AFLAC INCORPORATED **BENEFITS GUIDE**

2015

Your benefits.
Your way.

2015 BENEFITS ENROLLMENT GUIDE

Aflac is committed to providing its greatest asset—its talented employees—with comprehensive and affordable benefits. Our 2015 Health and Welfare Benefits offerings deliver maximum options and flexibility while reflecting our culture.

This guide will help you understand the full range of health and welfare benefits that will be available as of Jan. 1, 2015. After reading through the enclosed information, be sure to use this guide as a benefits resource you can refer to throughout the year.

The last page of the guide is a quick reference directory of telephone numbers and websites for all our providers. We encourage you to access these sites to become a more educated decision maker and consumer of Aflac's benefit programs.

Should you have questions that need more detailed explanation than you can find in this guide, visit the Benefits community at **myAflac.com**. Select the **Employee Services** tab and click **Benefits** or contact the Human Resources Benefits team at 706-317-0770.

Online Assistance

Visit Employee Self Service from any company computer or from home if you have VPN access, to review benefits materials online and to enroll. Benefits information is also posted on **myAflac.com > Employee Services > Benefits.**

Web Access

The 2015 Benefits Guide can be viewed from a personal device at **Aflac.com/BenefitsGuide**, as well as on the Benefits community page on **myAflac.com**.

The symbol indicates a hyperlink.

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Aflac Incorporated

About This Guide

This document is intended to highlight or summarize certain provisions of Aflac's benefit plans. It is not a Summary Plan Description (SPD) or an official plan document. Your rights and obligations under the plans are set forth in the plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriate plan fiduciary. In the case of an ambiguity or conflict between a provision in this summary and a provision in the plan documents, the terms of the plan documents control. Aflac reserves the right to review, change, or terminate the plan, or any benefits under it, for any reason, at any time, and without advance notice, unless required by law.

Aflac Incorporated provides benefits for Aflac and all its subsidiaries and related companies and shall not be deemed the employer of plan beneficiaries.

Enrollment is quick, easy and more convenient than ever. You may enroll online any time between October 27 and November 14.

When to Enroll

Open Enrollment 2015

Open Enrollment begins Oct. 27, 2014 and ends at 5 p.m. EST on Friday, Nov.14, 2014. You can enroll **at any** time during the open enrollment period. Please remember you must enroll on an Aflac computer or have VPN access to log in from a personal computer.

