, or 10% to 15% discount off total fees	None
Materials Discount	10% to 30% on first pair and additional purchases	None	10% to 30% on first pair and additional purchases	None
Contact Lens Formulary	No		No	

**From select providers*

Materials Discount for Covered Pair of Eyeglasses*

Benefit Description	Discount
Frames *(Discounts do not apply when prohibited by manufacturer.)*	20% off the difference between the covered frame allowance and the retail price of the selected frame
Lens Options/Upgrade	**Discount**
Standard Single Vision Lenses • Scratch Coat (factory)** • UV Coat • Standard AR Coat** • High Index 1.6** • Photochromics • Polycarbonate	20% off retail; your out-of-pocket will not exceed: • $13 • $15 • $50 • $55 • $80 • $40
Standard Lines Bifocal & Trifocal Lenses • Scratch Coat (factory)** • UV Coat • Standard AR Coat** • High Index 1.6*** • Polycarbonate*** • Photochromics***	20% off retail; your out-of-pocket will not exceed: • $13 • $15 • $50 • 20% off retail (with no out-of-pocket limit) • 20% off retail (with no out-of-pocket limit) • 20% off retail (with no out-of-pocket limit)
Additional Services available on any lens • Plastic Tints; Solid or Gradient • Glass Coloring • Power Over 4.00 D Sphere, 2.00 D Cylinder & 5.00 D Prism • Cosmetic Finishing, Beveling, Edging & Mounting • Miscellaneous Options	20% off retail; your out-of-pocket will not exceed: • $25 • $35 • 20% off retail (with no out-of-pocket limit) • 20% off retail (with no out-of-pocket limit) • 20% off retail (with no out-of-pocket limit)
Discounts for Use with Core Wellness Plan Superior Vision offers discounts on an unlimited number of materials. Please check with the website at www.superiorvision.com to find providers who will honor the discount features. • Additional exams • Frames and prescription lenses • Lens options, contacts, miscellaneous options • Disposable contact lenses	 • 30% off retail • 30% off retail • 20% off retail • 10% off retail

Discounts are subject to change without notice. Discounts do not apply if prohibited by the manufacturer. Contact lens fitting exams are not subject to discount features.

** Discounts available from specific providers only.*
*** Higher-end or brand-name lens upgrades are at an additional expense to member.*
**** An out-of-pocket limit does not apply to these lens upgrades or add-ons.*

Wellness Tip

Staying healthy starts with your eyes. A routine eye exam can lead to early identification of diabetes, high cholesterol, hypertension, and more.

Critical Illness

NEW! $25,000 option

Guaranteed Issue

This benefit does not require re-enrollment.

Critical Illness Insurance is administered by Allstate Benefits. The coverage pays a lump-sum benefit of up to $15,000 or $25,000 per diagnosis. You can use your benefit as you see fit.

Coverage

Allstate Benefits Critical Illness covers the following medical conditions:

Coverage Amount: $15,000 or $25,000	
Pays 100% of Benefit	**Pays 25% of Benefit**
Heart Attack	Carcinoma in Situ (non-invasive cancer)
Stroke	Coronary Artery Bypass Surgery
Major Organ Transplant	
Bone Marrow Transplant	
Invasive Cancer	
Paralysis	
End Stage Renal Failure	

Eligible Dependents

You must enroll to receive coverage for your dependents. Eligible dependents include your spouse or unmarried dependent child(ren) up to age 26, regardless of student status. If you and your spouse are both eligible to elect this coverage, only one of you may enroll for family coverage. An employee may not be covered both as an employee and as a dependent.

Meeting Your Needs

Critical illness coverage offers financial support should a covered illness be diagnosed.

- No pre-existing conditions
- Guaranteed issue - no health questions required
- Benefits paid directly to you
- No waiting period for new diagnosis
- There is a maximum of two payouts per diagnosis (12-month waiting period for reoccurrence)
- Benefits for covered dependents are the same as covered employees

Did You Know...

*Every 34 seconds, an American will suffer a heart attack.**
*Every 40 seconds someone in the U.S. has a stroke.**

*http://www.criticalillnessinsuranceinfo.org/learning-center/critical-illness-coverage-facts.php

Monthly Cost

The monthly premium for you and/or your dependent spouse is based on the age of the covered employee as of January 1 of the current plan year.

Employee/Dependent Spouse

Employee Age	$15,000	New $25,000 Option!
<25	$1.30	$2.18
25 – 29	$1.40	$2.34
30 – 34	$2.60	$4.34
35 – 39	$4.10	$6.84
40 – 44	$7.40	$12.34
45 – 49	$12.00	$20.00
50 – 54	$18.60	$31.00
55 – 59	$27.80	$46.34
60 – 64	$42.60	$71.00
65 – 69	$64.20	$107.00
70 – 74	$84.40	$140.66
75 – 79	$101.40	$169.00
80 +	$119.50	$199.18

Rates are based on five-year age bands and will increase when a covered person reaches a new age band.

Dependent Child(ren)	Monthly Rate
Up to age 26	No cost

Calculating Your Cost Example for $15,000 Option

Employee age is 43	$7.40
Spouse age is 39	$7.40
Three children (varying ages)	$0
Total Monthly Premium	$14.80

**For more information on the covered condition definitions, visit www.ncflex.org.*

Benefit Payment Example*

Covered Condition	Lump-Sum Benefit Payment Received
You have a heart attack	**$15,000 or $25,000**
Three months later, you are diagnosed with noninvasive cancer	**$3,750 or $6,250**
12 months later you have another heart attack	**$15,000 or $25,000**
Two months later you become paralyzed	**$15,000 or $25,000**
Total Payout	**Total = $48,750 or $81,250**

*Your individual experience may vary.

Beneficiary

To designate a beneficiary please visit NCFlex.org. Click on the "Enroll Now" button and login to designate your beneficiary.

Tax Issues

Whenever a benefit claim is paid, a 1099 tax form will be sent to your home address in January of the following year. You should consult with your tax advisor regarding the possible effects of the purchase and/or receipt of benefits under Allstate Benefits Critical Illness Insurance on certain other coverage of benefit that you might have or that you might obtain.

Certificate of Coverage

The Certificate of Coverage provides complete details about the benefits and the limits and exclusions. For complete details, you must review the Certificate of Coverage located at www.ncflex.org.

Exclusions and Limitations

Exclusions and Limitations are as follows and may vary: This plan will not pay benefits for a critical illness that is, or is caused by, contributed to, by, or results from:

1. Critical illness diagnosed prior to your effective date.
2. Active participation in a riot, insurrection, or rebellion.
3. Intentionally self-inflicted injury or action.
4. Illegal activities or participation in an illegal occupation.
5. Suicide while sane, or self-destruction while insane, or any attempt at either.

