



NCFLEX
STATE INSURANCE PLANS

2027

Benefits Guide
for eligible state employees

NCFLEX.ORG

NCFlex Overview

The NCFlex Benefits Program provides a variety of plans to meet the needs of employees and their families. An employee may enroll in any or all of the NCFlex benefits if they work for a state agency, university*, participating community college, or participating charter school for 20 hours or more (30 hours or more for the Disability Plan) per week in a permanent, probationary, or time-limited position. **NCFlex offers the following plans:**

NCFlex Benefits and Other Details	Features	Page
Health Care Flexible Spending Account (HCFA)	- Employees must enroll each year to contribute. - The annual contribution limit is \$3,400 per employee per federal regulation. - Roll over feature – up to \$680 of unused funds roll into the next plan year; minimum of \$25 balance.	6
Dependent Day Care Flexible Spending Account (DDCFSA)	- Employees must enroll each year to contribute. - The annual contribution limit is \$7,500 per household per federal regulation.	9
NCFlex Convenience Card	The card can be used for both the Health Care FSA and the Dependent Day Care FSA.	12
Accident	- Options include Classic or Enhanced. - Pays benefits directly to a covered employee for specific injuries and events resulting from a covered accident. - Both Options include a Wellness Benefit plus Voya Travel Assistance. - The Enhanced Option also includes a Sickness Hospital Confinement Rider.	13
Cancer and Specified Disease	- Options include Low, High, or Premium. - No EOI (Evidence of Insurability) is required to enroll. (EOI is required if there is a lapse in coverage.)	18
Critical Illness	- Options include \$15,000, \$25,000 or \$40,000 in coverage. - No EOI is required to enroll. - Includes a Wellness Benefit and Infectious Disease Benefit Rider. - Enrolled children up to age 26 are covered at no cost.	21
Dental	Options include High, Classic and Low.	24
Vision	Options include Core, Basic and Enhanced. The Core Option is free for employees; the Basic and Enhanced Options offer family coverage.	27
Group Term Life*	- For newly eligible employees, EOI is not required to enroll for amounts up to \$200,000. - Spouse and child coverage available.	31
Core Accidental Death & Dismemberment (AD&D)*	- If elected, \$10,000 of coverage is provided to the employee at no cost. - Coverage includes Voya Travel Assistance.	34
Voluntary Accidental Death & Dismemberment (AD&D)*	- Pays benefits if an employee (or their covered dependents) suffers a loss (death or dismemberment) as a result of a covered accident. Coverage of \$50,000 up to \$500,000 available. - Coverage includes Voya Travel Assistance.	36
Disability*	- For newly eligible employees, EOI is not required to enroll. - This is employee only coverage.	40
TRICARE Supplement	To enroll, an employee must be a retired uniform service member and have TRICARE Select, Prime, or TRR benefits.	51
Coverage Continuation Options at Termination	Employee options to continue certain benefits after coverage ends.	53
Contact Information	Vendor contact information for employees.	56

* University employees are not eligible for the NCFlex Voluntary Disability, Group Term Life, or Accidental Death and Dismemberment Plans.

NCFlex Advantages

Here are key advantages of participating in NCFlex:

- **Two Ways to Save:** First, we are able to offer benefits at lower group rates because the number of NCFlex-eligible employees gives us greater bargaining power, and this saves employees money. Second, the premiums for the insurance coverages and contributions employees make to the flexible spending accounts (FSAs) are deducted from their pay on a **pre-tax** basis, which can save employees 25-40% in taxes, depending on their tax bracket.
- **Flexibility:** Employees can sign up for any of the benefits offered through NCFlex. Then, each year during annual enrollment, employees can decide if they want to participate for the next year.

Note: The State of North Carolina is the employer of the NCFlex program.

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 plans. The State reserves the right to amend or terminate the plans or any benefits under the plans at any time. This guide is only a summary of the benefit plans. An employee may review and/or obtain a copy of the Certificates of Coverage by accessing our website at ncflex.org.

Benefits Resources

The State of North Carolina offers a variety of benefits that can help employees meet their health and financial goals. These include:

- Numerous pre-tax voluntary benefits under NCFlex
- Medical coverage through the State Health Plan
- Retirement benefits

This Benefits Guide, the employee Enrollment Guides (university and non-university), and the NCFlex website (ncflex.org) provide an overview of the available pre-tax NCFlex benefits. To view current NCFlex benefits elections, employees can go to the online enrollment system by clicking *Enroll Now* on ncflex.org.

To obtain information on other benefits or for help in making NCFlex elections, employees may visit the websites listed below.

Employees who want information about benefits specific to their state agency, university, participating community college, or participating charter school, should contact their local Health Benefit Representative (HBR) or Human Resources Department.

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

How to Enroll

Employees have two ways to enroll:



Go online to ncflex.org and click the *Enroll Now* button. To log in, the employee should:

- Click the button for their enrollment system. If the employer is not listed, select the "eBenefits" button or contact their HR representative for assistance.
- Once logged in, the enrollment system will walk the employee through the steps to enroll.



Call the eligibility and enrollment call center at 855-859-0966 or 833-862-1490 for employees of the University System. Find hours of operation on the [back of this guide](#).

Please note, employees of the University System use a separate platform when enrolling for NCFlex benefits. The Empyrean platform can be linked for their institution from the enrollment page on the UNC System Human Resources site at myapps.northcarolina.edu/hr/benefits-leave/health-and-welfare-benefits/health-benefits-enrollment.

Eligibility

Eligibility and Effective Date

Employees are eligible to participate in any or all of the NCFlex benefits if they are actively employed with a state agency, university, participating community college, or participating charter school for 20 hours or more per week in a permanent, probationary, or time-limited position.*

**Applies to all benefits except the NCFlex Voluntary Disability, Group Term Life, or Accidental Death and Dismemberment Plans. To be eligible for the Disability Plan, an employee must work 30 hours or more per week. Employees of The University of North Carolina and any constituent institution are not eligible for the NCFlex Voluntary Disability, Group Term Life, or Accidental Death and Dismemberment Plans.*

Benefits elections made during annual enrollment will begin on January 1 of the following year. **Newly eligible employees must enroll within 30 days of their employment date. Coverage begins the first day of the month following the date of hire.***

Any expenses or claims incurred prior to an employee's effective date of coverage or after an employee's plan termination date will not be eligible for reimbursement.

**For the Voluntary Disability Plan, coverage is effective on the first day of the month following enrollment in the plan. However, if an employee enrolls in the plan on the first day of the month, the effective date will be that day.*

Dependent Eligibility

Coverage for eligible dependent(s) is available for most NCFlex benefits (see the specific benefits section for details). Eligible dependents are defined as the employee's:

- Legally married spouse.
- Any child, including natural, stepchild, or adopted child, until the end of the month in which the child turns age 26, including:
 - The employee's child who is dependent on him/her for support and maintenance. The child does not need to be claimed as a dependent on the employee's federal income tax return.
 - A child for whom the employee has legal obligation for purposes of adoption.
- Any child, including stepchild, of any age who is unable to make a living because of a mental or physical disability.*

For Accident, Critical Illness, Life, and AD&D, dependents also must meet the following requirements to be covered:

- The employee's unmarried child less than 26 years of age. This includes the employee's natural, stepchild, or adopted child who is dependent on the employee for support and maintenance. The child does not need to be claimed as a dependent on the employee's federal income tax return.

Important Considerations:

- An employee must be enrolled in a plan for their eligible dependent(s) to participate.
- An employee may not be covered as both an employee and a dependent and children may not be dually enrolled.
- Employees should consult with their tax advisor if they have questions as to whether someone qualifies as an income tax dependent.
- Dependents do not have to be enrolled on the employee's health plan in order to be enrolled on their NCFlex plan(s).

Note: Some exceptions apply when noted in specific benefit sections.

For the HCFSA employees 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 the employee, and for whom the employee provides 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 9** for details.

**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 they are incapable of earning a living and such disability developed or began to develop before the dependent's 26th birthday if the dependent was covered by the NCFlex plan for which the employee wants to continue coverage.*

Life Events

If an employee has a qualified life event (also referred to as a family or employment status change), it is the employee's responsibility to log onto the benefits enrollment platform and make appropriate changes within 30 days. See the *Changing Elections During the Year* on **page 5** for details. More detailed life events information is also available at ncflex.org.

Changing Elections During the Year

Qualifying Life Events

Each year during annual enrollment employees can choose to participate in any or all of the NCFlex benefits they are eligible for. Once employees have made their elections, they **cannot add, change or cancel their elections during the year unless they have a qualifying life event — a change in family or employment status.**

Qualifying life events include, but are not limited to:

- Marriage
- Divorce or legal separation
- Birth or adoption (or placement for adoption) of a child
- Death of a covered dependent
- Unpaid leave of absence
- Change in the spouse's employment that impacts the employee's benefits eligibility
- A dependent turns age 26
- Legal guardianship
- Court order
- Reduction in hours

For more details about qualifying life events, visit the Qualifying Life Events page on [ncflex.org](https://www.ncflex.org).

To change benefit elections, an employee must log onto the benefits enrollment platform and make changes within 30 days of the event. Valid changes to elections are effective on the first day of the month following the date of the life event.* **For most life events, the employee will be required to provide documentation to verify the change.**

The changes the employee wants to make 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, an employee cannot switch from the Dental Low Option PPO to the Dental High Option PPO, or vice versa.)

**For the Voluntary Disability Plan, coverage is effective on the first day of the month following the employee's enrollment in the plan. However, if an employee enrolls on the first of the month, coverage will be effective on that date.*

***If an employee is enrolled in the Core Vision Plan and has a qualifying life event that allows him/her to add family members to their plan, they may be allowed to change options during the plan year.*

Non-Qualifying Life Events

If any events other than those listed under "Qualifying Life Events" occur, employees should check with their HBR to see if they may make changes to their NCFlex coverage during the year.

Some examples of events that do not allow employees to change NCFlex elections are:

- The employee is re-hired within 30 days of termination date.
- The benefit cost is too high/the employee did not realize how much was going to come out of their paycheck.
- An employee decides they don't like the coverage.

Transfers

The State of North Carolina is the employer of the NCFlex program. When an employee transfers between a state agency, university, participating community college, or participating charter school, they cannot make changes to benefit elections or elect new benefit options*. Employees must transfer their existing NCFlex benefits to the new work location. **The employee must check the online enrollment system to ensure benefits have transferred.**

**If transferring from a university to a non-university, employees are eligible to enroll in the NCFlex plans not offered by the university.*

Limitation Affecting Increases to Spending Account Elections

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

Deduction Corrections and Bank Account Changes

- An employee should review their pay stub to make sure the deductions are correct. If deductions are incorrect on the pay stub, the employee should contact their HBR or benefits department immediately.
- If an employee changes banks or bank accounts during the year, they will need to notify their HBR or benefits department so that reimbursements will be credited to the correct account.



Employees **MUST**
ENROLL in the
HCFSAs each year.

Health Care Flexible Spending Account

A Health Care Flexible Spending Account (HCFSAs) helps an employee save money on taxes by paying for eligible out-of-pocket medical, dental, vision, or other qualifying expenses for the employee and their eligible dependents (as defined by the IRS) with pre-tax dollars.

The maximum amount an employee can contribute is \$3,400 and the minimum amount is \$120 (as determined by the IRS). Employer payroll units deduct an employees' annual contribution amounts (in equal portions) from their paychecks throughout the plan year. However, an employee's entire annual election amount is available to him/her on the first day of the plan year or the first day benefits become effective. Participants of the plan can roll over up to \$680 of unused account balances into the next plan year, as long as they have a minimum balance of at least \$25. Learn more about the order rollover funds are used on the next page.

Employees who enroll in the HCFSAs will receive a debit card, the NCFlex Convenience Card. The card makes it easy to access the funds in the HCFSAs. See [page 12](#) for more information.

HCFSAs Rollover Feature

If an employee participated in the HCFSAs in 2026, up to \$660 of the unused account balance from 2026 will roll over to pay eligible expenses in 2027 as long as they have a minimum balance of \$25. If an employee did not re-enroll in the FSA for 2027, they cannot make new contributions but may still use these rollover funds. This rollover feature only applies to the HCFSAs, not to the DDCFSAs.

For the 2027 plan year, expenses must be incurred between January 1 and December 31, 2027, to be eligible for reimbursement. Employees have until March 31, 2028, to submit claims for reimbursement. Employees can roll over up to \$680 of unused account balances into 2028 as long as they have a minimum balance of \$25. Any funds exceeding this amount will be forfeited.

Eligible and Ineligible Expenses

Go to [ncflex.org](https://www.ncflex.org) for a sample list of eligible and ineligible expenses. To access the IRS list of expenses, visit [irs.gov/publications/p502](https://www.irs.gov/publications/p502).

Eligible Health Care Expenses*

Employees may use the HCFSAs for reimbursement of the following out-of-pocket health care expenses incurred during the plan year:

- Deductible(s) and copayments for the employee's health plan or their qualifying relative's plan.
- Coinsurance for any medical or dental bills after the deductible is met.
- Any amount employees are required to pay after reaching the maximum benefit under a medical or dental plan.

- Over-the-counter medicines — no prescription needed. Vitamins and supplements are not included in over-the-counter medications but may be covered with a physician's prescription.
- Other allowable expenses including but not limited to:
 - Dental expenses
 - Hearing aid and its batteries
 - Infertility treatment
 - Menstrual items
 - Insulin and diabetic supplies
 - Mileage (\$0.21 per mile for 2027) to/from medical provider's office for treatment (For up-to-date rates, go to [irs.gov](https://www.irs.gov).)
 - Orthodontia
 - Prescription drugs
 - Refractive surgery (RK, PRK, LASIK)
 - Smoking cessation programs
 - Medical supplies
 - Tuition at a special school or specially trained tutor for disabled children
 - 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
 - Personal care items such as sunscreen (SPF 15+), bandages, shoe insoles, inserts, and cushioning

** Some health care expenses may require a letter of medical necessity written by an authorizing physician. There is a standard form available at [ncflex.org](https://www.ncflex.org) that an employee's physician can complete.*

Ineligible Health Care Expenses

Medical, dental, and other premiums cannot be reimbursed through the HCFSAs. In addition, elective cosmetic procedures and similar expenses are not allowable expenses according to the IRS. Common ineligible expenses include:

- 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 teeth.

Shop for Eligible Expenses Online at the FSA Store — and Save!

Employees can experience convenience and savings when they shop at the FSA Store, a one-stop shop that offers significant discounts on thousands of pre-approved eligible FSA products. The NCFlex Convenience Card can be used to purchase these items. Visit ncflex.padmin.com to access the FSA Store today!

How to Submit FSA Claims

The Health Care and Dependent Day Care FSAs are administered by P&A Group. Employees have several claim submission options:

- 1 From a Smartphone or device:** Take a picture of the receipt or documentation. Download the **P&A Group mobile app** and log in. Go to the menu and tap **Upload Claim/Documentation** to submit claims **OR** log into ncflex.padmin.com from the web browser and follow the prompts.
- 2 From a computer:** Log into the P&A Account at ncflex.padmin.com. Go to **Member Tools > Upload Claim > New Claim**.
- 3 By fax or mail:** Go to ncflex.padmin.com to access the FSA claim form. When submitting a paper claim the employee must attach an itemized, third-party receipt or the insurance company Explanation of Benefits (EOB) form.
Fax: 877-213-8917
Mail: Attn: NC FSA Plan
6400 Main Street, Suite 201
Williamsville, NY 14221

If a claim is reimbursable by a medical, dental, or vision plan, the employee will need to file a claim with that plan first.