New Hires

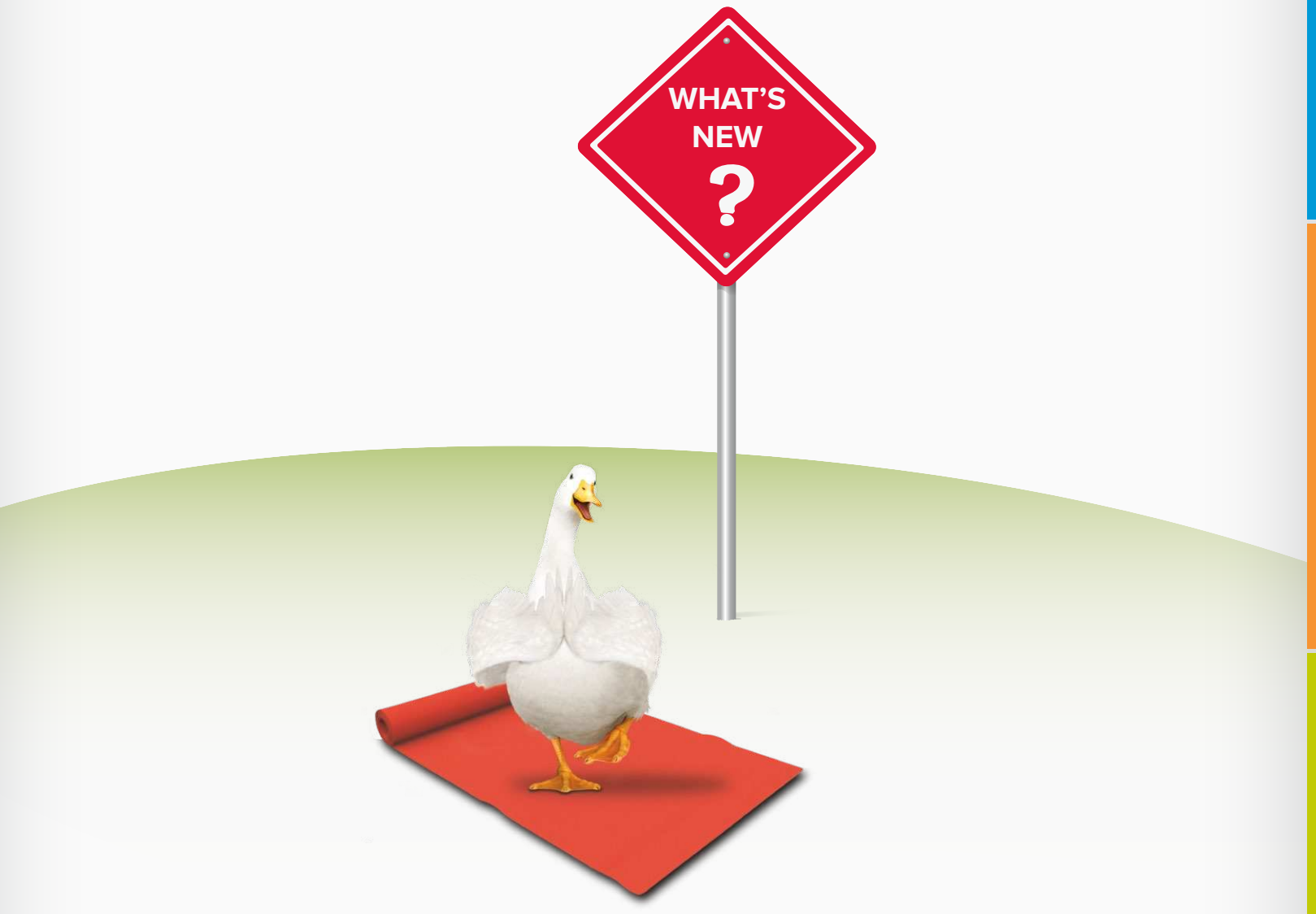
If you are new to Aflac, make your benefit elections for 2015 no more than 30 days from your date of hire.

New employees are automatically enrolled in the Group Term Life Plan in company-paid options of Basic Group Life and Basic Accidental Death & Dismemberment at one and one-half times your base annual salary.

The Aflac 401(k) Plan has a default contribution (automatic enrollment) of 6 percent of your gross salary.

If you'd like to enroll in the dental, vision or medical plan and apply for additional life or AD&D coverage, you must make these elections during your initial enrollment period, which is no more than 30 days from your date of hire. We encourage you to make your election as soon as possible after your date of hire to ensure premium deductions for any changes in your elections start with your first pay statement. You may change your 401(k) at any time after enrollment.

WHAT'S NEW IN 2015



WHAT'S NEW IN 2015

Each year HR reviews all benefit offerings to ensure that they are relevant, priced appropriately and meet our employees' needs. The following list includes changes that will take place beginning Jan. 1, 2015.

1

Medical Premiums in 2015. Each year, an extensive analysis occurs before the next year's medical premiums are known. Claims experience, medical inflation and other factors are considered. We are delighted to announce that our medical premiums will not increase for 2015. Maintaining healthy lifestyles, use of generic prescriptions when available, using the ER only for emergencies, and so on will enable us to continue the favorable trend! The 2015 premiums can be found at **myAflac.com > Employee Services > Benefits.**

2

"My allergies are driving me nuts. I wish I could just call a doctor instead of having to go for an office visit." Well, now you can! LiveHealth Online enables you to talk to a doctor for non-emergency illnesses such as sinus or respiratory infections, allergies, cold and flu to mention a few. Help is available 24/7 and you can even communicate using a computer. The doctor can call in certain prescriptions to the pharmacy of your choice. Please see page 16 for details.