Portability Privilege

The portability feature allows continuation of your critical illness coverage when your employment ends or the policy terminates, by paying premiums directly to Allstate Benefits.

Compare Your Options: Cancer and Specified Disease vs. Critical Illness Coverage

Features	Cancer and Specified Disease	Critical Illness		
Benefit	Benefits correspond with actual expenses up to a specified amount	Pays lump sum benefit upon diagnosis		
Covered Illnesses	Cancer and 29 specified diseases such as Multiple Sclerosis, Sickle Cell Anemia, Hepatitis, and Lyme Disease	• Heart Attack • Stroke • Major Organ Transplant • Bone Marrow Transplant • Invasive Cancer • Paralysis • End Stage Renal Failure • Carcinoma in Situ • Coronary Artery Bypass	$15,000 $15,000 $15,000 $15,000 $15,000 $15,000 $15,000 $3,750 $3,750	$25,000 $25,000 $25,000 $25,000 $25,000 $25,000 $25,000 $6,250 $6,250
Wellness Benefit	Yes	No		
Dependent Coverage	Yes	Yes		
Coverage Continuation	Portable/Continuation	Portable/Continuation		
Rating Basis	Composite Rates (Flat rate for employee or family)	Rates based on five-year age bands		
Advantages	• Wellness benefit paid for annual cancer screenings • Benefits paid directly to the insured to be used at their discretion • Covers cancer and 29 other diseases • Benefits payable for the treatment of skin cancer • No lifetime maximum on most payable benefits	• Lump-sum benefit is available immediately upon diagnosis and receipt of written proof of claim • Do not have to submit ongoing expense receipts • Pays even in the event of death • Benefits paid directly to the insured to be used at their discretion		

This benefit does not require annual re-enrollment.

Cancer and Specified Disease

Guaranteed Issue

NCFlex offers Cancer and Specified Disease Insurance through Allstate Benefits. It is hard to face the facts, but cancer will affect many of us — regardless of age, gender, or lifestyle. While treatment has advanced the fight against caner, it still occurs in slightly less than one in two men and in one in three women, according to Cancer Facts and Figures, American Cancer Society, 2016.

Coverage

You can choose between three plan options depending on your cancer insurance needs and specified diseases. All three plan options offer the same type of benefits and/or services. In most cases, however, the amount of coverage differs. The benefits under the Low, High, and Premium Options are progressively higher than the previous option. Refer to the *Summary of Benefits* on page 26 for more details.

In addition to cancer coverage, this insurance pays benefits for 29 other specified diseases listed below:

- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Muscular Dystrophy
- Poliomyelitis
- Multiple Sclerosis
- Encephalitis
- Rabies
- Tetanus
- Tuberculosis
- Osteomyelitis
- Diphtheria
- Scarlet Fever
- Cerebrospinal Meningitis (bacterial)
- Brucellosis
- Sickle Cell Anemia
- Thallasemia
- Rocky Mountain Spotted Fever
- Legionnaire's Disease
- Addison's Disease
- Hansen's Disease
- Tularemia
- Hepatitis (chronic B or C)
- Typhoid Fever
- Myasthenia Gravis
- Reye's Syndrome
- Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
- Lyme Disease
- Systemic Lupus Erythematosus
- Cystic Fibrosis
- Primary Biliary Cirrhosis

Example

Joe's spouse is diagnosed with Leukemia and is confined to the hospital for 28 days in January for a stem cell transplant. She continued to be admitted to the hospital on and off until the end of May. The NCFlex High Cancer Plan paid Joe for the hospital confinements, stem cell transplant, inpatient drugs, attending physician, chemo, radiation, blood, wellness visit, anesthesia, transportation, and the extended benefit. Over $42,000 was paid in claims from January through May.

Cost

The monthly premium you pay for cancer coverage is based on the plan you choose and whether you choose to cover yourself only or yourself and your family. There is no EOI for new hires within a 30-day window.

Cost	Employee Only	Employee and Family
Low Option	$6.38	$10.56
High Option	$15.18	$25.16
Premium Option	$20.28	$33.54

Examples of Net Cost

Each plan option includes the Cancer Screening Benefit, which pays a benefit for each covered insured **annually** for taking certain tests, regardless of the cost of the test. In addition, since your monthly premium is subtracted from your pay before taxes, you receive tax savings.

The following are a few examples of how the Cancer Screening Benefit and the tax savings affect the total cost for your NCFlex Cancer and Specified Disease Insurance.

Option	Annual Cost	Cancer Screening Benefit	Tax Savings (30% Tax Bracket)	NET Annual Cost
Low — Employee	$76.56 ($6.38/Month)	$25	$22.97	$28.59 ($2.38/ Month)
High — Family	$301.92 ($25.16/Month)	$200 (2 @ $100)	$90.58	$11.34 ($0.95/ Month)
Premium — Family	$402.48 ($33.54/Month)	$200 (2 @ $100)	$120.74	$81.74 ($6.81/ Month)

Exceptions and Limitations

Pre-Existing Condition — A pre-existing condition is a disease or physical condition for which medical advice or treatment was received by the covered person during the 12-month period prior to his or her effective date of coverage. Allstate Benefits does not pay benefits for a pre-existing condition during the 12-month period beginning on the date coverage starts. Any covered loss that is incurred after the 12-month period is payable.

For complete details on exclusions and limitations, see the Certificate of Coverage located at **www.ncflex.org.**

Summary of Benefits

You must review the Certificates of Coverage for complete details regarding these benefits.