Claim Reimbursements

Claims are processed each day, with the exception of holidays. Reimbursements are issued Monday through Friday. The next business day after the claim was adjudicated a reimbursement will be issued to the bank account on file. Depending on how long the banking institution takes to process the payment, it may take an additional 2 to 4 days for the payment to appear in the participant's account. If P&A Group has the employee's e-mail address, they will automatically notify him/her when the claim is received and again when it is paid.

Employees may choose to pay for eligible health care expenses using the NCFlex Convenience Card. See *NCFlex Convenience Card* on [page 12](#) for more information.

Claim reimbursement is based on the date an employee receives eligible expenses, not the date they pay the invoice or the billing date, which must be between January 1, 2027 (the plan effective date) and December 31, 2027, provided the employee remains in the plan for all of 2027.

With the HCFSAs an employee can be reimbursed for the entire claim up to their plan-year election minus any previous claim reimbursements, even if that amount has not yet been deducted from pay. **FSA reimbursements are made by direct deposit. If an employee changes banks or switches accounts, they need to notify their HBR or benefits department to avoid payment delays.**

During the plan year, claims are paid in this order:

- 2026 rollover funds are used to pay any 2026 claims, up to the March 31, 2027 claims deadline for 2026 expenses. Any remaining funds can then be used for 2027 claims.
- 2027 plan year contributions will be used for 2027 claims *before* using 2026 rollover funds.

Termination of Employment

If an employee terminates employment or coverage during the plan year, they may submit claims for services incurred before the coverage termination date. **Services incurred after the coverage termination date cannot be reimbursed unless the employee elects to continue coverage under COBRA.** In accordance with IRS regulation, any unused money in an employee's account is forfeited and remains with the state.

Can a Spouse Have a Health Savings Account (HSA) if an Employee Has an HCFSAs?

If an employee is enrolled in the HCFSAs, their spouse cannot make or receive tax-favored HSA contributions. This is because the HCFSAs are available to reimburse the qualified expenses of the employee and the employee's spouse and dependents, so a spouse's contributions to an HSA would violate IRS rules.

Contributions that are made by or on behalf of an individual who is HSA-eligible are considered "excess contributions" and a 6 percent excise tax is imposed on the HSA owner for all excess contributions.

HCFSA Worksheet

Employees can use this worksheet to calculate the amount they want to contribute to the HCFSA for out-of-pocket expenses for the upcoming plan year. The HCFSA worksheet is also available online by visiting ncflex.org.

Step 1 Based on records for the past few years, fill in the anticipated eligible expenses.

- If the expense is paid by a health care plan, enter the copayment and any deductible. For members enrolled in the State Health Plan, visit aetna.com to view current and prior year expenses. Members enrolled in the NCFlex Dental or Vision Plans can visit the vendor online portals found on ncflex.org to view prior year out-of-pocket costs.
- If the expense is not covered by the health care plan, enter the entire cost.

Step 2 Add up the total annual expenses for the employee and their family (A + B + C = D).

Step 3 Enter the amount (D) in the online enrollment system.

Cost For:	Employee	For Spouse	For Children
Medical plan deductibles	\$ _____	\$ _____	\$ _____
Medical plan copayments	\$ _____	\$ _____	\$ _____
Prescription drug copayments	\$ _____	\$ _____	\$ _____
Routine physicals/exams	\$ _____	\$ _____	\$ _____
Dental care/orthodontia	\$ _____	\$ _____	\$ _____
Vision care	\$ _____	\$ _____	\$ _____
Hearing care	\$ _____	\$ _____	\$ _____
Health services/supplies	\$ _____	\$ _____	\$ _____
Other eligible expenses	\$ _____	\$ _____	\$ _____
Total Annual Health Care Expenses	(A) \$ _____	+ (B) \$ _____	+ (C) \$ _____
Annual Election (A + B + C = D)	D) \$ _____		

(Enter amount D in the benefits enrollment platform)

Example of Tax Savings When Using an FSA

Annual Savings Example	With FSA	Without FSA
Annual Income	\$50,000	\$50,000
Annual Pre-Tax FSA Contribution	- \$2,000	- \$0
Annual Taxable Income	= \$48,000	= \$50,000
Annual Tax Withholdings (approximately 30% of the annual taxable income)	\$14,400	\$15,000
Total Annual Savings (approximately \$300 for every \$1,000 withheld in the FSA per year)	\$600	\$0

Tax Considerations

The HCFSA is based on current tax laws. Employees should keep in mind the following tax considerations before participating in the HCFSA:

- Plan participation may affect future Social Security retirement benefits. This could happen if an employee's 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 employees may contribute to a 401(k), 403(b), or 457 retirement plan.
- An employee cannot claim the same expenses through the HCFSA and on their tax return. Currently, only health care expenses over 10% of adjusted gross income are deductible for income tax purposes. But with the HCFSA, employees can save taxes immediately on the very first dollar not reimbursed by the health care plan.

Note: Check the IRS website for the latest information. Employees should consult their tax advisor on these issues as well as whether someone qualifies as an income tax dependent.

Dependent Day Care Flexible Spending Account



An employee **MUST ENROLL** in the DDCFSA each year.

The Dependent Day Care Flexible Spending Account (DDCFSA) offers employees a tax-free way to pay themselves back for eligible dependent care expenses throughout the year. An employee can contribute between \$120 and \$7,500 each plan year to the DDCFSA to pay for dependent day care and elder care expenses on a pre-tax basis if both the employee and their spouse work, the spouse goes to school full-time, or the spouse isn't able to care for himself or herself. The spouse may also be unemployed but actively looking for work. If the spouse works part-time, the employee's election cannot be greater than either the employee's annual income or their spouse's annual income, whichever is lower. The IRS sets the maximum contribution, which is **\$7,500 per family, per year**.

Qualifying Family Members

Eligible day care expenses may be reimbursed for:

- A "qualifying child" under age 13 for whom the employee is the legal guardian and who has the same principal residence as the employee 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.
- A qualifying child (as defined above) of any age, spouse, or other dependent (e.g., a disabled elderly parent), who is physically or mentally incapable of caring for himself or herself and has the same principal place of residence as the employee for more than one-half of the year and who receives over one-half of his or her support from the employee. To reimburse day care received outside of the home, a disabled dependent must spend at least eight hours per day in the employee's home.

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

Note: An employee should consult with a tax advisor if they have questions about whether someone qualifies as an income tax dependent.

To contribute, employees must enroll in this plan each year.

How to Use the DDCFSA

An employee can contribute from \$120 to \$7,500 pre-tax each plan year, subject to the following legal limits:

- The \$7,500 maximum applies to all contributions an employee and their spouse make to any DDCFSA during the calendar year, whether through NCFlex or another employer.

- If an employee and their spouse file a joint income tax return, the employee may contribute up to \$7,500 for the year, regardless of the number of eligible dependents they have.
- If an employee and their working spouse file separate income tax returns, the maximum annual contribution is \$3,750.

When an expense qualifies for reimbursement, an employee can either use the NCFlex Convenience Card to pay for the expense or submit a claim with any necessary documentation to receive a tax-free reimbursement. To learn more about how to file a claim, see *How to Submit FSA Claims* on [page 7](#).

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

Claim Reimbursements

Claims are processed each day, with the exception of holidays. Reimbursements are issued Monday through Friday. The next business day after the claim was adjudicated a reimbursement will be issued to the bank account on file. Depending on how long the banking institution takes to process the payment, it may take an additional 2 to 4 days for the payment to appear in the participant's account. If the employee provides P&A Group an e-mail address, they will automatically notify him/her when the claim is received and again when it is paid.

Claim reimbursement is based on the date the dependent day care service is received, not the date the invoice is paid or the date of billing. For the 2027 plan year, expenses must be incurred January 1, 2027, through March 15, 2028, to be eligible for reimbursement. An employee has until March 31, 2028, to submit claims for reimbursement. **An employee will be reimbursed up to the available balance in their DDCFSA on the processing date. The available balance is equal to the amount the employee has actually contributed to their account (via payroll deductions) minus any previous claim reimbursements. Any unused funds will be forfeited.**

When an employee enrolls in the DDCFSA, they will receive a claims kit containing a claim form and the procedures they need to follow when filing a claim.

NCFlex Convenience Card

An employee can use the NCFlex Convenience Card to pay for eligible dependent care expenses, up to the amount payroll deducted and available in the account.



Eligible and Ineligible Expenses

Go to [ncflex.org](https://www.ncflex.org) for a complete listing of eligible and ineligible DDCFSA expenses, which can be found under the *Flexible Spending Account* section.

Eligible Dependent Day Care Expenses

The employee can be reimbursed through the 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 the employee's tax dependent or child if under age 19 as of the end of the calendar year.
- Payments (in lieu of regular day care) to day camp (e.g., soccer, computers, etc.), but not overnight camps.

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 the employee and their spouse are not working (except for short temporary absences like vacation and minor illnesses).
- Expenses for overnight camps.
- Virtual camps.
- Transportation fees.
- Prepayment for services not received while covered.
- Late payment fees.

Plan Carefully

Employees should carefully consider their contributions to the DDCFSA. **Under IRS regulations, any money remaining in an employee's account after the deadline to submit eligible claims — March 31, 2028 — will be forfeited.**

Termination of Employment

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

**Only pertains to the Dependent Day Care FSA.*

Important Issues

If both the employee and their spouse contribute to this plan or to a similar plan where he or she works, the IRS only allows a maximum family contribution of \$7,500 per calendar year.

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

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

- If an employee's spouse is a full-time student or totally disabled, they are treated as having income of \$250* a month (\$500* a month if two or more dependents receive dependent day care). If the spouse is actively looking for work, their income for the year must exceed the employee's DDCFSA annual election.
- If the employee is considered highly paid by the IRS (earning over \$160,000* in the previous plan year of 2026 and indexed for inflation in future years), the pre-tax dependent day care election may need to be adjusted based on the results of IRS non-discrimination tests. The employee will be notified if affected.
- An employee who is divorced or legally separated must have legal custody of the child for over half the year to participate in the DDCFSA.

**This amount is subject to the Internal Revenue Service (IRS)'s cost of living adjustment and may be indexed annually.*

DDCFSA Worksheet

Employees can use this worksheet to identify dependent day care out-of-pocket expenses for the upcoming plan year. The DDCFSA worksheet is also available online at [ncflex.org](https://www.ncflex.org).

To get an idea of dependent day care expenses, an employee should review records for the past few years. Using this information, add any new types of expenses anticipated and complete the following worksheet:

Upcoming Plan Year

Child care (children under age 13)	\$ _____
Dependent adult day care	\$ _____
Day camp (not overnight camp)	\$ _____
Cost for preschool (prior to kindergarten)	\$ _____

Total Annual Expenses: = \$ _____

Annual Election

(Enter amount in the benefits enrollment platform) = \$ _____

Example of Tax Savings When Using a DDCFSA

Without DDCFSA		With DDCFSA	
Gross Annual Pay	\$50,000	Gross Annual Pay	\$50,000
Tax Rate (30%)	-\$15,000	Annual Dependent Care FSA Contribution	- \$5,000
Net Annual Pay	= \$35,000	Adjusted Gross Pay	= \$45,000
Annual Dependent Care Expenses	- \$5,000	Tax Rate (30%)	- \$13,500
Final Take-Home Pay	= \$30,000	Final Take-Home Pay	= \$31,500
Take home this much more when a DDCFSA is used			\$1,500

Tax Considerations

The DDCFSA is based on current tax laws. Employees should keep in mind the following tax considerations before participating in the DDCFSA:

- An employee may prefer to use dependent day care expenses to claim a Child Care Credit when filing federal and state income tax returns.
- The law permits an employee to use the Child Care Credit and the DDCFSA but not for the same expense. (The Child Care Credit is reduced dollar-for-dollar by any amount claimed through the DDCFSA.)
- The spending account is an alternative way to save taxes for employees who may prefer not to file for the Child Care Credit or who would receive greater tax savings through the DDCFSA.



Use card for eligible
HCFSA and DDCFSA
expenses.

NCFlex Convenience Card

Employees who enroll in the HCFSA or DDCFSA will automatically receive an NCFlex Convenience Card to use for either or both accounts, at no cost.

If an employee is new to the plan and this is the first time they receive a card, the card will automatically be activated upon first use.

How It Works

The NCFlex Convenience Card automatically checks the employee's account for available funds. Anytime an employee incurs an eligible HCFSA or DDCFSA expense with a vendor that accepts credit cards, they can swipe the NCFlex Convenience Card at the point-of-service and the expense will be deducted from the employee's account. **Note: DDCFSA elections are available on the card as payroll deductions occur.**

In some situations, the employee may have to pay out of pocket for eligible expenses and submit a claim to P&A Group when there are not enough DDCFSA funds available on the card. Employees can check their account balance at any time by logging into their P&A account at ncflex.padmin.com or the **P&A Group mobile app**, or by calling the number on the card.

- As a reminder, the IRS may require P&A to obtain a receipt or documentation to process certain convenience card transactions and to ensure the card is being used for eligible expenses only. Employees may be asked to provide additional documentation of a purchase, so they need to keep their receipts.
- **If an employee does not submit requested receipts/ documentation within 40 days of the transaction date, their card will be turned off (or blocked) automatically and future claims may be used to offset the transaction.**

Claim Submission Methods

If a provider doesn't accept debit or credit cards, please review *How to Submit Claims* in the HCFSA section of this guide on [page 7](#).

How to Sign up

If this is an employee's first time enrolling in the HCFSA or DDCFSA, they will receive a card in the mail after enrolling. The NCFlex Convenience Card is automatically activated upon first use.

Remember, cards are good through the expiration date on the card and will NOT be automatically re-issued each January. If an employee already has an NCFlex Convenience Card, they should not throw it away! An employee's HCFSA annual election amount will be loaded onto the existing card each new plan year. The DDCFSA election will be loaded in equal amounts upon each payroll deduction.

Additional Cards

Employees may order additional cards for themselves, their spouse, or dependents (over 18 years of age) free of charge. Employees can order additional cards by logging into their account at ncflex.padmin.com or the **P&A Group mobile app**, or by calling **866-916-3475**.

How to Check the Account Balance

An employee can view their account balance directly from a smart phone, mobile device, or computer by going to ncflex.padmin.com or the **P&A Group mobile app**, and logging into their account to access up-to-date account information. Employees can check a balance over the phone by calling P&A Group's customer service team at **866-916-3475** to speak with a representative.

An employee can also sign up to receive account balance information via text message. The employee should update their online P&A Account profile at ncflex.padmin.com with their mobile number. Once the profile is updated, the employee can text the word BAL to the number 70626 to receive a text message with account balance information anytime, anywhere.