3

Expanded Dental Tiers. Both the Network Only and Choice Dental Plans will have 4 tiers (instead of 2). They are: Employee Only, Employee + Spouse, Employee + Child(ren), and Family. Expanded tiers allow for more equitable pricing based on the number of eligible dependents to be covered. The 2015 premiums can be found at **myAflac.com > Employee Services > Benefits.**

4

Medical FSA* Rollover. Aflac adopted the IRS-approved Rollover option for the Medical Flexible Spending Account. It allows participants to carry over unused balances of up to $500 to the next year. Keep in mind, the Medical FSA will no longer have the grace period. Also, funds that rollover do not reduce the IRS limit you may elect during open enrollment. Thus, you could elect $2,500 for 2015 even if I have unused funds rollover to 2015. *(The rollover feature does not apply to the Dependent Care FSA, which continues to allow the grace period of March 15, 2015 to incur eligible expenses and March 31, 2015 to submit for reimbursement.) * Does not apply to Puerto Rico.*

HOW TO MAKE YOUR

2015 BENEFIT ELECTIONS

FIRST, review all the benefit options summarized in this guide.

NEXT, go to **myAflac.com > Employee Services > Benefits** to review the 2015 Rates for each benefit.

FINALLY, record and save your elections online by going to **myAflac.com > Employee Services > Self-Service** and follow these steps:

1. When the **Aflac ESS** page opens, select **Benefits and Payments**.
2. Under **Benefits Enrollment**, select **Open Enrollment 2015**.
3. Read and accept the Terms and Conditions for enrolling in your Benefits.
4. There are a total of 7 steps to the enrollment process. Click the **Next** button when you have completed a step to go to the next step. If you need to go back to a step, click the previous button or you can click the box with the step number at the top of the window.

   Step 1 Personal profile - Confirm your address is correct. Click the **Edit Personal Profile** button to correct your address if needed.

   Step 2 Dependents and Beneficiaries - Check that your dependents and beneficiaries are correct. To add or change a dependent or beneficiary, click the **Edit Dependents and Beneficiaries** button. Make sure to add the Social Security number and date of birth for dependents you add. If you add a dependent to coverage, you will need to supply documentation to the Benefits department certifying their eligibility.

   Step 3 Benefits Summary - Review your current benefits elections and plans available that you are not currently enrolled in.

   Step 4 Health Plans - Click the pencil icon in the action column to change your election for plans you are currently enrolled in. Click the page icon in the action column to enroll in new plans. Click the option you wish to select and check the boxes for the dependents you wish to enroll. If a checkbox for a dependent is disabled, this means the dependent is not eligible for the plan. Click the add button to indicate your selection.

   Step 5 Insurance Plans - When electing life coverage, make sure to specify your beneficiaries in the bottom of the window. If a beneficiary is not listed, go back to Step 2 and add them then return to Step 5. You can click on the box with the step number at the top of the screen to go directly to a step. Note: There is no Beneficiary selection for spouse life for your spouse or domestic partner, dependent life for your child(ren) or the child(ren) of your registered domestic partner, or accidental death and dismemberment insurance options. If you see a popup box with the heading " EOI (Evidence of Insurability) REQUIRED!", this means you must provide evidence of insurability for the coverage you have selected before the coverage will become active. Refer to the instructions in the popup window. You will also receive an email notifying you of your insurance change and the need to provide evidence of insurability. The coverage you selected is pending until you provide evidence of insurability.

   Step 6 Flexible Spending Accounts - When enrolling in your flexible spending account, specify the Annual contribution amount and click the calculate button to see how much you will be contributing **per pay period**. The annual amount will be divided into 24 equal payroll deductions in 2015.

Step 7 Review and Save - Review your changes and confirm they are correct. Click the Save button at the top of the screen to submit your enrollment elections. **NOTE: You must click the save button for your elections to be recorded.**

Your elections will be displayed on the next screen. Click the "Print Benefit Elections Summary" link to display your Enrollment Confirmation Statement. In the Confirmation Statement window, print your elections by moving your mouse pointer to the bottom of Confirmation statement window. A tool bar will appear. Click the printer button on the toolbar. Keep this copy of elections for your records. You will also receive an email with your Enrollment Confirmation Statement upon successful completion of enrollment.