Benefit	Low Option	High Option**	Premium Option**
Cancer Prevention and Screening Benefit* (per calendar year/per covered insured)	$25	$100	$100
Continuous Hospital Confinement (per day) (up to 70 days for each period of continuous confinement)	$100	$200	$300
Extended Benefits** (per day after 70 days)	up to $100	up to $200	up to $300
Surgery** (per surgery, based on surgical schedule)	up to $1,500	up to $3,000	up to $4,500
Second Surgical Opinion**	up to $200	up to $400	up to $600
Anesthesia**	up to 25% of surgery benefit		
Ambulatory Surgical Center** (per day)	up to $250	up to $500	up to $750
Radiation/Chemotherapy** (per 12-month period)	up to $2,500	up to $7,500	up to $10,000
Inpatient Drugs and Medicine**	up to $25 per day while confined in the hospital		
Private Duty Nursing Services** (per day)	up to $100	up to $200	up to $300
New or Experimental Treatment**	up to $5,000 per 12-month period		
Blood, Plasma, and Platelets** (per 12-month period)	up to $2,500	up to $7,500	up to $10,000
Physician's Attendance**	up to $50 per day		
At-Home Nursing** (per day)	up to $100	up to $200	up to $300
Prosthesis**	up to $2,000 per amputation		
Ambulance**	up to $100		
Hospice Benefits:			
Freestanding Hospice Care Center** (per day)	up to $100	up to $200	up to $300
Hospice Care Team** (per day; limit 1 visit/day)	up to $100	up to $200	up to $300
Government or Charity Hospital (per day; in lieu of all other benefits in the policy, except the Waiver of Premium benefit)	$100	$200	$300
Outpatient Lodging** (day/per 12 months)	$50/$2,000	$50/$2,000	$50/$2,000
Non-Local Transportation	pays coach fare or $0.40 per mile		
Family Member Lodging and Transportation (for one adult member of covered person's family)			
Lodging**	up to $50 per day; maximum 60 days		
Transportation**	round-trip coach fare on common carrier or $0.40 per mile		
Extended Care Facility** (per day)	up to $100	up to $200	up to $300
Physical or Speech Therapy**	up to $50 per day		
Comfort/Anti-Nausea**		up to $200 per calendar year	
Bone Marrow or Stem Cell Transplant			
Transplant other than non-autologous (per calendar year)	up to $500	up to $1,000	up to $1,500
Transplant for non-autologous; treatment of cancer or other specified disease; except Leukemia (per calendar year)	up to $1,250	up to $2,500	up to $3,750
Transplant for non-autologous; treatment of Leukemia (per calendar year)	up to $2,500	up to $5,000	up to $7,500
Waiver of Premium	premiums waived after 90 days of disability due to cancer for insured employee		

**Cancer Prevention and Screening Benefit includes: CA-15-3 (cancer antigen 15-3 blood test for breast cancer); CA125 (cancer antigen 125-blood test for ovarian cancer); CEA (carcinoembryonic antigen-blood test for colon cancer); chest x-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; mammography; Pap smear; PSA (Prostate Specific Antigen blood test for cancer); and Serum Protein Electrophoresis (test for myeloma). This benefit is paid regardless of the result of the test.*

***These benefits are payable based on actual charges up to the maximum amount listed.*

No EOI required for plan year 2017

Medicaid Information

For individuals who are eligible for Medicaid, this cancer insurance policy may not be the best choice for you. Benefits assigned under the policy are required to be assigned back to Medicaid.

Exclusions and Limitations — The policy does not pay for any loss except those due from cancer or a covered specified disease. A diagnosis must be submitted to support each claim.

Portability Privilege

The portability feature allows continuation of your cancer coverage when your employment ends or policy terminates, by paying premiums directly to Allstate Benefits.

Certificate of Coverage

The Certificate of Coverage provides complete details about the benefits and the limits and exclusions. For complete details, you must review the Certificates of Coverage located on www.ncflex.org.

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Evidence of Insurability

Evidence of Insurability (EOI) is a way of providing proof of good health. This evaluation may include your current health status, medical history and family history. If you are required to submit EOI, Allstate Benefits must approve your EOI before coverage becomes effective. You can access an EOI form by visiting the "Cancer & Specified Disease" section at www.ncflex.org.

The Certificate of Coverage provides complete details about the benefits and the limits and exclusions. For complete details, you must review the Certificates of Coverage located on www.ncflex.org.

The Critical Illness and Cancer coverage is provided by Limited Benefit insurance, policy forms GVCIP2 and GVCP2, or state variations thereof. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), the underwriting company and a subsidary of The Allstate Corporation.

This benefit does not require re-enrollment

Group Term Life

NCFlex is offering Voluntary Group Term Life Insurance administered by Voya Financial and underwritten by ReliaStar Life Insurance Company.

Voluntary Group Term Life Insurance pays a benefit to your beneficiary(ies) if you die while covered under the policy. Please note that this is strictly a life insurance policy that provides a benefit if you die. There is no accumulated cash value.

Coverage Options

Employee & Spouse*

- $20,000 to a maximum of $500,000 in $10,000 increments

(*spouse coverage cannot exceed 100% of employee's elected amount*)

Child(ren)*

- $10,000 without EOI for 2017

*Employee must be enrolled to cover spouse/child(ren).

Enrollment/Evidence of Insurability Options

Evidence of Insurability (EOI) may be required when enrolling in this plan to determine if coverage will be granted. EOI consists of health questions that may include your current health status, medical history, and family medical history.

New Employee – may elect $20,000 up to $200,000 on yourself and $20,000 up to $50,000 on your spouse without EOI.

Existing Employee during Annual Enrollment – if you/your spouse are not currently enrolled in the group term life coverage during this annual enrollment period, you/your spouse may purchase $20,000 of coverage on a guaranteed issue basis (if you were not previously denied coverage). Amounts over $20,000 require EOI.

If you/your spouse are currently enrolled in Group Term Life, you may add either $10,000 or $20,000 of additional coverage at each annual enrollment up to the guaranteed issue amount of $200,000 for employees and $50,000 for spouse (no EOI required).

Existing Employee outside of Annual Enrollment – if you experience a qualifying life event that allows you to add or increase your life insurance amount, you will be subject to EOI.

Child(ren) coverage – may elect $10,000 without EOI for 2017.

Submitting EOI

If EOI is required, Voya Financial will mail the appropriate EOI form to the employees' address on file. This form must be completed, signed, and returned to Voya Financial for review.

Monthly Cost and Coverage

The monthly premium for you and/or your dependent spouse is based on the age of the covered employee as of January 1 of the current plan year. The following chart outlines the cost of coverage per $1,000 increment based on age.

Employee/Dependent Spouse

Your Age	Monthly Rates*/ $1,000 Coverage	Monthly Cost for Sample Coverage Amounts		
		$20,000	$50,000	$100,000
0 – 24	$0.04	$.80	$2.00	$4.00
25 – 29	$0.05	$1.00	$2.50	$5.00
30 – 34	$0.07	$1.40	$3.50	$7.00
35 – 39	$0.08	$1.60	$4.00	$8.00
40 – 44	$0.09	$1.80	$4.50	$9.00
45 – 49	$0.13	$2.60	$6.50	$13.00
50 – 54	$0.22	$4.40	$11.00	$22.00
55 – 59	$0.40	$8.00	$20.00	$40.00
60 – 64	$0.64	$12.80	$32.00	$64.00
65 – 69	$1.27	$25.40	$63.50	$127.00
70 – 74	$2.06	$41.20	$103.00	$206.00
75+	$2.06	$41.20	$103.00	$206.00

Child(ren)

$0.68 for $5,000 of coverage for child(ren)

$1.36 for $10,000 of coverage for child(ren)

If electing employee-only coverage, premiums will be deducted on a pre-tax basis.

If electing employee plus dependent coverage, premiums for the employee and dependent(s) will be deducted on a post-tax basis.