**Wellness Benefit
Included!**

Accident

NCFlex offers an Accident Plan that pays benefits for specific injuries and events resulting from a covered accident that occurs on or after an employee's coverage effective date. The benefit amount depends on the type of injury and care received. Employees can choose between two plan options: the Classic Option and the Enhanced Option. Employees can also choose who to cover: employee only, employee plus spouse, employee plus child(ren), or employee plus family.

The Accident Plan is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid directly to the employee and are paid in addition to any other insurance they may have.

How Can the Accident Plan Help?

The Accident Plan can help an employee pay for:

- Medical expenses, such as deductibles and copays
- Home health care costs
- Lost income due to lost time at work
- Everyday expenses, like utilities and groceries

Monthly Cost

All employees pay the same rate, no matter their age.

Coverage Level	Classic Option	Enhanced Option
Employee Only	\$6.94	\$15.98
Employee and Spouse	\$11.50	\$28.46
Employee and Child(ren)	\$13.64	\$31.26
Employee and Family	\$18.20	\$43.72

Note: An employee may not be covered as both an employee and a dependent. Also, dependent children may not be covered under both parents' plans if the employee and their spouse are eligible to elect coverage as employees.

24/7 Coverage and Additional Benefits:

The Accident Plan covers members 24/7 for accidents on or off the job and pays in addition to other benefits. If employees choose the Enhanced Option they get higher payments for injuries and care, as well as access to the **Wellness Benefit*, Sickness Hospital Confinement Benefit*, and Travel Assistance services***.

*Details on these additional benefits can be found on [page 15, 16, and 17](#). The Wellness Benefit and Travel Assistance services are available on both the Classic and Enhanced Option Plans.

What Accident Benefits are Available?

The following list is a summary of the benefits provided by the Accident Plan. For a complete description of the available benefits, exclusions, and limitations, see the certificate of insurance and any riders, which are available at ncflex.org.

In addition to what is listed below, also included in the Accident Plan coverage is the Sports Accident Benefit. If a covered accident occurs while participating in an organized sporting activity as defined in the certificate, the Accident Hospital Care, Accident Care, or Common Injuries benefit will be increased by 25% to a maximum additional benefit of \$1,000. If the employee's spouse and/or children are/is covered under the Accident Plan, their coverage includes this benefit.

Event	Classic Option	Enhanced Option
Accident Care		
Initial doctor visit	\$100	\$120
Emergency room treatment	\$300	\$400
Ground ambulance	\$360	\$600
Air ambulance	\$1,500	\$2,500
Follow-up doctor treatment	\$100	\$120
Medical equipment	\$120	\$500
Physical or occupational therapy (per treatment up to 10)	\$60	\$75
Speech therapy up to 6 per accident	\$60	\$75
Prosthetic device (one)	\$750	\$1,500
Prosthetic device (two or more)	\$1,200	\$2,400
Major diagnostic exam	\$240	\$500
X-ray	\$75	\$100
Chiropractic treatment	N/A	\$75 (per visit)
Outpatient surgery (once per accident)	N/A	\$300
Common Injuries		
Emergency dental work (crown)	\$480	\$525
Emergency dental work (extraction)	\$90	\$180
Eye injury (removal of foreign object)	\$100	\$120
Eye injury (surgery)	\$350	\$420
Torn knee cartilage surgery no repair or if cartilage is shaved	\$225	\$280
Torn knee cartilage surgical repair	\$800	\$1,000
Laceration ¹ treated no sutures	\$60	\$80
Laceration ¹ sutures up to 2"	\$100	\$120

¹ Laceration benefits are a total of all lacerations per accident.

Event	Classic Option	Enhanced Option
Laceration ¹ sutures 2" - 6"	\$240	\$480
Laceration ¹ sutures over 6"	\$480	\$960
Ruptured disk surgical repair	\$800	\$1,000
Tendon/ligament/rotator cuff exploratory arthroscopic surgery/no repair	\$720	\$900
Tendon/ligament/rotator cuff one, surgical repair	\$1,020	\$1,275
Tendon/ligament/rotator cuff two or more, surgical repair	\$1,520	\$1,900
Concussion	\$450	\$525
Paralysis – paraplegia	\$16,000	\$20,000
Paralysis – quadriplegia	\$24,000	\$30,000
Burns 2nd degree, at least 36% of the body	\$1,250	\$1,750
Burns 3rd degree, at least 9 but less than 35 square inches of the body	\$7,500	\$10,000
Burns 3rd degree, 35 or more square inches of the body	\$15,000	\$22,000
Skin grafts	25% of the burn benefit	50% of the burn benefit
Fractures	Closed/open reduction²	
Hip	\$5,000/\$10,000	\$6,000/\$12,000
Leg	\$2,800/\$5,600	\$3,500/\$7,000
Ankle	\$2,500/\$5,000	\$3,125/\$6,250
Kneecap	\$2,500/\$5,000	\$3,125/\$6,250
Foot excluding toes, heel	\$2,500/\$5,000	\$3,125/\$6,250
Upper arm	\$2,750/\$5,500	\$3,500/\$7,000
Forearm, hand, wrist except fingers	\$2,500/\$5,000	\$3,125/\$6,250
Finger, toe	\$400/\$800	\$500/\$1,000
Vertebral body	\$4,200/\$8,400	\$5,250/\$10,500
Vertebral processes	\$2,000/\$4,000	\$2,500/\$5,000
Pelvis except coccyx	\$4,000/\$8,000	\$5,000/\$10,000
Coccyx	\$500/\$1,000	\$625/\$1,250
Bones of the face except nose	\$1,400/\$2,800	\$1,750/\$3,500
Nose	\$750/\$1,500	\$950/\$1,900
Upper jaw	\$1,750/\$3,500	\$2,200/\$4,400
Lower jaw	\$2,000/\$4,000	\$2,500/\$5,000
Collarbone	\$2,000/\$4,000	\$2,500/\$5,000
Rib or ribs	\$600/\$1,200	\$750/\$1,500

Event	Classic Option	Enhanced Option
Skull – simple except bones of face	\$1,750/\$3,500	\$2,200/\$4,400
Skull – depressed except bones of face	\$5,000/\$10,000	\$6,250/\$12,500
Sternum	\$500/\$1,000	\$625/\$1,250
Shoulder blade	\$2,500/\$5,000	\$3,125/\$6,250
Chip fractures	25% of the closed reduction amount	25% of the closed reduction amount
Dislocations	Closed/open reduction³	
Hip joint	\$4,000/\$8,000	\$5,000/\$10,000
Knee	\$3,000/\$6,000	\$3,750/\$7,500
Ankle or foot bone(s) other than toes	\$1,800/\$3,600	\$2,250/\$4,500
Shoulder	\$2,200/\$4,400	\$2,750/\$5,500
Elbow	\$1,500/\$3,000	\$1,875/\$3,750
Wrist	\$1,500/\$3,000	\$1,875/\$3,750
Finger/toe	\$350/\$700	\$450/\$900
Hand bone(s) other than fingers	\$1,500/\$3,000	\$1,875/\$3,750
Lower jaw	\$1,500/\$3,000	\$1,875/\$3,750
Collarbone	\$1,500/\$3,000	\$1,875/\$3,750
Partial dislocations	25% of the closed reduction amount	25% of the closed reduction amount
Accident Hospital Care		
Surgery open abdominal, thoracic	\$1,250	\$2,500
Surgery exploratory or without repair	\$350	\$500
Blood, plasma, platelets	\$600	\$650
Hospital admission	\$1,250	\$2,000
Hospital confinement per day, up to 365 days	\$200	\$300
Critical care unit confinement per day, up to 30 days	\$400	\$500
Coma duration of 5 or more days	\$10,000	\$20,000
Transportation per trip, up to 3 per accident	\$750	\$840
Lodging per day, up to 30 days	\$180	\$225

¹ Laceration benefits are a total of all lacerations per accident.

² Closed Reduction of Fracture = Non-surgical. Open Reduction of Fracture = Surgical.

³ Closed Reduction of Dislocation = Non-surgical reduction of a completely separated joint. Open Reduction of Dislocation = Surgical reduction of a completely separated joint.

Wellness Benefit (Both Classic and Enhanced Options)

The Wellness Benefit is included in both Accident Plan options. If the employee completes an eligible health screening test, they are eligible for a Wellness Benefit payment. The health screening test must occur on or after the coverage effective date. If the employee's spouse and/or children are covered under their Accident Plan, they're also eligible for this benefit payment for a covered health screening.

Only one benefit is payable per covered member per calendar year, regardless of how many screenings are completed by that member.

Covered Member	Wellness Benefit available once per year with a covered screening:
Employee	\$50
Spouse	\$50
Child	\$25

What types of health screening tests are eligible?

Health screening tests include, but are not limited to:

- Blood tests for triglycerides
- Pap smear or thin prep pap test
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Hearing test
- Routine eye exam
- Routine dental exam
- Well child/preventative exams through age 18
- Biometric screenings
- Electrocardiogram (EKG)
- Annual Physical Exam – Adults
- CA 125 (ovarian cancer)
- Tests for sexually transmitted infections (STIs)
- Ultrasound screening for abdominal aortic aneurysms
- Hemoglobin A1C (HbA1c)
- Bone density screening
- COVID-19 test

Voya Travel Assistance (Classic and Enhanced Options):

Voya Travel Assistance* offers a covered employee and their covered dependents enhanced security for their leisure and business trips when traveling 100 miles or more from their primary residence.

- **Emergency Medical Transport Services**
- **Medical Assistance Services**
- **Travel Assistance Services**
- **Security Assistance Services**

These services can help ease stress if something goes wrong in an unfamiliar place away from home. Visit [page 38](#) in this guide or the Accident page on ncflex.org to learn more and find out how to access these services.

*Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

Sickness Hospital Confinement Rider (Enhanced Option):

This rider provides daily benefit payments for each day a covered employee or their covered dependent is confined to a hospital due to a covered sickness for up to 30 days. For an employee and their covered spouse, the benefit is \$200 per day. For a covered child, the benefit is \$150 per day. There is a 30-day waiting period from the effective date of coverage for this benefit to be available. This benefit excludes pre-existing conditions if the hospital stay occurs in the first 12 months from the effective date of coverage. After the first 12 months, pre-existing conditions are covered by this rider. For a full list of exclusions and limitations, please see the Accident Plan certificate available on ncflex.org. Note that you should file an accident claim rather than a hospital indemnity claim to receive this benefit.



Exclusions and Limitations

Exclusions for the Certificate, Spouse Accident Insurance, and Children's Accident Insurance are listed below. (These may vary by state.) Benefits are not payable for any loss caused in whole or directly by any of the following*:

- Participation or attempt to participate in a felony or illegal activity.
- An accident while the covered person is operating a motorized vehicle while intoxicated. Intoxication means the covered person's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.
- Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane.
- War or any act of war, whether declared or undeclared, other than acts of terrorism.
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Operating, training to operate, serving as a crew member of, or participating in jumping, parachuting from, or falling from any aircraft or hot-air balloon including those which are not motor-driven.

- Flying as a fare-paying passenger is not excluded. Performing these acts as part of employment with the employer is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting, kite surfing, or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any sickness or declining process caused by sickness.

** See the certificate of insurance and riders for a complete list of available benefits, exclusions, and limitations.*

Continuation Options

If an employee leaves employment or retires, portability of the Accident Plan is available, if elected prior to the employee reaching age 70. For details and rates, employees may contact Voya at **877-464-5111**.

Tax Considerations

If Voya pays a covered individual benefits totaling \$2000 or more in a plan year, the employee will receive an IRS 1099-MISC after the plan year ends. Employees should consult with a tax advisor regarding the possible effects to their taxes.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Accident Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Forms include: Policy Form #RL-ACC3-POL-16; Certificate Form #RL-ACC3-CERT-16; and Rider Forms: Spouse Accident Rider Form #RL-ACC3-SPR-16, Children's Accident Rider Form #RL-ACC3-CHR-16. Form numbers, provisions and availability may vary by state.



Governor's Mansion Garden | © N.C. Department of Natural & Cultural Resources



**Wellness Benefit
Included!**

Cancer and Specified Disease

The Cancer and Specified Disease Plan pays cash benefits for cancer and 29 other specified diseases to help with the costs associated with treatments and expenses as they happen. This coverage can help pay for hospitalization, surgery, radiation/chemotherapy and more.

Employees can choose between three plan options (Low, High and Premium) depending on their cancer insurance needs and specified diseases. All three plan options cover the same type of services. In most cases, however, the amount of coverage differs based on the option chosen.

Coverage

Refer to the *Summary of Benefits* on [page 19](#) 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
- Thalassemia
- Rocky Mountain Spotted Fever
- Legionnaires' 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

Cost

The monthly premium is based on the plan an employee chooses and who they cover. New hires do not need to provide Evidence of Insurability (EOI) if they enroll within 30 days of their date of hire. (See *Evidence of Insurability* on [page 20](#) for more details.)

Coverage Level	Low Option	High Option	Premium Option
Employee Only	\$6.06	\$14.42	\$19.26
Employee and Family	\$10.02	\$23.90	\$31.84

Examples of Net Cost

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

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

Option	Annual Cost	Cancer Screening Benefit	Tax Savings (30% Tax Bracket)	NET Annual Cost
Low: Employee	\$72.72 (\$6.06/month)	\$25	\$21.82	\$25.90 (\$2.16/month)
High: Family	\$286.80 (\$23.90/month)	\$200 (2 @ \$100)	\$86.04	\$76 (\$0.06/month)
Premium: Family	\$383.08 (\$31.84/month)	\$200 (2 @ \$100)	\$114.92	\$68.16 (\$5.68/month)

Summary of Benefits

Employees should review the Certificates of Coverage for complete details regarding these benefits.

Benefit	Low Option	High Option	Premium Option
Cancer Prevention and Screening Benefit - Refer to page 20 for list of screenings (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		

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

Cancer Prevention and Screening Benefit Includes:

- Biopsy for skin cancer
- Blood test for triglycerides
- Bone Marrow Testing
- CA125 (cancer antigen 125 - blood test for ovarian cancer)
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CEA (carcinoembryonic antigen - blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Doppler screening for carotids
- Doppler screening for peripheral vascular disease
- Echocardiogram
- EKG (Electrocardiogram)
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- HPV (Human Papillomavirus) Vaccination
- Lipid Panel (total cholesterol count)
- Mammography, including Breast Ultrasound
- Pap Smear, including ThinPrep Pap Test
- PSA (prostate specific antigen - blood test for prostate cancer)
- Serum Protein Electrophoresis (test for myeloma)
- Stress test on bike or treadmill
- Thermography
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms

Medicaid Information

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

Exceptions and Limitations

The Standard 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. 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.

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

For complete details on exclusions and limitations, see the Certificate of Coverage located at [ncflex.org](https://www.ncflex.org).

Evidence of Insurability

Evidence of Insurability (EOI) is a way of providing proof of good health. This evaluation may include the employee's current health status, medical history and family history. If an employee is required to submit EOI, The Standard must approve EOI before coverage becomes effective. The EOI form is available on the "Cancer & Specified Disease" section at [ncflex.org](https://www.ncflex.org).

Portability Privilege

The portability feature allows employees to continue cancer coverage when their employment ends or policy terminates, by paying premiums directly to The Standard. Employees can contact The Standard for more information at **866-232-1517**.