Review your Aflac policies and choose whether to apply for any you don't already own. Your existing policies automatically continue into 2015. You don't have to select a policy for which you don't intend to make changes. See How to **Apply for Aflac Coverage** on page 9 for more information.

Your Cost

Prior to enrollment, go to **myAflac.com > Employee Services > Benefits** to review the 2015 Rates sheet. Any cost you pay is shown online with each of your benefit options.

Details and Tools

Go to **myAflac.com > Employee Services > Benefits**. or click the link for**.**

If You Don't Enroll

We encourage all employees to complete enrollment and obtain a Benefits Confirmation to ensure your benefit elections are accurate. If you take no action on your enrollment, your current elections will remain in place for 2015, **except** any contributions to a medical, dependent care or commuter flexible spending accounts will end. **You must make a new election to participate in the flexible spending accounts each year.**

Don't Want Coverage?

If you currently are covered by any of the following benefits and want to stop coverage for 2015, you must go online to **Self Service** during open enrollment and select the **Waive** option:

- Health, dental and vision plans.
- Employee supplemental, spouse and dependent life insurance.
- Voluntary accidental death and dismemberment insurance.

Adding Beneficiaries and Dependents

If you are adding beneficiaries in 2015, you must complete the following steps before you begin enrolling for 2015 benefits.

Is a beneficiary or dependent missing from **Self Service** or do you need to add a beneficiary? If so:

- Go to **myAflac.com > Employee Services > Benefits** for information on adding a dependent.
- Go to Employee Self Service to add a beneficiary.
- In the menu bar, select **Personal Information**, then **Family Member/Dependents** to add individuals.
- Add dependent's full name, date of birth and Social Security number.
- Provide the address information for any individual whose address differs from yours.
- Enrollments lacking required proof of dependency will be removed.

Defining Eligible Dependents

Dependents eligible under the Aflac Health Plan are legal spouses, registered domestic partners, the biological children of employees, the biological children of registered domestic partners, the stepchildren of employees, adopted children and children placed in an employee's home for adoption before reaching age 18, and children for whom an employee is appointed as legal guardian. Dependent children are eligible for coverage until age 26.

- If a dependent child enrolled in the plan is physically or mentally handicapped on the date coverage would otherwise end, the child's eligibility will be extended for as long as the employee is covered by the plan and as long as the disability continues and the child continues to qualify for coverage in all aspects other than age. Employees must show proof and/or documentation that enrolled dependents are physically or mentally disabled at initial enrollment and on a periodic basis.
- Any employee enrolling a new spouse, a new registered domestic partner or any dependent children will need to provide the Employee Benefits department with the following information before enrollment becomes effective: a marriage certificate or certificate of registration as a domestic partner, and the birth certificates of all children being added to the plan.

How to Apply for Aflac Coverage

Remember: All Aflac employees receive an Aflac-paid Cancer policy for themselves, if qualified; however, new employees must apply during initial enrollment to verify eligibility for this Aflac-paid policy.

For Aflac employees, just as for our policyholders, Aflac policies provide additional security to help pay unexpected expenses resulting from illness or injury. Open enrollment is the time to review your current policies to determine whether they meet your family's needs and to consider additional Aflac policies or a group plan.

Each policy available through the Aflac benefit program is listed as a separate link on **myAflac.com > Employee Services > Self Service > Benefits and Payment**. Click on any policy link to open the enrollment screen and view your existing policy information. You will also see:

- Total premium paid each pay period.
- Portion of the premium paid by Aflac on your behalf.
- Your share of the premium.

Your Current Policies

- You don't need to re-enroll for an Aflac policy you already own.
- To add eligible dependents to an existing policy, call the Customer Service Center at 800-992-3522.

To Apply for a New Insurance Policy

To learn about new policies you're considering, select them by name to access their brochures. To apply:

- Review the instructions posted on **myAflac.com > Employee Services > Benefits > How to Apply for Aflac Policies**.
- Choose the policy level and any riders.
- Carefully read and answer all questions, and click on the **Next** button until you get to the application review page.
- Review your application for completeness, and then select the **Accept** button to complete the application.