Underwritten by ReliaStar Life Insurance company, policy form LPOOGP. Rates shown are guaranteed until 12/31/2021.

When Coverage Begins

Newly Eligible:
If you are a new hire and enroll for coverage of $200,000 or less, your coverage will begin on the first day of the month following your date of hire. You must enroll within 30 days of your hire date.

If you have to submit EOI as part of your enrollment, your coverage will begin the first of the month on or following the date your EOI is approved.

Existing Employees:
Annual Enrollment: If you enroll for coverage during annual enrollment and your EOI is approved prior to January 1, your coverage will be effective January 1, 2017. If your EOI date of approval is after January 1, 2017, your coverage will be effective on the first of the month following the date your EOI is approved.

If you are on disability, you may enroll when you return to active status.

Life Event: If EOI is not required, coverage begins on the 1st of the month following the life event. If EOI is required, coverage begins on the 1st of the month following the date your EOI is approved.

Disability Waiver of Premium

If you become totally disabled prior to age 60, as defined under the policy and satisfy certain conditions, ReliaStar Life waives the life insurance premium that becomes due while you are totally disabled. (This includes spouse and child(ren) coverage.)

Premiums are waived until the earlier of:

- the date you are no longer disabled;
- the date you do not give ReliaStar Life proof of total disability when asked; or
- the date you turn age 70.

Your Benefit After Age 75

Your benefit will be reduced to 50% if you are still employed with NC State Government after age 75.

Note: Once the coverage is reduced due to age, the insured is no longer able to increase coverage.

Funeral Planning and Concierge Services

Planning a funeral can be time-consuming and emotionally draining. Funeral planning services allow employees to contact professionals who will help with funeral planning for themselves and eligible family members. This service helps you and your family prepare for and deal with all aspects of a funeral, easing the burden on you. Funeral Planning and Concierge Services are provided by Everest Funeral Package, LLC, Houston, TX. Services are not available in all states. For more information, visit www.ncflex.org.

Expanded Accelerated Death Benefit

The policy allows you to collect a portion of your benefit amount if you become terminally ill and are expected to live six months or less. You may collect 50% of your benefit up to a maximum of $250,000. The remaining benefits will be paid to the beneficiary after death.

- **When diagnosed with a terminal illness:** if you have been diagnosed with a terminal illness and have fewer than six months to live, you can receive 50% of the death benefit while living.
- **When diagnosed with a condition requiring continuous confinement:** If you have a medical condition that is reasonably expected to require continuous confinement in an institution, and you are expected to remain there for the rest of your life, you can receive 50% of the death benefit while living.

Exclusion

The policy has a suicide exclusion. Your claim will be denied if you have been covered under the Voluntary Group Term Life Insurance policy for less than two years and a claim is filed for death by suicide. Your beneficiary(ies) will not receive a benefit; however, ReliaStar Life will refund premiums paid.

Portability

You may continue your term life insurance coverage under the NCFlex Voluntary Group Term Life Insurance policy if you terminate employment or retire prior to age 70 (without a physical examination). Premium rates for portable term life insurance are generally less expensive than the whole life insurance conversion rate.

Active coverage at age 70 or retirement after age 75 will be eligible for conversion ONLY.

Conversion

Upon termination/retirement, you may convert your term life insurance coverage to an individual whole life policy without a physical examination, regardless of age. The whole life policy builds cash value and the premiums do not change as you get older. You pay the full cost of individual policy coverage, plus a billing fee. Premium rates for life insurance conversion are generally more expensive than portable life insurance rates.

Wellness Tip

Don't forget to periodically review and update your beneficiaries!

You must enroll to receive this no-cost benefit. This benefit does not require re-enrollment.

Core Accidental Death & Dismemberment

The Core Accidental Death and Dismemberment (AD&D) Insurance Plan is administered by Voya Financial and underwritten by ReliaStar Life Insurance Company, a member of the Voya family of companies. It can pay a benefit if you suffer a loss as the result of a covered accident while you are insured under the plan. It also pays a benefit if you suffer certain disabling injuries while covered. The coverage is effective 24 hours a day, 365 days a year. It includes accidents on or off the job, while traveling by car, train, boat, some forms of air travel, or any other public or private form of transportation. Please refer to the Certificate of Coverage for specific exclusions and limitations. This coverage is in addition to any other coverage you have under any other insurance policy.

Coverage

The amount of insurance provided to you, if elected, at no cost is called the Principal Sum.

Principal Sum	Cost for Employee
$10,000	$0.00

If you suffer any one of the losses listed on the chart below, as the result of a covered accident, the loss will be deemed a covered loss and paid, as listed. The maximum percentage paid for losses from any one accident is 100%.

Accident	Percentage Principal Sum
Life, Loss of	100%
Sight of Both Eyes, Loss of	100%
Speech and Hearing of Both Ears, Loss of	100%
Both Hands or Both Feet, Loss of	100%
One Hand and One Foot, Loss of	100%
Quadriplegia	100%
Paralysis of Three Limbs	85%
Paraplegia/Hemiplegia	75%
Paralysis of One Limb	50%
Either Hand or Foot, Loss of	50%
Sight of One Eye, Loss of	50%
Speech or Hearing of Both Ears, Loss of	50%
Hearing of One Ear, Loss of	25%
Thumb and Index Finger of Same Hand, Loss of	25%

Note: Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Coverage After Age 70

If you are actively at work at age 70 and beyond, the percentage of the amount payable declines as follows:

Age	Percentage of Full Benefit
70 – 74	65%
75 – 79	45%
80 – 84	30%
85 and older	15%

What is Excluded from Coverage

Please note that coverage will not be in place during an unpaid leave of absence. We will not pay a claim for a loss that is caused by or resulting from:

- suicide or intentionally self-inflicted injury, while sane or insane;
- bacterial infection or bacterial poisoning;
- any armed conflict, whether declared as war or not, involving any country or government;
- injury suffered while in the military service for any country or government;
- injury which occurs when you commit or attempt to commit a crime;
- use of any drug, narcotic, or hallucinogenic agent, unless taken as directed as prescribed by a doctor - which is illegal or which is not taken as directed by a doctor or manufacturer;
- your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Voya Travel Assistance: Worldwide Emergency Travel Assistance Services

Being in an unfamiliar place can cause stress, especially if something goes wrong. Voya Travel Assistance offers you and your dependents four types of services when traveling more than 100 miles from home: Pre-Trip Information, Emergency Personal Services, Medical Assistance Services, and Emergency Transportation Services. This provides peace of mind, allowing you to relax and enjoy your trip. Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD. Services are not available in all states.

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information
- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

Wellness Tip

Healthy sleep patterns can reduce our chances of causing a traffic accident.