Certificate of Coverage

The Certificate of Coverage provides complete details about the benefits and the limits and exclusions. For complete details, review the Certificates of Coverage located on [ncflex.org](https://www.ncflex.org).

The coverage provided is limited benefit supplemental cancer and specified diseases insurance, policy form GVCP2, or state variations thereof. The Standard is the marketing name used for American Heritage Life Insurance Company, Home Office, Jacksonville, FL, a wholly owned subsidiary of StanCorp Financial Group, Inc.

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.



**Wellness Benefit
Included!**

**Child coverage at no
cost!**

Critical Illness

The Critical Illness Plan, administered by Voya Financial and underwritten by ReliaStar Life Insurance Company, pays a benefit if a covered individual is diagnosed with a covered illness or condition on or after the coverage effective date. Employees can choose a benefit amount of \$15,000, \$25,000 or \$40,000.

The Critical Illness Plan is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Benefit Amount: \$15,000, \$25,000 or \$40,000	
Pays 100% of benefit in the event of:	Pays 10% to 50% of benefit in the event of:
- Cancer - Heart Attack - Stroke - Major Organ Transplant - Bone Marrow Transplant - Carcinoma in situ - Permanent paralysis - Coma - Severe Burns - Loss of Sight/Speech/Hearing - Advanced Dementia - Benign Brain Tumor - Parkinson's Disease - Multiple Sclerosis - Muscular Dystrophy - Occupational HIV - Hepatitis B or C - Type 1 Diabetes - ALS - Huntington's Disease - Coronary artery bypass - Stem cell transplant	- Skin Cancer: 10% - Sudden Cardiac Arrest: 25% - Pacemaker placement: 10% - Infectious disease: 25% - Transient Ischemic Attack: 10% - Open heart surgery for valve replacement or repair: 25% - Transcatheter heart valve replacement or repair: 10% - Coronary angioplasty: 10% - ICD placement: 25% - Aneurysm (ruptured or dissecting, abdominal aortic, or thoracic aortic): 10% - Addison's disease: 10% - Systemic sclerosis: 10% - Myasthenia gravis: 50% - Systemic Lupus Erythematosus: 50%

Features of the Critical Illness Plan include:

- Guaranteed issue — no health questions required at initial enrollment.
- Benefits paid directly to the employee.
- No waiting period for new diagnosis.
- Benefits for covered dependents are the same as covered employees.
- Total payable for each insured person is unlimited for most diagnoses.
- Same diagnosis of a critical illness for which benefits were previously paid by Voya must have 6-month separation period between diagnoses.
- Skin cancer benefits are payable only up to 10 times per covered member.

Monthly Cost

The monthly premium for the employee and/or spouse is based on the age of the covered employee as of January 1 of the current plan year and are in five-year age bands. An employee may not be covered both as an employee and as a dependent.

Employee/Spouse

Employee Age	Benefit Amount*		
	\$15,000	\$25,000	\$40,000
<25	\$1.35	\$2.25	\$3.60
25 – 29	\$1.80	\$3.00	\$4.80
30 – 34	\$3.30	\$5.50	\$8.80
35 – 39	\$4.20	\$7.00	\$11.20
40 – 44	\$6.45	\$10.75	\$17.20
45 – 49	\$12.15	\$20.25	\$32.40
50 – 54	\$16.80	\$28.00	\$44.80
55 – 59	\$24.60	\$41.00	\$65.60
60 – 64	\$46.05	\$76.75	\$122.80
65 – 69	\$65.10	\$108.50	\$173.60
70 +	\$77.25	\$128.75	\$206.00

*The costs are per covered person (employee/spouse) for the benefit amount elected.

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

Example: Calculating Cost for \$15,000 Option

Employee age is 43	\$6.45
Spouse rate based on employee age	\$6.45
Three children (varying ages)	\$0
Total Monthly Premium	\$12.90

*For more information on covered illnesses/condition definitions, visit ncflex.org.

Additional Benefits: Each Critical Illness option includes a **\$50 or \$25 Wellness Benefit** per covered person for one health screening test per year. See [page 23](#) for more information.

Also included on all three options, the **Infectious Disease Benefit Rider**. The Diagnosis Benefit pays \$100 once per calendar year per covered person for a COVID-19 diagnosis. The Hospital Confinement Benefit pays \$2,000 once per calendar year per covered person if confined to a hospital due to COVID-19.

Example: Benefit Payment*

Covered Condition	Lump-Sum Benefit Payment Received
The employee has a heart attack	\$25,000
Three months later, the employee is diagnosed with noninvasive cancer	\$6,250
12 months later the employee has another heart attack	\$25,000
Two months later the employee becomes paralyzed	\$25,000
Total Payout	\$81,250

**This example represents an employee who has chosen the \$25,000 option. An employee's individual experience may vary.*

Beneficiary

To designate a beneficiary, please visit ncflex.org. Click on the "Enroll Now" button and log in to designate a beneficiary.

Tax Considerations

If Voya pays an employee benefits totaling \$2000 or more in a plan year, they will receive an IRS 1099-MISC after the plan year ends. The employee should consult with a tax advisor regarding the possible effects to their taxes.

Certificate of Coverage

The Certificate of Coverage, which can be found in the Critical Illness section of ncflex.org, provides complete details about the benefits and the limitations and exclusions.

Pre-Existing Condition

A pre-existing condition means a sickness or condition which resulted in medical treatment, consultation, care or services (including diagnostic measures) for a designated period of time before the coverage effective date. There are no pre-existing condition limitations on this Critical Illness Insurance coverage. Covered members will be eligible for the benefit amount as shown on the schedule of benefits in the certificate, if they are diagnosed with a covered Critical Illness on or after their coverage effective date. For a complete description of available benefits, exclusions and limitations, see the certificate of insurance and any riders.

Portability

If an employee leaves employment or retires, portability of the Critical Illness Plan is available, if elected prior to the employee reaching age 70. For details and rates, employees may contact Voya at **877-464-5111**.



Wellness Benefit:

The Wellness Benefit is included in all three Critical Illness Plan options. If a participating employee completes an eligible health screening test, they are eligible for a Wellness Benefit payment. The health screening test must occur on or after their effective date. If the employee's spouse and/or children are covered under their Critical Illness Plan, they're also eligible for this benefit payment for a covered health screening.

Only one benefit is payable per covered member per calendar year, regardless of how many screenings are completed by that member.

Covered Member	Wellness Benefit available once per year with a covered screening:
Employee	\$50
Spouse	\$50
Child	\$25

What types of health screening tests are eligible?

Health screening tests include, but are not limited to:

- Blood tests for triglycerides
- Pap smear or thin prep pap test
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Hearing test
- Routine eye exam
- Routine dental exam
- Well child/preventative exams through age 18
- Biometric screenings
- Electrocardiogram (EKG)
- Annual Physical Exam – Adults
- CA 125 (ovarian cancer)
- Tests for sexually transmitted infections (STIs)
- Ultrasound screening for abdominal aortic aneurysms
- Hemoglobin A1C (HbA1c)
- Bone density screening
- COVID-19 test



Local Artist's Gourd Art
© N.C. Department of Natural & Cultural Resources



Three dental options
available through
MetLife

Dental

Why Employees Should Consider Dental Coverage

Maintaining good oral health matters. When preventive care is covered, an employee is more likely to go for cleanings and checkups — this can help the employee avoid problems before they become too costly or complicated. Plus, going to the dentist regularly can help prevent problems that have been linked to diabetes or heart disease.¹ That's where a good dental plan comes in.

Through MetLife, we offer three Dental Plan options that cover routine checkups and other dental care: the High Option, the Classic Option and the Low Option. These plans differ in how much an employee pays per pay period and at time of service. Refer to the *Summary of Benefits* section on [page 25](#) to review the services covered under each plan.

1. *Dentists: Doctors of Oral Health, American Dental Association, Chicago, IL, ada.org/en/about-the-ada/dentists-doctors-of-oral-health.*

Save When Using a Network Provider

No matter which Dental Plan option an employee elects, they can visit any licensed dentist, in or out of the MetLife Preferred Dental Provider (PDP) Plus Network, and still receive benefits. When employees go to a participating dentist, they can save even more since in-network dentists accept negotiated fees that are typically 30-45% less than the average charges in the same area².

2. *Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing, and benefit maximums. Negotiated fees are subject to change.*

To find a participating dentist, go to dentalprovider.metlife.com, enter the zip code, and select the PDP Plus Network. Employees can also call **855-676-9441** to request a provider list.

Changing Dental Plan Options

Once an employee chooses a Dental Plan (High Option, Classic Option or Low Option), they must keep that option for the entire plan year, even if they have a qualified life event. An employee may only change their Dental Plan option during the annual enrollment period. (For example, an employee cannot switch from the Low Option to the High Option, or vice versa.)

Monthly Cost

Coverage Level	High Option	Classic Option	Low Option
Employee Only	\$58.76	\$37.94	\$25.64
Employee and Spouse	\$117.88	\$76.06	\$51.70
Employee and Child(ren)	\$127.12	\$82.40	\$55.54
Employee and Family	\$208.12	\$130.22	\$88.50

Dental Claims Processing

MetLife encourages employees to discuss their treatment plan with their 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, an employee should have their dentist submit a request online at dentalprovider.metlife.com or call **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...	Look Under...	Find...
ncflex.org	Dental	- MetLife MyBenefits website link - Dental Forms - Online Tools - Plan Certificates
metlife.com/mybenefits	Enter "NCFlex" as the company name and create a unique User ID and password. Click on the <i>Register Now</i> button and enter the required information.	- Dental Benefits information, claims history, etc. <i>Find a Dentist</i> - Oral Health Library - Mobile Application

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 ncflex.org.

Summary of Dental Benefits

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

Benefit Category	High Option*	Classic Option*	Low Option*
Type I — Diagnostic and Preventive			
Oral Examination (two per calendar year)	100%	100%	100% after deductible
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% after deductible	60% after deductible	50% after deductible
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% after deductible		
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)			
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% after deductible	50% after deductible	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 and Classic Option — dependent children up to age 19)			
Orthodontic Treatment in Progress (Treatment plans not started under the High Option or Classic Option Plans will be prorated based on the date the benefit is eligible on the Dental Plans. Reimbursement will not be paid beyond the date the child turns the age of 19).	50%	50%	Not Covered
Maximums/Deductibles			
Calendar-Year Maximum (Per covered person; excludes orthodontic services under the High Option and Classic Option Plans)	\$5,000	\$1,500	\$1,000
Lifetime Orthodontic Maximum (per covered person) The lifetime maximum will include any reimbursement received from the prior carrier.	\$1,500	\$1,500	N/A
Calendar-Year Deductible (per person/per family)	\$50/\$150	\$25/\$75	\$25/\$75

* Benefits are subject to the Maximum Allowable Charge (MAC). The MAC for in-network dental providers is the negotiated in-network fee. Reimbursement for out-of-network services is based on reasonable and customary (R&C) charge for the area. R&C is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area. The employee may be responsible for the difference between the R&C charge and what an out-of-network dentist charges

Exclusions and Limitations

This is a partial listing of the exclusions listed with the plan policy. Please refer to the 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:

- Services which are not dentally necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition.
- Services or supplies received by the employee or their dependent before the dental insurance starts for that person.
- Services which are primarily cosmetic.
- Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Missed appointments.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Pulp vitality, diagnostic photographs and bacteriological studies for determination of bacteriologic agents.
- Labial veneers.
- Local chemotherapeutic agents.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth).
- Replacement of a lost or stolen appliance, Cast Restoration or Denture.
- Replacement of an orthodontic device.
- Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with treatment of temporomandibular joint disorders.

The Dental Plan certificate can be found on the NCFlex website at ncflex.org.

Orthodontia coverage is only for covered children only up to age 19. Employees/spouses are not covered for orthodontia.

Continuation of Coverage

Employees who terminate employment may continue their MetLife dental coverage by paying their monthly premiums directly to the COBRA vendor. COBRA enrollment materials will be sent to the employee's last known address.





**This benefit does not
require re-enrollment
each year.**

Vision

The Vision Plan is administered by EyeMed Vision Care and underwritten by Fidelity Security Life Insurance. It offers two schedules of benefits (Basic and Enhanced) — both provide a comprehensive eye exam and benefits for vision materials. A covered participant may receive either eyeglass lenses or contact lenses in a benefit period but not both.

Another option (available to employees only) is the Core Wellness Exam Plan which is available at no cost to the employee if he or she enrolls.

Core Wellness Exam Plan

The Core Wellness Exam Plan is available at no cost to the employee if they enroll in coverage. An employee can receive an annual comprehensive eye exam for a \$20 copay. If vision materials are needed, there are lens allowances and discounts on frames from providers in the EyeMed network. Go to ncflex.org to find a network provider.

Basic Plan: Exam and Materials

The Basic Plan provides an annual comprehensive eye exam and a choice of eyeglass lenses or contact lenses (\$120 allowance) once every 12 months, per covered person, and frames (\$125 allowance) once every 24 months, per covered person.

Enhanced Plan: Enhanced Exam and Materials

The Enhanced Plan provides an annual comprehensive eye exam and a choice of eyeglass lenses or contact lenses (\$175 allowance) and frames (\$200 allowance) once every 12 months, per covered person.

Vision Network

The Core, Basic, and Enhanced Plans offer in-network and non-network benefits. Employees pay less when they use a network provider. The employee is responsible for paying any charges in excess of the covered benefit. When using a non-network provider, the employee pays the provider in full and submits an out-of-network claim form (along with a copy of the receipt) to EyeMed. They will be reimbursed up to the amount of the out-of-network allowance.

There are more than 6,306 providers in the state, including independent eye doctors, retail stores, and even online options. If an employee's vision care provider is not part of the EyeMed network, they (or the provider) may contact EyeMed with the provider's name, address, and telephone number to begin the provider nomination process.

Cost

The monthly vision premium is based on the plan an employee chooses and whom they cover. Even if the employee only wants to participate in the Core Wellness Exam Plan, they must still enroll.

Coverage Level	Core Wellness Exam	Basic Plan	Enhanced Plan
Employee Only	No charge	\$4.50	\$8.00
Employee and Family	N/A	\$11.66	\$20.52

LASIK or PRK Surgery

EyeMed members save 15% off retail price or 5% off the promotional price of LASIK. To find a LASIK location, visit eyemedlasik.com or call **800-988-4221**.

Find a Provider

Need help locating the nearest eye doctor?
Visit eyemedvisioncare.com/ncflex or call EyeMed at **866-248-1939**.

On the go? Download the EyeMed Members App (in the App Store or Google Play) to find an eye doctor and get directions, view the member ID card, save a vision prescription and more.

Using EyeMed Benefits with In-Store Discounts

Some eye doctors and retailers occasionally run special promotions that may require that participants not use their benefits to take advantage of special pricing. When considering a purchase, employees should talk with the provider about their options or call EyeMed at **866-248-1939**.

Employees can access members-only special offers by registering on eyemedvisioncare.com/ncflex or by downloading the EyeMed Members App (in the App Store or Google Play) for special offers on vision-related products and services, such as:

- Discounts on frames and lenses
- Savings on contacts
- Exclusive offers from network providers and retailers
- Free shipping from online retailers
- Special pricing on lens cleaners, eyeglasses cases and more.