Aflac Group Critical Illness Insurance[1]

As you consider your benefits options, take a moment to think about how you would protect yourself or your family from the financial impact of a critical illness. With advances in medicine, the odds of surviving a critical illness—such as cancer, heart attack, stroke, end-stage renal failure or coronary artery disease—are greater than ever. But during treatment, there are still bills that must be paid.

That is the benefit of enrolling in group critical illness insurance. While Aflac group critical illness coverage provides a benefit for cancer, it is important for you to know that the cancer coverage is not equivalent to benefits provided under the Aflac individual cancer policy. Additionally, it is important to understand that benefits that may have accrued under an existing individual cancer policy are not transferrable to an Aflac group critical illness insurance plan.

To Enroll in Aflac Group Critical Illness Insurance

Enrolling in the Aflac group critical illness plan is different than applying for traditional (individual) Aflac policies. To enroll in group critical illness coverage:

- Select the plan from the list on **myAflac.com > Employee Services > Self Service > Benefits and Payment** and answer all questions.
- Once you are finished, review your answers and select the **Accept** button.

If You Have an Aflac Specified Health Event Policy ...

If you have an existing specified health event policy, you may keep it and continue to pay your premiums through payroll deduction. However, any Aflac group critical illness coverage you purchase will be limited to that plan's guaranteed amount.

[1] Aflac Group is the marketing name for Continental American Insurance Company (CAIC), a wholly owned subsidiary of Aflac Incorporated. CAIC underwrites group coverage but is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Portability

It is important to understand that Aflac specified health event policies are guaranteed-renewable and are available on a direct bill basis once employment with Aflac ends. Because the policy is an individual plan, your coverage will remain in force as long as premiums are paid.

Your coverage under the Aflac group critical illness plan is portable only as long as the master policy remains in force. While there are no current or anticipated plans to cancel the master policy, if circumstances change and Aflac cancels the master policy for any reason, all coverage under the master policy will be terminated. However, as long as the plan is in force, you can continue your coverage if you change jobs or retire. Simply notify Aflac Group in writing within 31 days after you leave Aflac's employment. Aflac Group will then establish a direct-bill payment plan for you to pay the premiums necessary to keep the coverage in force.

For more information about Aflac policies and the Aflac group critical illness plan, review the product brochures on **myAflac.com > Employee Services > Self Service > Benefits and Payment**, or call 800-992-3522 (for Aflac policies) or 800-433-3036 (for the Aflac group critical illness plan). For questions, check out the online FAQs and for rates, go to the **Aflac Policies Rate sheet.**

HEALTH AND WELLNESS PLANS

Aflac Health Plan

And Prescription Drug Benefits

Eligibility

All full-time employees, their legal spouses or registered domestic partners, and eligible dependents are eligible for coverage on first day of employment. Part-time employees are not eligible.

You Should Know

- Health plan coverage is administered by Anthem Blue Cross Blue Shield.
- Aflac's robust Health Care Plan provides much of the preventive care and essential health benefits to plan participants that are required by the Patient Protection and Affordable Care Act.
  - A Summary of Benefits and Coverage posted online and on page 60 of this guide. To view, visit **myAflac.com**, select the **Employee Services tab** and click **Benefits.**

  We will continue to monitor the requirements of the health care reform legislation and keep you informed as to how it may affect you.
- You have the freedom to use in-network or out-of-network care providers. See the directory of doctors and hospitals at **anthem.com**

Support for chronic conditions: The health plan claims administrator, Anthem, offers a support team that provides assistance if you or a family member has a chronic condition, such as those listed below. Services include help with understanding your coverage and filing claims, as well as support for your doctor-prescribed treatment plan through guidance and education.

- Diabetes
- Asthma
- Cardiovascular Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Congestive Heart Failure
- High-Risk Maternity

Call Anthem at 888-893-6366 for more information.