Benefit Highlights of Core AD&D and Voluntary AD&D

	Core AD&D	Voluntary AD&D	
	Employee Only	Employee Only	Family
Your Cost Per Month (if elected)	$0.00	$1.70*	$2.70*
Your Benefit Amount	$10,000	$100,000 *	$100,000*
Enroll During Annual Enrollment	✓	✓	✓
Accidental Death & Dismemberment	✓	✓	✓
Paralysis, Quadriplegia, Paraplegia, Hemiplegia	✓	✓	✓
Voya Travel Assistance	✓	✓	✓
Rehabilitation Benefit		✓	✓
Common Disaster Benefit		✓	✓
Coma Benefit		✓	✓
Accidental In-Hospital Indemnity		✓	✓
Safe Driver Benefit		✓	✓
Criminal Assault Benefit		✓	✓
War Risk Benefit		✓	✓
Burn Disfigurement		✓	✓
Accidental HIV Benefit		✓	✓
Custodial Care Benefit		✓	✓
Therapeutic Counseling Benefit		✓	✓
Adaptive Home & Vehicle Benefit		✓	✓
Surgical Reattachment Benefit		✓	✓
Portability		✓	✓
Coverage for Your Spouse			✓
Survivor's Benefit			✓
Education Benefit			✓
Spouse Training Benefit			✓
Coverage for Your Dependent Children			✓

See page 32 for complete information about the Voluntary AD&D benefit.

** $100,000 benefit amount is one example. Other benefit amounts are available from $50,000 to $500,000.*

Voluntary Accidental Death & Dismemberment

This benefit does not require annual enrollment

The Voluntary Accidental Death and Dismemberment (AD&D) Insurance Plan is administered by Voya Financial and underwritten by ReliaStar Life Insurance Company, a member of the Voya family of companies. It can pay a benefit if you suffer a loss as the result of a covered accident while you are insured under the plan. It also pays a benefit if you suffer certain disabling injuries while covered.

The coverage is effective 24 hours a day, 365 days a year. It includes accidents on or off the job, while traveling by car, train, boat, some sorts of air travel, or any other public or private form of transportation. Please refer to the Certificate of Coverage for specific exclusions and limitations. This coverage is in addition to any other coverage you have under any other insurance policy.

The benefit amounts are shown below. **If you and your spouse are both eligible to elect this coverage as state agency, university, select community college, or select charter school employees, you both may elect to participate as employees, but only one may enroll for employee and family coverage.** The spouse who elects employee and family coverage will not have coverage for his or her spouse, only children. An employee may not be covered as both an employee and a dependent.

Monthly Cost and Principal Sum

The amount of insurance you purchase is called the Principal Sum. You may select one of the following Principal Sums for yourself:

Principal Sum	Cost for Employee Only	Cost for Employee & Family	Principal Sum	Cost for Employee Only	Cost for Employee & Family
$50,000	$0.85	$1.35	$300,000	$5.10	$8.10
$100,000	$1.70	$2.70	$350,000	$5.95	$9.45
$150,000	$2.55	$4.05	$400,000	$6.80	$10.80
$200,000	$3.40	$5.40	$450,000	$7.65	$12.15
$250,000	$4.25	$6.75	$500,000	$8.50	$13.50

Family Principal Sum

In addition to insurance for yourself, you can elect to purchase insurance for your spouse and unmarried dependent children (see *Eligible Dependents*, page 33). If you elect family coverage, your family members' Principal Sum will be a percentage of your Principal Sum.

Family Members	Percentage of Your Benefit Payable
Spouse only	60%
Spouse and children	50% spouse; 10% each child
Children only	15% each child

Coverage

If you or one of your covered dependents suffers any one of the losses listed on the chart below, as the result of a covered accident, the loss will be deemed a covered loss and a benefit will be paid, based on the applicable Principal Sum. The maximum percentage paid for losses from any one accident is 100%.

Accident	Percentage Principal Sum
Life, Loss of	100%
Sight of Both Eyes, Loss of	100%
Speech and Hearing of Both Ears, Loss of	100%
Both Hands or Both Feet, Loss of	100%
One Hand and One Foot, Loss of	100%
Quadriplegia	100%
Paralysis of Three Limbs	85%
Paraplegia/Hemiplegia	75%
Paralysis of One Limb	50%
Either Hand or Foot, Loss of	50%
Sight of One Eye, Loss of	50%
Speech or Hearing of Both Ears, Loss of	50%
Hearing of One Ear, Loss of	25%
Thumb and Index Finger of Same Hand, Loss of	25%

Note: Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Coverage After Age 70

If you are actively at work at age 70 and beyond, the percentage of the amount payable declines as follows:

Age	Percentage of Full Benefit
70 – 74	65%
75 – 79	45%
80 – 84	30%
85 and older	15%

Additional Benefits

If insured under the plan, the following benefits are available to you as part of your Voluntary Accidental Death and Dismemberment coverage. For more information, please visit www.ncflex.org and view the Voluntary AD&D certificate.

- Enhancement for Children* *(family option only)*
- Surgical Reattachment Benefit
- Coma Benefit
- Accidental HIV Benefit
- Burn Disfigurement Benefit
- Rehabilitation Benefit*
- Therapeutic Counseling Benefit*
- Adaptive Home & Vehicle Benefit*
- Accidental In-Hospital Indemnity Benefit*
- Custodial Care Benefit*
- Seat Belt Benefit*
- Air Bag Benefit*
- Criminal Assault Benefit*
- Common Disaster Benefit*
- Survivor's Benefit* *(family option only)*
- Education Benefit* *(family option only)*
- Spouse Training Benefit* *(family option only)*
- Child Care Benefit* *(family option only)*
- Disability Waiver of Premium
- **Worldwide Emergency Travel Assistance Services (extends to enrolled family members; see page 31 for detailed description)**

Eligible Dependents

Child:

- your natural or adopted child, who is dependent on you for support and maintenance. The child need not be claimed as a dependent on your federal income tax return.
- a child for whom you have legal obligation for purposes of adoption
- a child for whom you are required by court order to provide health coverage
- a child who is primarily dependent on you for support and who is your stepchild, foster child, or a chid for whom you are a legal guardian

Dependent:

- your legal spouse
- your unmarried child less than 26 years of age;
- your unmarried child of any age who is medically certified as disabled and financially dependent upon you.