Wellness Tip

The eye is the only area of the body with a clear view of blood vessels. Using vision benefits can help spot serious conditions like: cancer, diabetes, heart disease, high blood pressure, high cholesterol, neuromuscular diseases, rheumatic diseases, and sickle cell anemia.



Additional Member-Only Savings*

Employees receive additional savings just for being an EyeMed member, such as:

- 20% off any remaining cost for frames once the frame allowance has been applied.
- 40% off unlimited, additional complete pairs of prescription eyewear.
- 15% off any balance over the conventional contact lens allowance.
- 20% off any item not covered by the benefit.
- Discounted set pricing on hearing aids and free batteries.

*At participating in-network providers. Refer to the special offers page on EyeMed's website for details and exclusions.

Changing Plans

During annual enrollment, an employee may change between the Core, Basic, and Enhanced Plans. The frame allowance, if applicable, will change each calendar year depending on the plan an employee enrolls in. An employee may enroll in only one of the three vision coverage options. To receive family coverage, an employee must enroll in the Basic or Enhanced Plan.

Continuation of Coverage

Employees who terminate employment may continue their EyeMed vision coverage by paying their monthly premiums directly to the COBRA vendor. COBRA enrollment materials will be sent to the employee's last known address.

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. An employee may review and/or obtain a copy of the Certificate of Coverage by visiting ncflex.org.



Summary of Benefits

Vision Care Services	Basic Plan		Enhanced Plan	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**
Exam with Dilation as Necessary	\$20 copay	Up to \$44	\$20 copay	Up to \$44
Retinal Imaging	Up to \$39	N/A	Up to \$39	N/A
Frames	\$0 copay, \$125 allowance, 20% off balance over \$125	Up to \$50	\$0 copay, \$200 allowance, 20% off balance over \$200	Up to \$93
Standard Plastic Lenses				
Single Vision	\$0 copay	Up to \$34	\$0 copay	Up to \$34
Bifocal	\$0 copay	Up to \$48	\$0 copay	Up to \$48
Trifocal	\$0 copay	Up to \$64	\$0 copay	Up to \$64
Lenticular	\$0 copay	Up to \$88	\$0 copay	Up to \$88
Standard progressive lens	\$50 copay	Up to \$64	\$50 copay	Up to \$64
Premium progressive lens	\$70-\$95 copay	Up to \$64	\$70-\$95 copay	Up to \$64
Tier 1	\$70 copay	Up to \$64	\$70 copay	Up to \$64
Tier 2	\$80 copay	Up to \$64	\$80 copay	Up to \$64
Tier 3	\$95 copay	Up to \$64	\$95 copay	Up to \$64
Tier 4	\$50 copay, 20% off retail less \$120 allowance	Up to \$64	\$50 copay, 20% off retail less \$120 allowance	Up to \$64
Lens Options				
UV treatment	\$15	N/A	\$15	N/A
Tint (solid and gradient)	\$15	N/A	\$15	N/A
Standard plastic scratch coating	\$13 copay	Up to \$2	\$13 copay	Up to \$2
Standard polycarbonate – adults	\$40	N/A	\$40	N/A
Standard polycarbonate – kids under 19	\$40	N/A	\$40	N/A
Standard anti-reflective coating	\$45	N/A	\$45	N/A
Premium anti-reflective coating	\$57-\$68	N/A	\$57-\$68	N/A
Tier 1	\$57	N/A	\$57	N/A
Tier 2	\$68	N/A	\$68	N/A
Tier 3	20% off retail	N/A	20% off retail	N/A
Photochromatic/transitions plastic	\$75	N/A	\$75	N/A
Polarized	20% off retail	N/A	20% off retail	N/A
Other add-ons and services	20% off retail	N/A	20% off retail	N/A
Contact Lens Fit and Follow Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed.)				
Standard contact lens fit & follow up	\$20 copay, paid-in-full and two follow-up visits	Up to \$44	\$20 copay, paid-in-full and two follow-up visits	Up to \$44
Premium contact lens fit & follow up	\$20 copay, 10% off retail price, then apply \$55 allowance	Up to \$44	\$20 copay, 10% off retail price, then apply \$55 allowance	Up to \$44
Contact Lenses (Contact lens allowance includes materials only.)				
Conventional	\$0 copay, \$120 allowance, 15% off balance over \$120	Up to \$100	\$0 copay, \$175 allowance, 15% off balance over \$175	Up to \$117
Disposable	\$0 copay, \$120 allowance	Up to \$100	\$0 copay, \$175 allowance	Up to \$117
Medically necessary	\$0 copay, paid in full	Up to \$210	\$0 copay, paid-in-full	Up to \$210
Laser Vision Correction				
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A	15% off the retail price or 5% off the promotional price	N/A
Hearing Care				
Hearing Health Care from Amplifon Hearing Network	Discounted set pricing on hearing aids and free batteries.	N/A	Discounted set pricing on hearing aids and free batteries.	N/A
Frequency				
Examination	Once every calendar year		Once every calendar year	
Lenses or contact lenses	Once every calendar year		Once every calendar year	
Frame	Once every other calendar year		Once every calendar year	

*In-Network copays represent the most an employee will have to pay for specific in-network benefits.

**Out-of-Network allowance amounts represent the most the plan will pay for specific out-of-network benefits. Employees pay 100% of any expense over the allowance amount.

Summary of Benefits

Vision Care Services	Core Plan	
	In-Network*	Out-of-Network**
Exam with Dilation as Necessary	\$20 Copay	Up to \$44
Retinal Imaging	Up to \$39	N/A
Frames* <i>Complete pair eyeglasses purchase discounts*. Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.</i>	35% off retail price	N/A
Standard Plastic Lenses		
Single vision	\$50	N/A
Bifocal	\$50	N/A
Trifocal	\$105	N/A
Standard progressive lens	\$135	N/A
Lens Options		
UV treatment	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard plastic scratch coating	\$15	N/A
Standard polycarbonate – adults	\$40	N/A
Standard polycarbonate – kids under 19	\$40	N/A
Standard anti-reflective coating	\$45	N/A
Polarized	20% off retail	N/A
Other add-ons and services	20% off retail	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	15% off retail	N/A
Disposable	0% off retail	N/A
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	Discounted set pricing on hearing aids and free batteries.	N/A
Frequency		
Examination	Once every calendar year	
Lenses or contact lenses	Unlimited	
Frame	Unlimited	
<i>*Frame, lens, and lens option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.</i>		
Additional Discounts (Additional discounts are not insured benefits.)		
Non-prescription sunglasses	20% off	N/A
Remaining balance beyond plan coverage	20% off	N/A

*In-Network copays represent the most employees will have to pay for specific in-network benefits.

** The Out-of-Network allowance for vision exam is the most employees will pay for this benefit. Employees pay 100% of any expense over the allowance amount.

Plan Exclusions

No benefits will be paid for services or materials connected with or changes arising from:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses.
- Medical, pathological and/or surgical treatment of the eye, eyes or supporting structures.
- Any vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Plano (non-prescription) lenses.
- Non-prescription sunglasses.
- Two pairs of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and services rendered to the Insured Person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.



**This benefit does not
require re-enrollment
each year.**

Group Term Life

NCFlex offers a Voluntary Group Term Life Insurance Plan administered by Voya Financial and underwritten by ReliaStar Life Insurance Company.

Voluntary Group Term Life Insurance pays a benefit to an employee's beneficiary(ies) if the employee dies while covered under the policy and pays a benefit to the employee if a covered dependent dies. Please note that this is strictly a life insurance policy that provides a benefit in the event of death of a covered person. There is no accumulated cash value. An employee may not be covered as both an employee and a dependent. Also, eligible employees must choose to be covered as an employee, not as a dependent, and children may not be dually enrolled. Employees of The University of North Carolina System are not eligible for this benefit.

Coverage Options

An employee must be enrolled to cover spouse and/or children.

Employee and 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)

- \$5,000 or \$10,000 without EOI (as long as coverage is elected: within 30 days of becoming eligible, within 30 days of a qualified life event, or during the annual enrollment period.)

Enrollment/Evidence of Insurability Options

Evidence of Insurability (EOI) is required for amounts above the Guaranteed Issue (GI) amount when enrolling in this plan to determine if coverage will be granted. If EOI is required, Voya Financial will send an invitation to the email address on file in the enrollment platform. If the employee does not have an email address on file, Voya Financial will mail the invitation to the mailing address in the enrollment platform. Voya Financial must approve EOI before the increased amount will take effect.

If the Employee Is	Coverage Options
New Hire/Newly Eligible	As a new hire (or newly eligible for benefits), the employee may elect from \$20,000 up to \$200,000 on himself/herself and \$20,000 up to \$50,000 on their spouse without having to provide EOI.*
Existing Employee	
• Electing or adding coverage during annual enrollment*	If the employee is not currently enrolled in Group Term Life, during annual enrollment, they may purchase \$20,000 of coverage on themselves (and on their spouse, if desired) on a guaranteed issue basis (if the employee was not previously denied coverage). Amounts over \$20,000 require EOI. If the employee is currently enrolled in Group Term Life, they 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 the employee and \$50,000 for the spouse (no EOI required).
• Making coverage changes during the plan year*	If the employee experiences a qualifying life event that allows the employee to add or increase their life insurance amount, they will be allowed to elect coverage on a guaranteed issue basis up to the amounts shown under New Hire/Newly Eligible above.

Underwritten by ReliaStar Life Insurance company, policy form LPOOGR. Rates shown are guaranteed until Dec. 31, 2027.

**The employee may elect up to \$10,000 of coverage for eligible children without having to provide EOI for 2027.*

Monthly Cost and Coverage

The monthly premium for the employee and their spouse is based on the age of the covered employee as of January 1 of the plan year. The following chart outlines the cost of coverage per \$1,000 increments based on age. An employee may not be covered as both an employee and a dependent and children may not be dually enrolled.

Employee/Spouse

Employee 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

**The costs are per covered person (employee/spouse) for the benefit amount elected.*

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.

When Coverage Begins

Newly Eligible

For new hires who enroll for coverage of \$200,000 or less, coverage will begin on the first day of the month following their hire date. An employee must enroll within 30 days of the hire date.

Coverage over the Guaranteed Issue (GI) amount will not go into effect until the first of the month following the date EOI is approved by the insurance company.

Existing Employees

Annual Enrollment: Employees who enroll for coverage during annual enrollment and whose EOI is approved prior to January 1, coverage will be effective January 1, 2027. If the EOI date of approval is after January 1, 2027, coverage will be effective on the first of the month following the date EOI is approved.

Employees who are on a leave of absence may enroll once returned to active status.

Life Event: If EOI is not required, coverage begins on the first of the month following the life event. Coverage over the Guaranteed Issue (GI) amount will not go into effect until the first of the month following the date EOI is approved by the insurance company.

Disability Waiver of Premium

If an employee becomes totally disabled prior to age 60, as defined under the policy and satisfies certain conditions, they may apply for a waiver of premium. ReliaStar Life waives premiums for employee's coverage only that becomes due while the employee is totally disabled.

Premiums are waived until the earlier of:

- The date the employee is no longer disabled
- The date the employee does not give ReliaStar Life proof of total disability when asked, or
- The date the employee turns age 70.

Coverage After Age 75

The employee's Life Insurance coverage amount will reduce to 50% on January 1st, following the employee's 75th birthday. Dependent spouse Life Insurance coverage will also reduce to 50% on the same date.

Note: Coverage cannot be increased once coverage is reduced due to age. Any reduced coverage may be eligible for conversion.

Bereavement Support

Includes funeral planning & will preparation.

Empathy helps families prepare for the future and navigate the emotional and practical challenges associated with loss.

From planning a funeral to the logistics of winding down an estate, Empathy offers an impactful solution to you and your family after the loss of a loved one. Empathy's bereavement support is also accessible to loved ones, and various family members can share and join an employee's account. For more information, visit the Group Term Life section at ncflex.org.

These services are provided by The Empathy Project, Inc., New York, NY. Services are not available in all states.

Accelerated Death Benefit

Fifty percent of the covered person's benefit amount may be payable while they are living if they are diagnosed with a terminal illness or diagnosed with a condition requiring continuous confinement and other conditions are met. The Accelerated Death Benefit is only payable once per covered person. The remaining benefits will be paid to the beneficiary after death.

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

Exclusion

This policy pays a benefit for all causes of death. However, if the covered person commits suicide while sane or insane within 2 years of their effective date, premiums will be refunded instead of a death benefit.

Portability

Portability is an option for employees who want to continue their term life insurance, are under age 70, and no longer active at work due to a leave of absence or separation from employment (including retirement). Contact Voya at **877-464-5111** to obtain your rates for your ported coverage.

Portability for Dependent coverage is only available when the employee's coverage is ported.

Conversion

Conversion may be an option for covered employees and/or covered dependents whose term life insurance ends. This includes but is not limited to: a leave of absence, separation from employment (including retirement) or active employees that have their coverage reduced due to age.

Conversion premium rates are generally higher than portability as the coverage converts to a Whole Life Policy that builds cash value. These premiums do not change with age.

For more information, employees may contact Voya at **877-464-5111**.



Downtown Hillsborough Farmers Market
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Core Accidental Death & Dismemberment



Employee must enroll to receive this no-cost benefit. No yearly re-enrollment required.

The Core Accidental Death and Dismemberment (AD&D) 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 an employee suffers a loss as the result of a covered accident while insured under the plan. It also pays a benefit if an employee suffers 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. Please refer to the Certificate of Coverage for specific exclusions and limitations. This coverage is in addition to any other coverage an employee has under any other insurance policy. Employees of the University of North Carolina System are not eligible for this benefit.

Coverage

If an employee elects coverage, the amount of insurance provided to an employee at no cost is called the Principal Sum.

Principal Sum	Cost for Employee
\$10,000	\$0.00

If an employee 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 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 75

If an employee is actively working at age 75, the amount of insurance will decrease to 50%.

What is Excluded from Coverage

Please note that coverage will not be in place during an unpaid leave of absence. ReliaStar Life does not pay benefits for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning.

Exceptions:

- Bacterial infection resulting from an accidental injury.
- The involuntary inhalation of gas and fumes and the involuntary taking of poison.
- Riding in or descending from an aircraft as a pilot or crew member.
- 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 the manufacturer.
- The covered individual's intoxication. Intoxication means the individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Voya Travel Assistance

If an employee is enrolled in the Core or Voluntary AD&D Plan, they also have access to Voya Travel Assistance services.

Traveling to an unfamiliar place can cause stress, especially if something goes wrong. Voya Travel Assistance offers employees and their covered dependents four types of services when traveling 100 miles or more from their primary residence:

- Emergency Medical Transport Services
- Medical Assistance Services
- Travel Assistance Services
- Security Assistance Services

Employees can access these services 24 hours a day, 365 days a year - from anywhere in the world. Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

See [page 38](#) for more information.

Wellness Tip

Getting enough sleep and avoiding texting while driving can reduce our chances of causing a traffic accident.



Underwritten by ReliaStar Life Insurance Company, a Member of the Voya Family of Companies.