Coverage	PPO Plan	
	Individual	Family
	Plan Pays (unless otherwise noted):[1]	
➤ In-network expenses	• 80% after you meet the in-network annual deductible • 100% after your share of eligible expenses reaches the in-network maximum annual of out-of-pocket expenses	
➤ Out-of-network expenses[2]	• 60% after you meet the out-of-network annual deductible • 100% after your share of eligible expenses reaches the out-of-network maximum of annual out-of-pocket expenses	

Coverage	PPO Plan	
	Individual	Family
	You Pay:[1]	
Annual deductible		
➤ In-network	$ 500	$1,000
➤ Out-of-network[2]	$ 1,000	$ 2,000
Maximum annual out-of-pocket expenses		
➤ In-network	$ 2,000	$ 4,000
➤ Out-of-network[2]	$ 4,000	$ 8,000
Physician services, office visits and wellness visits		
➤ In-network	• $25 for primary care physician and mental health providers; $35 for specialist	
➤ Out-of-network[2]	• 40% after annual out-of-network deductible	
Vision care	$200 maximum benefit[3] per covered member toward eye exams and corrective devices every two years. For assistance, call Anthem at 1-888-893-6366.	
➤ Prescription drugs	See page 17.	

[1] Plan considers only covered services and reasonable and customary charges. Charges for all covered services received in-network are considered reasonable and customary.
[2] The out-of-network benefit includes only covered services at reasonable and customary charges. You pay the full amount of any expenses that are not covered and any portion of charges that exceed reasonable and customary.
[3] The maximum benefit does not apply to routine vision screening for children.

Coverage	PPO Plan
Imaging services (CT, MRI , PET scans, ultrasounds)	
➤ In-network	$50 after annual in-network deductible
➤ Out-of-network[4]	40% after annual out-of-network deductible
Diagnostic X-ray and laboratory services	• Plan pays 100%, no deductible • Mammograms: 1 free screening per year • Colonoscopy: 1 free screening per year
➤ In-network (Increased benefit for in-network diagnostic X-ray and lab services)	
➤ Out-of-network[4]	40% after annual out-of-network deductible
Chiropractic care (limited to 30 combined in-network and out-of-network visits per covered person, per year)	
➤ In-network	$35
➤ Out-of-network[4]	40% after annual out-of-network deductible
Maternity care (Maternity for dependent children not covered)	
➤ In-network	• Physician services: $35 for initial visit, then 20% • Hospital delivery: 20% after annual in-network deductible
➤ Out-of-network[4]	40% for physician services and hospital delivery after out-of-network deductible
Hospital inpatient services	
➤ In-network	20% after annual in-network deductible
➤ Out-of-network[4]	40% after annual out-of-network deductible
Hospital or ambulatory surgical centers – outpatient surgical services	
➤ In-network	20% after annual in-network deductible
➤ Out-of-network[4]	40% after annual out-of-network deductible
Emergency room services	
➤ In-network	$ 200 (waived if admitted)[5]
➤ Out-of-network[4]	$ 200 (waived if admitted)[5]
Urgent care	
➤ In-network	$35
➤ Out-of-network[4]	40% after annual out-of-network deductible

[4] The out-of-network benefit includes only covered services at reasonable and customary charges. You pay the full amount of any expenses that are not covered and any portion of charges that exceed reasonable and customary.

[5] Emergency Room: Coverage of hospital emergency room care is for initial services rendered for symptoms of a life-threatening condition or serious accidental injury that requires immediate medical care. A medical emergency is a severe and sudden condition that would lead a prudent layperson with an average knowledge of medicine and health to believe that failure to obtain immediate medical care could place his or her life in danger or cause serious harm. Use of the emergency room for non-life-threatening conditions is subject to additional out-of-pocket expense.