The term "dependent" does not include:

- a spouse or child living outside the United States
- a spouse or child eligible for Employee's Insurance under the Group Policy
- a spouse or child on active military duty
- a parent of you or your spouse

What is Excluded from Coverage

The plan will not pay a claim for a loss that is contributed to, caused by, or resulting from:

- suicide or intentionally self-inflicted injury, while sane or insane;
- bacterial infection or bacterial poisoning;
- any armed conflict, whether declared as war or not, involving any country or government;
- injury suffered while in the military service for any country or government;
- injury which occurs when you commit or attempt to commit a crime;
- use of any drug, narcotic, or hallucinogenic agent, unless taken as directed as prescribed by a doctor – which is illegal or which is not taken as directed by a doctor or manufacturer;
- your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Continuation Options

Portability of Voluntary AD&D services are available. For details and rates please contact Voya at 1-877-464-5111.

** Additional benefits apply only if there has been a covered loss as shown on page 32.*

TRICARE Supplement Plan

Benefit for the military community. This benefit does not require re-enrollment.

What is TRICARE Supplement Plan?

TRICARE Supplement is administered by Selman & Company and underwritten by Transamerica Premier Life Insurance Company.

If you currently have TRICARE Standard/Extra, Prime, or TRS benefits offered to the military community, you may be eligible and interested in the TRICARE Supplement Plan.

This plan pays the cost TRICARE leaves behind.

There are no pre-existing conditions or deductibles.

Who is Eligible?

Employees must follow the NCFlex eligibility guidelines. Eligible employees are retired uniform service members enrolled in either TRICARE Standard/Extra, Prime, or TRS and are not eligible for Medicare, including:

- Retired military entitled to retired or retainer pay
- Retired reserve members between the ages of 60 and 65 and entitled to retired and retainer pay
- Retired Reserve members under age 60 and enrolled in TRICARE Retired Reserve (TRR)
- Spouses/surviving spouses of the above
- Retired military personnel, spouse/surviving spouse age 65 or older and resides outside the U.S. or its territories (must be enrolled in Medicare)
- Retired military personnel, spouse/surviving spouse age 65 or older and ineligible for Medicare (must have Statement of Disallowance form Social Security Administration)
- TRICARE Reserve Select (TRS) members and their eligible dependents

Eligible Dependents Include

- Unmarried dependent children up to age 21 or if the child is a full-time student, up to age 23. Documentation that a child, age 21-22, is a full time-student must be provided.
- Incapacitated dependents are covered after age 21, 23, or 26, if the child(ren) are dependent on the member for primary support/maintenance and eligible for TRICARE. Proof of continued incapacity and dependency is required. Documentation must be provided.
- Adult dependent children who are younger than 26 and who are enrolled in TRICARE Young Adult (TYA). The child must provide a copy of his TYA Enrollment ID card to Selman & Company.

Eligible individuals must be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must not be eligible for Medicare. An individual who is unsure if he/she is eligible for TRICARE should confirm eligibility with DEERS before enrolling in the TRICARE Supplement. If a dependent's Military ID card has expired or if information has changed (i.e., address corrections), call DEERS at 1-800-538-9552.

How the TRICARE Supplement Works with TRICARE

TRICARE and the TRICARE Supplement Plan are separate plans. However, these plans work together to maximize your benefits and minimize your out-of-pocket expenses. Not all services are covered by TRICARE and the TRICARE Supplement Plan. For a complete list of covered services under TRICARE, please visit www.tricare.mil.

Monthly Cost

Coverage Tier	Cost
Employee Only	$60.50
Employee + Child(ren)	$119.50
Employee + Spouse	$119.50
Employee + Family	$160.50

After TRICARE pays, here's how the TRICARE Supplement Plan works:

Care Required	TRICARE Standard/Extra Pays	TRICARE Standard/Extra Supplement Pays	TRICARE PRIME or Point-of-Service (POS) Pays	TRICARE Prime or Point-of-Service (POS) SUPPLEMENT Pays
INPATIENT FACILITY SERVICES in civilian hospitals for RETIREES and their dependent family members (room, board, supplies, and staff services billed by the hospital)	The TRICARE Standard DRG[1] allowed amount (contracted rate for TRICARE Extra minus your cost share)	The lesser of $810 per day or 25% of the billed amount, not to exceed the TRICARE Standard DRG amount (lesser of $250 per day or 20% cost share of the contracted rate for TRICARE Extra)	**PRIME** – All but the Prime co-payments **POS** – 50% of the TRICARE allowed amount after the deductible has been met	**PRIME** – All the Prime co-payments **POS** – The 50% POS cost share
INPATIENT PROFESSIONAL SERVICES in civilian hospitals for RETIREES and dependent family members (doctors and other inpatient services not billed by the hospital)	75% of the TRICARE Standard allowed amount (80% for TRICARE Extra) for doctors and other professional services	Your 25% Standard/ 20% Extra cost share	**PRIME** – All but the Prime co-payments **POS** – 50% of the TRICARE allowed amount after the deductible has been met	**PRIME** – All but the Prime co-payments **POS** – The 50% POS cost share
INPATIENT CARE in military hospitals	All but the daily subsistence fee	The daily subsistence fee	The daily subsistence fee	The daily subsistence fee
OUTPATIENT CARE for RETIREES and their dependent family members (office visits, clinics, lab, etc.)	75% of the TRICARE Standard allowed amount (80% for TRICARE Extra) after you pay the TRICARE Outpatient Deductible	Your 25% Standard/ 20% Extra cost share and 100% of the TRICARE Outpatient Deductible[2] of $150 per person or $300 per family PLUS 100% of Covered Excess Charges	**PRIME** – All but the Prime co-payments **POS** – 50% of the TRICARE allowed amount after the deductible has been met	**PRIME** – All Prime co-payments **POS** – The 50% POS cost share and 50% of the POS deductible[2] of $300 per person or $600 per family PLUS 100% of the Covered Excess Charges
PRESCRIPTION DRUGS Civilian network pharmacy; up to a 30-day supply	All but co-payments: $10 generic, $24 brand name or $50 non-formulary	All co-payments	**PRIME** – All but the Prime co-payments	**PRIME** – All co-payments
PRESCRIPTION DRUGS Home delivery or mail order; up to a 90-day supply; co-pays based on each 30-day supply	All but co-payments: $20 brand name or $49 non-formulary	All co-payments	**PRIME** – All but the Prime co-payments	**PRIME** – All co-payments
PRESCRIPTION DRUGS Civilian non-network pharmacy; up to a 30-day supply	All but the deductible and co-payments: $24 generic/brand name, $50 non-formulary or 20% of total cost, whichever is greater	Co-payments: $24 generic/brand name, $50 non-formulary, or 20% of total cost, whichever is greater and 100% of the TRICARE Outpatient Deductible[2] of up to $150 per individual or $300 per family	**POS** – 50% of the TRICARE allowed amount after the TRICARE deductible has been met	**POS** – The 50% POS cost share and 50% of the POS Deductible[2] of $300 per person or $600 per family

TRICARE Supplement Policy MZ0925783H0000A does not have a plan deductible.