The information in this guide is in abbreviated form only. It is provided to give employees a general understanding of the ReliaStar insurance coverage available, but it is subject to verification by ReliaStar. An employee's actual coverage and amounts are subject to all the terms, limitations, and exclusions in the ReliaStar Certificate of Coverage. If the information in this guide differs from the group insurance policy held by the employer or plan administrator, the terms of that group insurance policy will govern.

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

	Core AD&D	Voluntary AD&D	
	Employee Only	Employee Only	Family
Cost Per Month (if elected)	\$0.00	\$1.80*	\$2.60*
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 Spouse			✓
Survivor's Benefit			✓
Education Benefit			✓
Spouse Training Benefit			✓
Coverage for Dependent Children			✓

See [page 36](#) 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 re-enrollment each year.

The Voluntary Accidental Death and Dismemberment (AD&D) Plan is administered by Voya Financial and underwritten by ReliaStar Life Insurance Company, a member of the Voya family of companies. The plan pays a benefit if an employee (or their covered dependents) dies or has certain disabling injuries as the result of a covered accident.

The coverage is effective 24 hours a day, 365 days a year. It includes accidents on or off the job. Please refer to the Certificate of Coverage for specific exclusions and limitations. This coverage is in addition to any other coverage the employee may have under any other insurance policy.

The benefit amounts are shown below. **If the employee and their spouse are both eligible to elect this coverage as employees, 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. Also, eligible employees must choose to be covered as an employee, not as a dependent, and children may not be dually enrolled. Employees of The University of North Carolina System are not eligible for this benefit.

Monthly Cost and Principal Sum

The amount of insurance an employee purchases is called the Principal Sum. An employee may select one of the following Principal Sums:

Principal Sum	Cost for Employee Only	Cost for Employee and Family	Principal Sum	Cost for Employee Only	Cost for Employee and Family
\$50,000	\$0.90	\$1.30	\$300,000	\$5.40	\$7.80
\$100,000	\$1.80	\$2.60	\$350,000	\$6.30	\$9.10
\$150,000	\$2.70	\$3.90	\$400,000	\$7.20	\$10.40
\$200,000	\$3.60	\$5.20	\$450,000	\$8.10	\$11.70
\$250,000	\$4.50	\$6.50	\$500,000	\$9.00	\$13.00

Family Principal Sum

An employee may also elect insurance for their spouse and unmarried dependent children. (See *Dependent Eligibility*, page 4 for details.) If family coverage is elected, the family members' Principal Sum will be a percentage of the employee's Principal Sum.

Family Members	Percentage of Benefit Payable
Spouse	50%
Children	10% each child

Coverage

If the employee or 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 75

The amount of insurance will decrease to 50% when an employee turns age 75. Coverage cannot be increased once coverage is reduced due to age.

Additional Benefits

If insured under the plan, the following benefits are available to employees as part of Voluntary AD&D coverage:

- Enhancement for Child(ren)*
(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
- Voya Travel Assistance Services (extends to enrolled family members; see **page 38** for detailed description)

For more information, please visit ncflex.org and view the Voluntary AD&D certificate.

*Additional benefits apply only if there has been a covered loss as shown on **page 36**.

What is Excluded from Coverage

ReliaStar Life does not pay benefits for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning.

Exceptions:

- Bacterial infection resulting from an accidental injury.
- The involuntary inhalation of gas and fumes and the involuntary taking of poison.
- Riding in or descending from an aircraft as a pilot or crew member.
- 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 the manufacturer.
- The covered individual's intoxication. Intoxication means the individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Continuation Options

Portability is an option for employees who want to continue their Voluntary AD&D and are no longer active at work due to a leave of absence or separation from employment (including retirement).

Portability for Dependent coverage is only available when the employee's coverage is ported.

For details and rates, employees may contact Voya at **877-464-5111**.

Underwritten by ReliaStar Life Insurance Company, a Member of the Voya Family of Companies.

The information in this guide is in abbreviated form only. It is provided to give an employee a general understanding of the ReliaStar insurance coverage, but it is subject to verification by ReliaStar. An employee's actual coverage and amounts are subject to all the terms, limitations, and exclusions in the ReliaStar Certificate of Coverage. If the information in this guide differs from the group insurance policy held by the employer or plan administrator, the terms of that group insurance policy will govern.

Voya Travel Assistance: Security When Traveling

For participants in either of the Accidental Death & Dismemberment Plans and/or either of the Accident Plans.

Voya Travel Assistance offers employees enhanced security for their leisure and business trips when traveling 100 miles or more from their primary residence or in another country, for trips 180 days or less. Employees and their dependents will have access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year - from anywhere in the world. Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

Emergency Medical Transport Services

- Dispatch of a Physician
- Emergency Medical Evacuation
- Medical Repatriation
- Return of Dependent Children
- Return of Travel Companion
- Vehicle Return Services
- Visit of a Family Member or Friend
- Repatriation of Remains

Medical Assistance Services

- Convalescence Arrangements
- Outpatient & Inpatient Care
- Interpretation Services
- Medical Monitoring
- Medical & Dental Referrals
- Prescription Transfer & Shipping

Travel Assistance Services

- Emergency Cash Transfer
- Consulate and Embassy Location
- ID Theft Assistance
- Legal Referrals
- Lost Luggage and/or Document Assistance
- Pet Housing and Return
- Pre-Trip Informational Services
- Urgent Message Relay

Security Assistance Services

- Emergency Political Evacuation/Repatriation
- Location Intelligence App
- Natural Disaster Evacuation



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How it works

At any time before or during a trip, participants may contact Voya Travel Assistance for assistance services. Participants can access this document to print, at ncflex.org in the AD&D and Accident sections. They can use the wallet card (shown below) to have convenient access to the numbers that they need.

If you need emergency or pre-trip services...	Voya Travel Assistance
... use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program. You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described. Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.	Contact Voya Travel Assistance 24 hours a day, 365 days a year for: Emergency Medical Transport, Medical Assistance, Travel Assistance and Security Assistance Services. From anywhere in the world: +(317) 659-5841 Email: assist@imglobal.com Visit Online and Register: imglobal.com/member ✓ Select “Create an account” ✓ Enter referral code: VOYATRAVEL ✓ Click “continue” to enter your personal information, email address, and create your password.

Exclusions and limitations

Travelers are eligible when traveling 100 miles or more from their primary residence or in another country, for trips 180 days or less. Voya Travel Assistance shall not be responsible for any claim, damage, loss, costs, liability, or expense which arises as a result of Voya Travel Assistance's inability to contact the Group Policyholder's authorized Contact for any reason beyond Voya Travel Assistance's control or as a result of the failure and/or refusal of the Group Policyholder to authorize services proposed by Voya Travel Assistance.

Medical Transport Service

All transportations must be coordinated by Voya Travel Assistance in order to be eligible. IMG will not be responsible for medical transportations that are not coordinated by Voya Travel Assistance. Services are not available to the traveler for sickness, injuries, or losses resulting from:

- Normal childbirth, normal pregnancy (except complications of pregnancy), or voluntary induced abortion
- Traveling for the purpose of securing medical treatment
- A member's mental or nervous condition, unless hospitalized
- Active participation in war and/or terrorism
- Traveling against the advice of a physician

Security Assistance Services

All emergency medical transport, political, natural disaster, or security evacuation services will be coordinated by IMG. Services listed in this brochure are only valid if IMG remains a client of Voya Financial.

Evacuation services are provided to the nearest safe location and then to covered member's resident country, if needed.

Level 4 restriction: Services will be denied if the member's destination country is at a Level 4 Travel Advisory (other than for COVID) on the US State Department website at the time of the member's Scheduled Departure Date to travel there.

Voya Travel Assistance will not be responsible for political or natural disaster evacuations that are not coordinated and provided by Voya Travel Assistance or its security partner.

Voya Travel Assistance is not responsible for any medical expenses incurred by travelers under this quote.

Services are not available to the extent they would expose Voya Travel Assistance or any of its insurers to any sanction, prohibition or restriction under U.N. resolutions or the trade or economic sanctions, laws, or regulations of the E.U., U.K., or U.S.A.

All services are governed by the terms and conditions outlined in the contract between IMG and Voya.

This overview is for informational purposes only and describes IMG's general capabilities and a broad overview of the services it offers. The actual services and payments that IMG arranges or provides for you will be determined by your services contract.

ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya family of companies.



**This benefit does not
require re-enrollment
each year.**

Disability

Disability programs replace a portion of an employee's paycheck when they are ill, injured or recovering from childbirth. Keep reading to find out what disability benefits are offered through:

- **NCFlex:** For full-time active employees of a state agency, participating community college, or participating charter school, working at least 30 hours or more per week, employees can choose supplemental combined STD and LTD disability coverage. See the **NCFlex Voluntary Disability Plan** section, starting on this page.
- **The Disability Income Plan of North Carolina (DIP-NC):** Employees are eligible for basic short-term and long-term disability benefits if they participate in Teachers' and State Employees' Retirement System (TSERS) and meet other eligibility criteria. See the **Disability Benefits for Participants in TSERS** section, starting on **page 47**, for details.

Learn how the NCFlex Voluntary Disability Plan helps supplement basic STD/LTD with TSERS on **page 49**. The Voluntary Disability Plan does not require an employee to have any creditable service under their retirement plan before it begins paying benefits. In addition, voluntary disability coverage may increase the amount of benefits the employee receives each month.

NCFlex Voluntary Disability Plan

The Voluntary Disability Plan, offered by NCFlex through The Standard, provides short-term disability (STD) and long-term disability (LTD) coverages. Keep reading for details.

The Voluntary Disability Program from NCFlex offers	
Short-term Disability (STD)	Long-term Disability (LTD)
Covers first 60 days of disability	Begins on Day 61 of disability

Eligibility

Employees may enroll in the Voluntary Disability Plan if they are full-time active employees* of a state agency, participating community college, or participating charter school, working at least 30 hours per week.

** Employees of The University of North Carolina System are not eligible for this benefit.*

Important: For Participants in TSERS

State of NC employees who participate in the Teachers' and State Employees' Retirement System (TSERS) are provided with basic short-term disability (STD) and long-term disability (LTD) coverage at no cost. These basic STD and basic LTD benefits are provided under the Disability Income Plan of North Carolina (DIP-NC). See **Disability Benefits for Participants in TSERS** on **page 47** for details. Employees also can purchase additional protection by enrolling in the Voluntary Disability Plan, described in this section, that may increase the amount of STD and LTD benefits they receive each month.



Sea Lion at N.C. Aquarium
© N.C. Department of Natural & Cultural Resources

Enrollment/Evidence of Insurability

If You Are:	EOI
New Hire/Newly Eligible	If the employee is a new hire or newly eligible for benefits, they do not need to provide Evidence of Insurability (EOI) if they enroll in the NCFlex Voluntary Disability Plan within 30 days of their date of hire.
Existing Employee	
• Electing coverage during annual enrollment	If the employee is not currently enrolled in the NCFlex Voluntary Disability Plan, during annual enrollment they may enroll, but EOI will be required.
• Qualifying life event	If the employee experiences a qualifying life event that allows them to add coverage, they do not need to provide EOI if they enroll in the NCFlex Voluntary Disability Plan within 30 days of the qualifying life event and have not previously submitted EOI that was declined by The Standard.
• Returning from a leave of absence*	If the employee was enrolled in the NCFlex Voluntary Disability Plan prior to their leave, and coverage ended due to an unpaid leave of absence, the employee must re-enroll within 30 days of their leave ending; EOI is not required when an employee re-enrolls within that timeframe. If the employee doesn't re-enroll within 30 days, EOI will be required. An employee must be enrolled in the Plan before their leave to be eligible for re-enrollment upon return; otherwise, employees must wait to enroll during Open Enrollment or upon experiencing a qualifying life event.

If EOI is required, coverage will not go in effect until the first day of the month following the date EOI is approved by The Standard. However, if EOI is approved on the first day of the month, the effective date will be that day.

*The Standard does not accept direct payments from individual members, therefore if benefits are cancelled while on leave, no payments can be made unless the employer is able to submit these payments on behalf of the employee.

Definitions of Disability

STD: An employee will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder.

- They are unable to perform with reasonable continuity the material duties of their own occupation, and
- They suffer a loss of at least 20% of predisability earnings when working in their own occupation.

An employee is not considered disabled merely because their right to perform their own occupation is restricted, including a restriction or loss of license.

LTD: For the benefit waiting period and through the end of the first 24 months that LTD benefits are payable, an employee will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- They are unable to perform with reasonable continuity the material duties of their own occupation, and
- They suffer a loss of at least 20% of predisability earnings when working in their own occupation.

An employee is not considered disabled merely because their right to perform their own occupation is restricted, including a restriction or loss of license.

From the end of the Own Occupation Period (first 24 months) through the end of the maximum benefit period that LTD benefits are payable, an employee will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- They are unable to perform with reasonable continuity the material duties of any occupation*.
- They suffer a loss of at least 40% of predisability earnings when working in any occupation*.

*Any Occupation means any occupation or employment which they are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and which they can be expected to earn at least 60% of their Indexed Predisability Earnings within twelve months following their return to work, regardless of whether they are working in that or any other occupation.

Preexisting Condition Provision

An employee is not covered for a short or long term disability caused or contributed to by a preexisting condition unless on the date they become disabled, the employee has been continuously insured under the group policy for the exclusion period and has been actively at work for at least one full day after the end of a **12-month exclusion period**.

A preexisting condition is a mental or physical condition whether or not diagnosed or misdiagnosed during the 90-day period just before disability coverage becomes effective:

- For which the employee would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications.
- Which, as a result of any medical examination, including routine examination, was discovered or suspected.

Treatment-Free Period: If an employee is treatment-free for six consecutive months during the 12-month exclusion period, any remaining exclusion period will not apply.

Short Term Disability

Short Term Disability (STD) provides income replacement if an employee becomes unable to work due to a medical disability. STD benefits begin on the first day following the benefit waiting period:

What the Benefit Provides	The plan pays 66 ⅔% of earnings up to \$750 per week.
Benefit Waiting Period	14 calendar days for qualifying accident, physical disease, pregnancy or mental disorder. This is the length of time an employee must be disabled before benefits begin.
How Long the Benefits Last	60 calendar days from the date of disability.
Benefits Are Paid	Weekly.
Deductible Income (offsets)	There are no offsets to the STD Plan, meaning benefits are not reduced if the employee is receiving income from other sources, such as workers' compensation or Social Security.

Additional Features

24-hour coverage: Both STD and LTD benefits cover disabilities that occur on or off the job.

Personal Health Advocate: While on an approved STD claim, an employee will have access to a dedicated Personal Health Advocate who can assist with a wide range of services, such as coordinating health care with specialists and managing billing questions.

Reasonable accommodation expense benefit: This benefit helps modify the work environment to allow an employee to stay at work or return to work following a disabling condition.

Return to work incentive: While an employee is recovering from disability and if their doctor approves, they may be able to return to work while still receiving LTD benefits at a reduced rate.

Survivors benefit: If an employee dies while LTD benefits are payable, a survivor benefit may be payable to an eligible surviving family member. The survivors benefit is three times the employee's monthly LTD benefit without reduction by deductible income.