[1] *Diagnosis Related Group (DRG): Established standard hospital stays for categories of medical conditions.*

[2] *Reimbursement towards the fiscal year TRICARE Standard Outpatient Deductible is made only if the deductible is incurred after the effective date of coverage.*

Note: The TRICARE Supplement Plan pays virtually 100% of the TRICARE approved expenses after TRICARE has paid.

Note: Benefits are payable for covered cost share amounts up to the TRICARE Catastrophic Cap. The Catastrophic Cap is the maximum out-of-pocket amount you will pay each fiscal year (FY) (October 1 - September 30) for TRICARE-covered services.

Exclusions may vary by state and underwriter. See your Certificate for complete details.

This is not Medicare Supplement Insurance. For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

After TRICARE Reserve Select pays, here's how the TRICARE Supplement Plan works:

Care Required	TRICARE Reserve Select (TRS) Pays	After TRS Pays, the TRICARE SUPPLEMENT Pays
INPATIENT FACILITY SERVICES in civilian hospitals for TRS member and their dependent family members (room, board, supplies and staff services billed by the hospital)	All but $18 per day ($25 minimum)	$18 per day ($25 minimum)
INPATIENT PROFESSIONAL SERVICES in civilian hospitals for TRS member and their dependent family members (doctors, and other inpatient services not billed by the hospital)	Network Provider: 85% of the TRICARE negotiated rate Non-Network Provider: 80% of the allowed amount	Network Provider: 15% cost share Non-Network Provider: 20% cost share plus 100% of covered Excess Charges
INPATIENT CARE in military hospitals	All but the daily subsistence fee	The daily subsistence fee
OUTPATIENT CARE for TRS member and their dependent family members (office visits, clinics, lab, etc.)	Network Provider: 85% of the TRICARE negotiated rate after you pay the TRS deductible Non-Network Provider: 80% of the allowed amount after you pay the TRS deductible	Network Provider: 100% of the TRS deductible of up to $150 individual or $300 family and the 15% cost share Non-Network Provider: 100% of the TRS outpatient deductible and the 20% cost share plus 100% of covered Excess Charges
PRESCRIPTION DRUGS Civilian network pharmacy; up to a 30-day supply	All but co-payments: $10 generic, $24 brand name, or $50 non-formulary	All co-payments
PRESCRIPTION DRUGS Home delivery or mail order; up to a 90-day supply; co-pays based on each 30-day supply	All but co-payments: $20 brand name or $49 non-formulary	All co-payments
PRESCRIPTION DRUGS Civilian non network pharmacy; up to a 30-day supply	All but the TRS deductible and co-payments: $24 generic/brand name, $50 non-formulary, or 20% of total cost, whichever is greater	Co-payments: $24 generic/brand name, $50 non-formulary, or 20% of total cost, whichever is greater and 100% of the TRS outpatient deductible of up to $150 per individual or $300 per family
TRICARE Reverse Select (TRS) Supplement Policy MZ0925783H0000A does not have a plan deductible.		
Note: After you have met your TRICARE Supplement Plan deductible, the plan pays 100% of your approved expenses not paid by TRICARE. **Note:** Benefits are payable for covered cost share amounts up to the TRICARE Catastrophic Cap. The Catastrophic Cap is the maximum out-of-pocket amount you will pay each fiscal year (FY) (October 1- September 30) for TRICARE-covered services. Exclusions may vary by state and underwriter. See your Certificate for complete details. **This is not Medicare Supplement Insurance.** For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.		

Summary of Benefits *(continued)*

There is no deductible for this plan and it covers 100% of the TRICARE Standard deductible or 50% of the TRICARE POS deductible.

Please note that the TRICARE Supplement Plan follows the eligibility requirements of TRICARE. Since this is a Supplement to TRICARE, the rules and procedure of TRICARE must be followed.

Continuation of Coverage

Employees who terminate employment may continue coverage by paying their monthly premiums directly to Selman & Company. A Continuation of Coverage letter will be mailed to the terminating employee within five business days of receipt of the termination date received from the employer.

Premium payments will be offered at the same rates offered through the previous employer. There is no separate administrative fee required.

Continuation of coverage **does not** apply to an employee, spouse, or dependent child who no longer meets the TRICARE Supplement Plan eligibility requirements, e.g., an employee or spouse who attains age 65 and has Medicare as primary coverage or a dependent child who reaches age 21/23 and has not enrolled in the TRICARE Young Adult (TYA) program or is listed in DEERS.

Contact

Customer Service Call Center:	1-800-638-2610, Option 1
	Monday - Friday from 9:00 a.m. - 5:00 p.m. (ET)
	E-mail: memberservices@selmanco.com
	Website: www.selmantricareresource.com

Continuation Coverage (COBRA)

It is important that all covered individuals (employee, spouse, and dependent children) read this notice carefully and understand its contents.

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

The following chart shows the coverage provisions — **except the duration of coverage for the HCFSA, which can only be continued to the end of the plan year**.

Qualifying Event	Qualified Beneficiaries Who May Continue Coverage*	Duration of Coverage	Monthly Cost**
Your employment ends for any reason other than gross misconduct	you, spouse, dependent children	up to 18 months	102%
You lose benefit eligibility due to reduction in hours	you, spouse, dependent children	up to 18 months	102%
During the first 60 days of COBRA coverage, you or your dependent becomes disabled under the Social Security Act	you, spouse, dependent children	up to 29 months: months 1–18 months 19–29	102% 150%
You divorce or legally separate	ex-spouse and/or dependent children	up to 36 months from initial qualifying event	102%
Your dependent children lose eligibility	dependent children	up to 36 months from initial qualifying event	102%
You become covered by Medicare	spouse and/or dependent children	up to 36 months from initial qualifying event	102%
You die	spouse and/or dependent children	up to 36 months from initial qualifying event	102%

** You, your spouse, and your dependent children are only eligible to continue the coverage that you, your spouse, and/or dependent children have on the date of the qualifying life event.*

*** The cost to continue cancer and specified disease coverage is 100% of the monthly premium.*

**** The cost to continue dental or vision coverage is 102% of the contracted premium rate.*

Note: *Under no circumstance may the total amount of continuation coverage exceed 36 months (or to the end of the plan year for the HCFSA) from the initial qualifying life event date.*

Election Process

Under COBRA, you or your covered dependents have the responsibility to inform your Health Benefits Representative (HBR) or benefits department within 60 days of a divorce, a legal separation, a child losing dependent status under the plan, or upon receiving a written Social Security determination letter stating that a qualified beneficiary was disabled at the time of your termination, reduction in hours, or during the first 60 days of your COBRA coverage. If you do not notify your Health Benefit Representative or department within 60 days of these events and before the original 18-month COBRA period expires, then your rights to continuation coverage will end. Your HBR or benefits department has the responsibility to notify the NCFlex carriers of the employee's death, termination of employment, reduction in hours, or upon receiving notice of Medicare entitlement.