Long Term Disability

Long Term Disability (LTD) provides income replacement if an employee becomes unable to work due to a medical disability. LTD benefits begin to pay after the employee has been continuously disabled for 60 days. The monthly benefit will be reduced by deductible income, such as Social Security or workers' compensation benefits, and the employee's premium will be waived while LTD benefits are payable.

* Please see [page 44](#) for a list of deductible income sources.

What the Benefit Provides	The plan will replace up to 66 ⅔% of eligible earnings*, up to a maximum benefit of \$12,500 per month. Plan minimum per month: \$100 or 10% of the LTD benefit (whichever is greater). <i>*Eligible earnings are an employee's monthly pre-disability earnings, as defined by the group policy.</i>
Benefit Waiting Period*	60 days. <i>*If an employee suffers a qualifying disability, the benefit waiting period is the length of time the employee must be continuously disabled before they can begin receiving a monthly benefit.</i>
How Long the Benefits Last*	<i>Depending on the employee's age at the time of disability, their benefits may continue up to the Social Security Normal Retirement Age (SSNRA) provided the employee continues to meet the definition of disability.</i> <i>Please see the Maximum LTD Benefit Period chart below for details.</i>
Benefits Are Paid	Monthly.

Maximum LTD Benefit Period

If an employee becomes disabled before age 62, LTD benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years, 6 months, whichever is longer. If an employee becomes disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months if longer
63	To SSNRA, or 3 years if longer
64	To SSNRA, or 2 years 6 months if longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year



Deductible LTD Income

Employees' benefits will be reduced if they have *deductible income*, which is income they receive or are eligible to receive while receiving LTD benefits.

Deductible income includes:

- Sick pay, annual or personal leave pay, severance pay, or other forms of salary continuation, including donated amounts (but not vacation pay) paid that exceeds 100 percent of an employee's indexed pre-disability earnings when added to the LTD benefit.
- Benefits under a workers' compensation law or similar law.
- Amounts under unemployment compensation law.
- Social Security disability or retirement benefits.
- Amounts because of an employee's disability from any other group insurance.
- Any retirement or disability benefits an employee is eligible to receive from their employer's retirement plan.
- Benefits under any state disability income benefit law or similar law.
- Earnings from work activity while an employee is disabled, plus the earnings they could receive if they work as much as their disability allows.
- Earnings or compensation included in pre-disability earnings which an employee receives or is eligible to receive while LTD benefits are payable.
- Amounts due from or on behalf of a third party because of an employee's disability, whether by judgment, settlement or other method.
- Any amount an employee receives by compromise, settlement or other method as a result of a claim for any of the above.

NCFlex Voluntary Disability Plan Monthly Premium Rates

Age as of last January 1	Rate per \$100 of Covered Monthly Payroll
Less than age 25	\$1.01
25-29	\$0.92
30-34	\$1.02
35-39	\$0.90
40-44	\$0.92
45-49	\$1.20
50-54	\$1.52
55-59	\$1.83
60-64	\$2.02
65-69	\$1.78
70+	\$2.49

Use this formula to estimate monthly premium payments:

$$\frac{\text{Monthly Earnings*}}{\text{(Yearly base salary divided by 12)}} \times \frac{\text{Employee's rate from the table}}{\text{}} \div 100 = \frac{\text{Monthly Premium Estimate}}{\text{}}$$

**Earnings cannot be more than \$18,750 per month.*

If an employee receives biweekly paychecks, take the monthly premium and divide by 2 to get an estimate of the semi-monthly premium.

Note: This calculation is meant to provide an estimate of premium. Actual premium may vary based on an employee's salary provided by their employer and their age on the effective date of the disability coverage.

Changes in Premium

While insured under the plan, an employee's premiums may change due to the following:

- **Change in salary:** If an employee's salary changes while they are insured under the plan, the premium will be adjusted based on the new salary amount. The new premium will become effective the first of the month following the change. (Example: If an employee's salary increase occurs on July 15, increased premiums will be deducted in the next paycheck following August 1.)
- **Age band change:** If an employee ages out of their current age band while insured under the plan, premiums will be adjusted to the new age band. The new premium will become effective the following January 1. (Example: If an employee turns 35 on July 15, 2027, they will move from the 30-34 age band to the 35-39 age band. The higher premium will begin the first paycheck following January 1, 2028.)

Important Details

Here are more in-depth details about the plans. All of the details below apply to both the STD and LTD Plans except where noted.

Employee Coverage Effective Date

To become insured, an employee must:

- Meet the eligibility requirements.
- Apply for coverage and agree to pay premiums.
- Receive medical underwriting approval (if applicable).
- Be actively at work (able to perform all normal duties of the job) on the day before the scheduled effective date of insurance.

If an employee is not actively at work on the day before the scheduled effective date of insurance, disability insurance will not become effective until the first of the month following their first full day of active work as an eligible employee.

Reinstatements may be subject to medical underwriting approval. Employees should contact their Health Benefits Representative (HBR) for more information regarding the requirements that must be satisfied for their insurance to become effective.

Limitations – STD

Disability benefits are not payable for any period when the employee is:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard.
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless the disability prevents the employee from participating.
- Confined for any reason in a penal or correctional institution.
- Able to work in their own occupation and able to earn at least 20% of their Predisability Earnings but the employee elects not to.

Limitations – LTD

Disability benefits are not payable for any period when the employee is:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard.
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless the disability prevents the employee from participating.
- Confined for any reason in a penal or correctional institution.
- In the Own Occupation Period of their claim and able to work in their own occupation and earn at least 20% of their Indexed Predisability Earnings and elects not to.
- In the Any Occupation Period of their claim and able to work in any occupation and earn at least 20% of their Indexed Predisability Earnings and elects not to.

In addition, the length of time an employee can receive LTD benefits is limited to 12 months while the employee resides outside the United States or Canada.

Exclusions

Subject to state variations, an employee is not covered for a disability caused or contributed by any of the following:

- Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot.
- An intentionally self-inflicted injury, while sane or insane.
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature).
- The loss of the employee's professional or occupational license or certification.
- A preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date the employee becomes disabled, he or she has been continuously insured under the group policy for the exclusion period and he or she has been actively at work for at least one full day after the end of the exclusion period.

When Benefits End

Disability benefits end automatically on the date any of the following occur:

- The employee is no longer disabled.
- The employee's maximum benefit period ends.
- Long-term disability benefits become payable to the employee under an LTD Plan (applicable to STD only).
- The employee fails to provide proof of continued disability and entitlement to benefits.
- The employee dies.

When Disability Coverage Ends

An employee's disability coverage ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid.
- The date the group policy (or the employer's coverage under the group policy) terminates.
- The date the employee ceases to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances).
- The date their employment terminates.

Group Insurance Certificate

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

Filing Claims

The following information will help employees file a Disability claim with Standard Insurance Company (The Standard).

Reporting a Claim

Employees should report a claim as soon as they believe they will be absent from work beyond 14 calendar days. If an employee is uncertain about how long they will be absent or whether they should file a claim or not, they should go ahead and file a claim to give them some peace of mind and give The Standard time to begin its review and issue a timely payment if appropriate.

How to File a Claim

Here are instructions to provide employees who want to file a claim.

To File a Claim By	Contact
Telephone (Preferred Method)	Call The Standard's Claim Intake Service Center at 833-878-8858 .
Online	Go to standard.com and click on "File a Claim" to begin the claim process. Instructions will be provided through the entire claim submission process. Note: If you submit your claim online, the claim submission system will indicate a requirement for a Disability Insurance Employer's Statement to be received before a decision may be made on your claim. Although this is a requirement, you do not need to take this to your employer. Upon receipt of your Employee Statement, The Standard will reach out to your employer to obtain the necessary information needed for your claim.
Paper claim	Your Health Benefits Representative

A typical application for disability benefits contains the following documents:

- Employee's Statement¹
- Employer's Statement²
- Attending Physician's Statement (APS)³
- Authorization to Obtain and Release Information

¹ If the employee files online or by telephone, the submission serves as the Employee's Statement and The Standard will instruct the employee if any other documents need to be completed.

² The Standard will contact the Employer to obtain the information necessary on the Employer's Statement.

³ It is the employee's responsibility to ensure the Attending Physician Statement is completed and faxed back to The Standard.

Frequently Asked Questions About the Claims Process

Here are some questions that employees may ask about disability claims.

When I Report my Claim, What Information Will I Need to Provide?

You will be asked to provide the following information — in addition to other questions about your absence:

- Employer name: State of North Carolina / NCFlex.
- Group Policy number: 758162.
- Name and Social Security number.
- Last day you were at work.
- Nature of claim/medical information.
- Physician's contact information (name, address, phone and fax number).

What Are the Hours of Operation for the Claim Intake Service Center?

If you choose to submit your claim by telephone, The Standard's Claim Intake Service Center representatives are available to assist you Monday through Friday, 8 a.m. through 8 p.m., Eastern Time.

Where Do I Send the Completed Forms? Completed forms may be mailed to:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

Or if you prefer, you may fax completed forms to The Standard at **800-378-6053**.

What Can I Expect After I Submit the Completed Forms? Once The Standard receives the required paperwork, which includes the Employee's Statement, Employer's Statement, Attending Physician's Statement and Authorization to Obtain and Release Information, your benefits analyst will contact you to discuss any additional information that may be necessary to complete the processing of your claim and to answer any of your questions.

If My Claim for Benefits Is Approved, How Long Will It Take to Receive My First Check? After the Benefit Waiting Period as outlined in your group policy is completed, benefit payments are paid in arrears on a weekly (STD) or monthly (LTD) basis based on the date of disability and are mailed directly to your residence.

For LTD claims, direct deposit may be established. Benefit payments that are payable for retroactive claims will be paid immediately following claim approval.

Who Should I Call with Questions About My Claim? If you have already filed a claim, please call The Standard's Disability Benefits toll-free number, **833-878-8858** or email your question to **ncflex@standard.com**. If you are looking for general information, please contact your benefit administrator.

Who Is Responsible for Notifying My Employer of My Absence? It is your responsibility to follow the normal absence reporting procedures by notifying your manager or supervisor of your absence.

Disability Benefits for Participants in TSERS

State of NC employees who participate in the Teachers' and State Employees' Retirement System (TSERS), may qualify for disability benefits under the Disability Income Plan of North Carolina (DIP-NC). This section provides details about the DIP-NC disability benefits.

Eligibility

Whether an employee qualifies for STD or LTD benefits depends on how many years of creditable service they have as a participant in TSERS. In addition, disability benefits may be limited if an employee has fewer than five years of creditable service.

If an employee is eligible for STD coverage, after having been disabled for 60 days, the STD Plan begins paying a monthly disability benefit for up to a year. After a year, if the employee remains disabled and is eligible for LTD coverage, the LTD Plan pays a monthly benefit for as long as the employee qualifies as disabled. (See **Employees Can Supplement Basic STD/LTD through the NCFlex Voluntary Disability Plan** section on [page 49](#).)

STD Coverage through DIP-NC

If an employee has at least one year of contributing membership service in TSERS (earned within the 36 calendar months preceding the disability) and meets all plan requirements, the STD Plan will pay a benefit due to a qualified disabling illness or injury after a 60-day waiting period.

The STD Plan pays a monthly benefit equal to 50% of the employee's monthly salary, up to a maximum of \$3,000 per month. The plan continues to pay this benefit until the employee is no longer disabled, or 365 days have passed since the beginning of the disability, whichever comes first.

Here's a brief summary of the STD benefits under this plan:

Creditable Service as a Participant in TSERS	During This Period of Disability	STD Plan Benefit (DIP-NC)
Less than 1 year	For as long as the employee is disabled.	No benefit.
1 year or more	First year of disability.	After a 60-day waiting period, the plan pays 50% of the employee's monthly salary, up to a maximum of \$3,000 per month.*

* Offsets may apply.

The STD Plan does not pay benefits for disabilities that begin before an employee has at least one year of service as a participant in TSERS. However, employees can purchase supplemental disability coverage to provide a benefit if they become disabled during that first year.

Extended STD Coverage through DIP-NC

If an employee's disability is considered temporary but continues past the first year, an additional period of STD may be approved, not to exceed 365 days. The employee must meet all disability requirements and be approved by the plan's medical board.

Here's a brief summary of the Extended STD benefits under this plan:

Creditable Service as a Participant in TSERS	During This Period of Disability	Extended STD Plan Benefit (DIP-NC)
Less than 1 year	For as long as the employee is disabled.	No benefit.
1 year or more	During the second year of disability.	Following the initial STD period, the plan pays 50% of the employee's monthly salary, up to a maximum of \$3,000 per month.*

* Offsets may apply.

LTD Coverage through DIP-NC

If an employee has at least five years of membership service in TSERS, the LTD Plan will pay a benefit if they remain disabled for longer than 365 days and are considered permanently disabled.

The LTD Plan pays a monthly benefit equal to 65% of an employee's monthly salary, up to a maximum of \$3,900 per month. The plan continues to pay this benefit until the employee is no longer disabled, or when they qualify for retirement, whichever comes first. Other rules may apply which may offset or end payments.

Here's a brief summary of the LTD benefits under this plan:

Creditable Service as a Participant in TSERS	During This Period of Disability	LTD Plan Benefit (DIP-NC)
Less than 5 years	For as long as the employee is disabled.	No benefit.
5 years or more	Beginning the second year of disability and continuing for as long as the employee is disabled. ¹	The plan pays 65% of the employee's monthly salary, up to a maximum of \$3,900 per month. ²

Although the LTD Plan does not pay benefits for disabilities that begin before an employee has at least five years of service as a participant in their retirement plan, they can purchase supplemental disability coverage to provide a benefit if they become disabled during that time.

¹ See "Length of Long-Term Benefits" in the Disability Income Plan of NC handbook for details on how long benefits may last.

² Offsets may apply.

Employees Can Supplement Basic STD/LTD through the NCFlex Voluntary Disability Plan

Although being a member of TSERS provides basic STD and basic LTD coverage at no cost, eligible employees may wish to consider purchasing additional STD and LTD protection through the NCFlex **Voluntary Disability Plan** offered through The Standard. Keep reading to find out how this coverage works with basic STD and LTD coverages (and see **NCFlex Voluntary Disability Plan** on [page 41](#) for more details).

How the NCFlex Voluntary Disability Plan Works with Basic STD and LTD Coverage

The NCFlex Voluntary Disability Plan includes short-term disability (STD) coverage which pays a benefit of 66 ⅔% of earnings up to \$750 per week with no offsets following the benefit waiting period. If an employee is still disabled after 60 days, the claim will transition to long-term disability (LTD) coverage, which pays up to 66 ⅔% of an employee's salary with offsets for as long as the employee meets the definition of disability, but not to exceed normal Social Security retirement age.

The Voluntary Disability Plan begins paying a benefit if an employee is disabled for more than 14 calendar days. The 14-day period is called the *benefit waiting period*. The benefit waiting period is the length of time an employee must be disabled before they begin receiving benefits.

Generally, the plan supplements whatever basic STD or basic LTD benefit an employee may be receiving (including disability benefits provided through the DIP-NC coverage, plus certain other benefits as explained later). For the first 60 days the 66 ⅔% of earnings up to \$750 per week is on top of anything else the employee is receiving. After that, the payment is whatever amount is needed to bring the employee's total disability benefit up to 66 ⅔%. If the employee is not receiving any other disability benefits or other applicable deductible income, then the Voluntary Disability Plan pays all of the 66 ⅔% of their monthly salary itself.