After receiving notice of a qualifying event, a COBRA notice and election form will be sent to you by the appropriate carrier. If you are interested in continuing your NCFlex coverage, you must return a completed election form (signed and dated) to the appropriate carrier (address listed on the COBRA notice) within 60 days from the later of the date coverage is lost or from the date of the COBRA notification. If you fail to meet this deadline, your COBRA rights will end.

Premium Payments

There is an initial grace period of 45 days starting with the date you elect continuation coverage to pay any premiums, which are due from the date of the qualifying event to the current month. After the initial 45-day grace period, full premium payments are due on the first day of each month for that month's coverage and must be received no later than 30 days after that due date.

The COBRA payment address and instructions will be included in the COBRA materials you receive from the carrier.

COBRA Ending Date

COBRA coverage continues until the earliest of the following:

- your maximum amount of continuation coverage ends (see chart on page 38);
- the State of North Carolina no longer provides that coverage to any employee under the NCFlex Program;
- your premium for continuation coverage is not paid in full by the due dates listed;
- the qualified beneficiary becomes covered (after the date he/she elects COBRA coverage) under another similar group health plan, which does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have; or
- the qualified beneficiary extends coverage for up to 29 months due to disability, and there has been a final determination that the individual is no longer disabled.

If you or your covered dependents have any questions about your COBRA rights or have changed addresses or marital status, please contact the appropriate carrier (carriers' addresses and telephone numbers are listed on the back of this guide).

Federal Requirements

NCFlex and its carriers administer the dental, vision care and cancer and specified disease benefits, as well as the HCFSA in accordance with the HIPAA Privacy requirements. A HIPAA Privacy Notice is provided to participants by the carriers of each plan and is also available on the www.ncflex.org website.

Notes Page

Time to Choose Your State Health Plan Coverage for 2017!

Open Enrollment:
October 1 – 31, 2016

GET READY TO EN-ROLL WITH THE CHANGES!

What's NEW for 2017

YOU MUST TAKE ACTION. If you don't take action by October 31, 2016, you and any covered dependents will be **automatically enrolled in the Traditional 70/30 Plan**, which will include a NEW employee premium.

The State Health Plan is continuing to offer you these options:

- Consumer-Directed Health Plan (CDHP) 85/15
- Enhanced 80/20 Plan
- Traditional 70/30 Plan

You also continue to have the opportunity to earn wellness premium credits, which reduce your monthly health plan premiums, by completing certain wellness activities.

During Open Enrollment, to change your plan or complete wellness premium credit activities, you must visit **www.shpnc.org** or **www.ncflex.org** and click Enroll Now.

Additional benefit changes

- If you enroll in the Traditional 70/30 Plan, in order to receive coverage without paying the employee premium, you must attest that you are either tobacco-free or will enroll in the QuitlineNC tobacco-cessation program.
- Under the Traditional 70/30 Plan and the Enhanced 80/20 Plan, there are changes to the annual deductible, out-of-pocket maximum and various copays for medical and pharmacy services.
- Beginning Jan. 1, 2017, CVS/caremark will be the pharmacy benefit manager for all health plan options.

For More Information and Help With Making Your Choice

- Watch your mail for the 2017 Open Enrollment Decision Guide which provides more information about your State Health Plan choices.
- Roll on over to **www.shpnc.org** for more information and tools, including a Health Benefits Estimator to help you choose a coverage option, a Rate Calculator, informational videos and more.
- Contact the Eligibility and Enrollment Support Center at **855-859-0966**. During Open Enrollment, the Center will offer extended hours:
  Monday-Friday: 8 a.m.-10 p.m. ET and Saturday: 9 a.m.-3 p.m. ET

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

CONTACT INFORMATION

NCFlex
www.ncflex.org
- NCFlex benefits information
- Claim forms
- Certificates of Coverage

FLEXIBLE SPENDING ACCOUNTS

P&A Group
ncflex.padmin.com
Mail claims to:
17 Court Street, Suite 500
Buffalo, NY 14202
Fax claims to: 1-877-213-8917
Customer Service: 1-866-916-3475
M-F 8 a.m. – 10 p.m. (ET)
- Eligible and ineligible HCFSA and DDCFSA expenses
- Status of HCFSA and DDCFSA claims
- When to expect your reimbursement
- Claim forms may be downloaded from www.ncflex.org

DENTAL

MetLife
www.metlife.com/mybenefits
Mail claims to:
MetLife Dental Claims
PO Box 981282
El Paso, TX 79998-1282
Customer Service: 1-855-676-9441
M-F 8 a.m. – 11 p.m. (ET)
Automated service available 24/7 online at MyBenefits website!
- Find a dentist
- Review plan information and claims
- Print ID cards

VISION

Superior Vision
www.superiorvision.com
11101 White Rock
Rancho Cordova, CA 95670
Fax: 1-800-777-1811
Customer Service: 1-800-507-3800
M-F 8 a.m. – 9 p.m. (ET)
Sat 11 a.m. – 4:30 p.m. (ET)
- Vision care providers (see www.ncflex.org)
- Questions about plan options
- Request ID cards
- Questions about claims or benefits

TERM LIFE INSURANCE / AD&D

Voya
www.voya.com
For Customer Service:
LifeHelp
PO Box 492517
Redding, CA 96049
1-877-464-5111
M-F 9 a.m. – 6 p.m. (ET)
Mail EOI forms to:
ReliaStar Life Insurance Co.
PO Box 20
Mail Stop 4-S
Minneapolis, MN 55440
Fax claims to: 1-612-467-8721
- Voluntary Group Term Life Insurance coverage questions

CANCER & CRITICAL ILLNESS

Allstate Benefits (AB)
(American Heritage Life Insurance Company)
www.AllstateBenefits.com
Mail claims to:
Claims Department
1776 American Heritage Life Drive
Jacksonville,FL 32224-6688
Customer Service: 1-866-232-1517
M-F 8 a.m. – 8 p.m. (ET)
- Cancer/Specified Disease Insurance questions
- Critical Illness questions
- Claim forms may be downloaded from www.ncflex.org

BENEFIT ENROLLMENT

North Carolina's eEnroll System
www.shpnc.org or **www.ncflex.org** and click "Enroll Now"
Customer Service: 1-855-859-0966
M-F 8 a.m. – 5 p.m. (ET)
- Online enrollment inquiries

NCFLEX
STATE INSURANCE PLANS

If you are not interested in any of the NCFlex State Insurance Plans, please help us hold down costs by returning this guide to your Health Benefit Representative.

ncflex.org