In addition, enrolling in the Voluntary Disability Plan increases the maximum possible monthly benefit to \$12,500.

The plan pays benefits for a qualifying disability regardless of how many years of membership service an employee has as a participant in TSERS. Therefore, it fills in certain "gaps" during which basic disability coverage does not pay a benefit.



Duck Decoys at the N.C. Museum of History, Raleigh
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The table summarizes how the NCFlex Voluntary Disability Plan works with and supplements the basic STD and basic LTD Plans:

Service in TSERS	During this Period of Disability	Benefits Paid	
		Basic STD Plan and Basic LTD Plan	NCFlex Voluntary Disability Plan through The Standard
Less than 1 year	For as long as the employee is disabled, but not to exceed the maximum benefit period.	No benefit.	After the required waiting period, the plan pays 66 ⅔% of earnings up to \$750/week for the first 60 days and then 66 ⅔% of the employee's monthly salary**, up to a maximum monthly benefit of \$12,500.
1 through 4 years	First year of disability.	STD: After a 60-day waiting period, the plan pays 50% of the employee's monthly salary up to \$3,000 per month*.	After the waiting period, the plan pays 66 ⅔% of earnings up to \$750/week for the first 60 days and then day 61 going forward, 16 ⅔% (or more) of the employee's monthly salary, bringing the total benefit to 66 ⅔% of their monthly salary**, up to a maximum monthly benefit of \$12,500 per month.
	Beginning the second year of disability and continuing for as long as the employee is disabled, but not to exceed the maximum benefit period.	Extended STD: If disability is temporary but exceeding one year, the plan pays 50% of the employee's monthly salary, up to a maximum of \$3,000 per month* for the second year only. LTD: No benefit.	If an employee is approved for Extended STD, the plan pays the same benefit outlined for the first year of disability (see row above) for year two or until Extended STD ends. If the employee is not approved for Extended STD, or after Extended STD ends, the plan pays 66 ⅔% of their monthly salary**, up to a maximum of \$12,500 per month.
5 years or more	First year of disability.	STD: After a 60-day waiting period, the plan pays 50% of the employee's monthly salary up to \$3,000 per month*.	After the waiting period, the plan pays 66 ⅔% of earnings up to \$750/week for the first 60 days and then day 61 going forward, 16 ⅔% (or more) of the employee's monthly salary, bringing the total benefit to 66 ⅔% of their monthly salary**, up to a maximum monthly benefit of \$12,500 per month.
	Beginning the second year of disability and continuing for as long as the employee is disabled, but not to exceed the maximum benefit period.	LTD: The plan pays 65% of the employee's monthly salary, up to \$3,900 per month*.	The plan will pay a benefit to make the employee whole up to 66 ⅔% of their monthly salary**, up to a maximum of \$12,500 per month. The plan will pay a minimum of \$100/month or 10% of the LTD benefit (whichever is greater).

* Offsets may apply.

** Minus deductible income.

TRICARE Supplement Plan

for retired United States military



Yearly re-enrollment not required.

What is TRICARE Supplement Plan?

TRICARE Supplement Plan is administered by Selman & Company and underwritten by Hartford Life and Accident Insurance Company.

If an employee currently has TRICARE Select, Prime, or TRR benefits offered to the retired military community, they may be eligible and interested in the TRICARE Supplement Plan.

The TRICARE Supplement Plan works with TRICARE to pay the balance of covered medical expenses after TRICARE pays. The TRICARE Supplement Plan helps to pay 100% of members' TRICARE outpatient deductibles, cost shares, copayments plus 100% of covered excess charges up to the legal limit. Members have flexibility and freedom of choice in selecting civilian providers (i.e., physicians, specialists, hospitals, and pharmacies).

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 Select, Prime, or TRR 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).

Eligible Dependents

- 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. Incapacitated dependents must be enrolled in the TRICARE Supplement Plan before reaching age 21, or age 23 if a full-time student.
- Adult dependent children who are younger than 26 and who are enrolled in TRICARE Young Adult (TYA). The child must provide a copy of their TYA Enrollment ID card to Selman & Company and enroll in the supplement prior to their 26th birthday.

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 they are 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 **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 benefits and minimize 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 [tricare.mil](https://www.tricare.mil).

Monthly Cost

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

Coverage will terminate at the end of the month in which:

- Employee reaches age 65
- Dependent child(ren) reach age 26
- Eligibility is lost through NCFlex

Note: TRICARE eligibility must remain in place prior to these events.

There is no deductible for this plan, and it covers 100% of the TRICARE Select 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 procedures 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 NCFlex. There is no separate administrative fee required. No continuation of coverage is available in Massachusetts or Puerto Rico.

Continuation of coverage does not apply to an employee, spouse, or dependent child who no longer meets the TRICARE Supplement Plan eligibility requirements. For example, 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.

Employee Contact

Customer Service Call Center	800-638-2610 , Option 1 Monday - Friday from 9:00 a.m. - 7:00 p.m. (ET)
E-mail	memberservices@selmanco.com
Website	selmantricareresource.com/nc



Cherokee Unto These Hills Outdoor Dramas
© N.C. Department of Natural & Cultural Resources

Coverage Continuation Options at Termination

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

NCFlex Coverage	Option	Cost	Remarks
Health Care Flexible Spending Account	COBRA**	102%	P&A will send COBRA enrollment materials to the employee's last known address.
Dependent Day Care Flexible Spending Account	None		Cannot be continued. However, the available account balance can still be used for services incurred through the end of the calendar year and through the grace period of the plan.
Accident	Portability prior to age 70	100%	The employee will need to contact Voya by calling 877-464-5111 .
Cancer	Portability	100%	The Standard sends a portability letter to the employee upon receipt of the termination of employment.
Critical Illness	Portability prior to age 70	100%	The employee will need to contact Voya by calling 877-464-5111 .
Dental	COBRA**	100%*	The COBRA Administrator will send enrollment materials to the employee's last known address.
Vision Care	COBRA**	100%*	The COBRA Administrator will send enrollment materials to the employee's last known address.
Term Life	Continuation	Contact Voya for rates and to continue coverage at 877-464-5111 .	The employee will need to contact Voya by calling 877-464-5111 .
Core Accidental Death and Dismemberment (AD&D)	None		Cannot be continued.
Voluntary Accidental Death and Dismemberment (AD&D)	Portability	Contact Voya for rates and to continue coverage at 877-464-5111 .	The employee will need to contact Voya by calling 877-464-5111 .
Disability	None		Cannot be continued, unless employee has been approved to receive or is receiving a benefit from the plan.
TRICARE Supplement	Portability	100%	Selman will send COBRA enrollment materials to the employee's last known address.

* The rate is 100% of the combined employer and employee rate. University employees will be charged a 2% administrative fee.

** See chart on [page 54](#) for the COBRA coverage provisions.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allows the employee and/or his or her dependents to continue current NCFlex Dental, Vision, and HCFA coverages for a specific period when the employee and/or his or her dependents are enrolled and coverage is lost due to a qualifying event. The employee must pay the required cost of coverage.

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

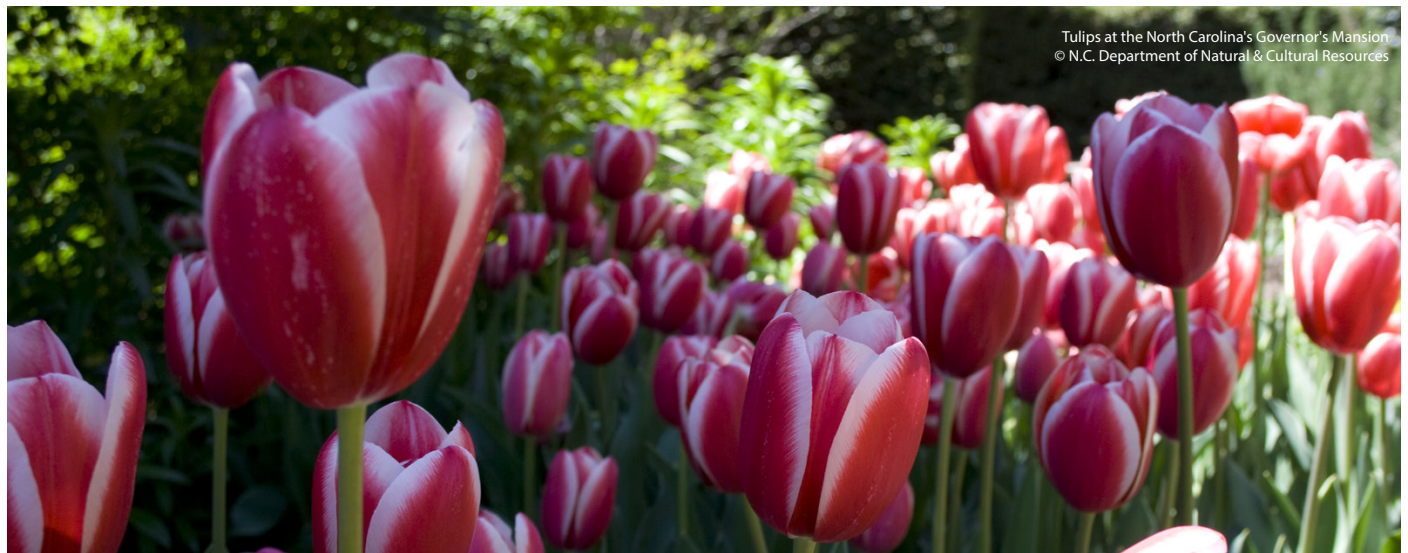
Qualifying Event	Qualified Beneficiaries Who May Continue Coverage	Duration of Coverage
Employment ends for any reason other than gross misconduct	Employee, spouse, dependent children	Up to 18 months
An employee loses benefit eligibility due to reduction in hours**	Employee, spouse, dependent children	Up to 18 months
During the first 60 days of COBRA coverage the employee or their dependent becomes disabled under the Social Security Act*	Employee, spouse, dependent children	Up to 29 months; months 1-18, 102% of premium; months 19-29, 150% of premium
An employee divorces or legally separates	Ex-spouse and/or dependent children	Up to 36 months from initial qualifying event
An employee's dependent children lose eligibility	Dependent children	Up to 36 months from initial qualifying event
An employee becomes covered by Medicare*	Spouse and/or dependent children	Up to 36 months from initial qualifying event
An employee dies	Spouse and/or dependent children	Up to 36 months from initial qualifying event

*Applies to medical coverage only.

**Employees must work 20 or more hours/week to be eligible for NCFlex coverage.

If a Benefits Claim is Denied

If an employee has a benefits claim that is denied by the carrier, they have certain rights as a plan participant to appeal. For information on the appeals process for specific benefits, employees may contact individual benefit carriers. The steps to the appeals process are outlined in the insurance certificates.



Tulips at the North Carolina's Governor's Mansion
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Election Process

Under COBRA, an employee and/or his or her covered dependents have the responsibility to inform a Health Benefits Representative (HBR) or the 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 the employee's termination, reduction in hours, or during the first 60 days of COBRA coverage. If the employee does not notify their HBR or benefits department within 60 days of these events and before the original 18-month COBRA period expires, then the employee's rights to continuation of coverage will end. The 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 the employee by the appropriate carrier. If the employee is interested in continuing NCFlex coverage, they 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 the employee fails to meet this deadline, their COBRA rights will end.

Premium Payments

There is an initial grace period of 45 days starting with the date an employee elects continuation of 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 the employee receives from the carrier.

COBRA Ending Date

COBRA coverage continues until the earliest of the following:

- The employee's maximum amount of continuation coverage ends (see chart on [page 54](#)).
- The State of North Carolina no longer provides that coverage to any employee under the NCFlex Program.
- The employee's premium for continuation coverage is not paid in full by the due dates listed.
- The qualified beneficiary becomes covered (after the date they elect COBRA coverage) under another similar group health plan, which does not contain any exclusion or limitation with respect to any pre-existing condition they may have.
- 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.

Employee or covered dependents who have questions about COBRA rights or have changed addresses or marital status, should 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 HCFA 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 at ncflex.org.

Contact Information

NCFlex

ncflex.org
ncflex@nc.gov

Flexible Spending Accounts

P&A Group
ncflex.padmin.com

Customer Service: 866-916-3475
Monday – Friday 8 a.m. – 10 p.m. (ET)

Mail claims to:
6400 Main Street, Suite 201
Williamsville, NY 14221

Fax claims to: 877-213-8917

Accident/Term Life/ AD&D/Critical Illness

Voya Financial

Customer Service:
LifeHelp
2990 Innsbruck Dr
Redding, CA 96003
877-464-5111
Monday – Friday 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: 844-449-2553 or
upload online at: [claimscenter.voya.com/
static/claimscenter](http://claimscenter.voya.com/static/claimscenter)

Cancer

The Standard
mybenefits.standard.com

Customer Service: 866-232-1517
Monday – Friday 8 a.m. – 8 p.m. (ET)

Mail claims to:
American Heritage Life Insurance Company
Claims Department
1776 American Heritage Life Drive
Jacksonville, FL 32224-6688

Dental

MetLife
metlife.com/mybenefits

Customer Service: 855-676-9441
Monday – Friday 8 a.m. – 11 p.m. (ET)

Mail claims to:
MetLife Dental Claims
PO Box 981282
El Paso, TX 79998-1282

Vision

EyeMed Vision Care
eyemedvisioncare.com/ncflex
4000 Luxottica Place
Mason, OH 45040

Customer Service: 866-248-1939
Monday – Saturday 7:30 a.m. – 11 p.m. (ET)
Sunday 11 a.m. – 8 p.m. (ET)

Disability

The Standard
standard.com

Customer Service: 833-878-8858
Monday – Friday, 8 a.m. – 8 p.m. (ET)

Mail EOI forms to:
Standard Insurance Company
Attn: Medical Underwriting
900 SW 5th Ave
Portland, OR 97204

Email EOI forms to:
MUSC@standard.com

Fax EOI forms to: 971-321-5994 or
971-321-5996

Mail claims to:
Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

Fax claims to: 800-378-6053

TRICARE Supplement

Selman & Company
One Integrity Parkway
Cleveland, OH 44143

Customer Service:
800-638-2610, option 1
Monday – Friday 9 a.m. – 7 p.m. (ET)

Benefit Enrollment

ncflex.org and click
Enroll Now

eBenefits for Non-University employees:

Customer Service: 855-859-0966
Monday – Friday 8 a.m. – 5 p.m. (ET)

Empyrean for University employees:

Customer Service: 833-862-1490
Monday – Friday 8 a.m. – 5 p.m. (ET)

COBRA for Dental and Vision

Non-University COBRA Administration

Customer Service: 877-679-6272
Monday – Friday 8 a.m. – 5 p.m. (ET)
mycobra.info

University COBRA Administration
Customer Service: 833-874-1600
Monday – Friday 8 a.m. – 8 p.m. (ET)
cobraandbillingservices.com

A Special Thank You!

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provided by North Carolina's Department of
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