Pre-certification and prior approval	The following services require pre-certification by Anthem. **You are responsible for making certain that your care provider obtains certification before you incur expenses; your benefit may be reduced if you do not.** • All inpatient admissions (except maternity)[6] • All transplant services (human organ and tissue/bone marrow/stem cell) • Behavioral health and substance abuse services ➤ Partial hospitalization ➤ Intensive outpatient services • Outpatient services – Plastic/reconstructive surgeries (including but not limited to the specific procedures listed): ➤ Blepharoplasty ➤ Rhinoplasty ➤ Hairplasty ➤ Panniculectomy and lipectomy/diastasis recti repair ➤ Insertion/injection of prosthetic material collagen implants ➤ Chin implant/mentoplasty/osteoplasty mandible • Durable medical equipment (DME)/Prosthetics: all DME equipment/prosthetics that exceed ➤ $2,500 ➤ Home health care/private duty nurse (home)[7] ➤ Lumbar spinal surgeries (fusion only) ➤ Sleep studies ➤ UPPP surgery (to correct sleep apnea)
Filing claims	• In-network: Providers will file claims for you. • Out-of-network: You may have to file your own claims. Form available at Employee Services[7], **myAflac.com>Benefits> Health**. • All claims should be mailed to: Anthem BC/BS, P. O. Box 54139, Los Angeles, CA 90054 or faxed to 866-816-5275
Your cost for coverage	You and Aflac share the cost of coverage, with Aflac paying the greatest share.

[6] Pre-certification is needed for childbirth if an inpatient stay exceeds 48 hours for a normal delivery and 96 hours for a cesarean delivery.
[7] Penalty applied per visit if pre-certification is not obtained.

LiveHealth Online

Your visits to the doctor are about to get a whole lot easier. With **LiveHealth Online**, you'll be able to talk to a doctor right away, any time of the day or night, from the comfort of your home or office. All you'll need is a phone or an Internet connection.

- 24/7 Online Access to Care (telephone, mobile device or computer – video is required for a prescription)
- Average LiveHealth Online doctor visit is 10 minutes
  - Those enrolled in Aflac's Medical/Prescription Drug Plan will pay the $15 co-pay and the plan will pay the difference.
  - Those not enrolled in Aflac's Medical/Prescription Drug Plan may use the service and pay full amount of $49.
  - Doctors answer questions, make a diagnosis and even prescribe basic medications, if needed.
  - You can access **instructions** through the portal and then go to **www.LiveHealthOnline.com**.

Anthem Mobile App

Accidents and illnesses can happen anywhere, while you're traveling on business, when your child is on a field trip or even during your summer vacation.

Now, you can find doctors, urgent care centers and hospitals from anywhere, too – all on your smart phone with the **Anthem Mobile App.** With the app, you can:

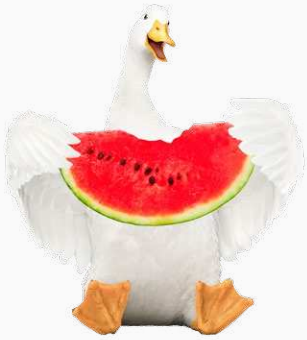
- Find a doctor
- Get to an urgent care center fast with maps and driving directions
- Locate a hospital or emergency room
- Access your Anthem Blue Cross and Blue Shield ID card on your phone
- See **more details** on the portal

Anthem's Future Mom's Program

Aflac is family focused! This is reflected in the number of babies born to or adopted by Aflac employees each year. High-risk pregnancies or pregnancies where complications occur are best managed from early pregnancy through delivery. Employees who will deliver or adopt during 2015 will receive a voucher for a new car seat when they enroll in Anthem's Future Mom's program **and** attend a Safe Kids presentation on car seat safety.

At the Safe Kids Buckle Up Child Passenger Safety Car Seat Class employees will receive personal hands-on safety instruction about car seats. Taught by nationally certified child passenger safety technicians, your concerns about seat selection, secure installation, proper fit, and LATCH are addressed. To register, go to **myAflac.com > Employee Services > Corporate Learning** and click **Register for a class**. Once in the system, click the **myLearning tab > Learning catalog**, type **Safe Kids** in the title box or **BB0934** in the ID box and hit enter. Once the 2015 classes appear, select the date and time most convenient for you and register.

Future Moms is your start to a healthy pregnancy. Having a healthy baby is every mom's goal. You want to make the right choices and take care of yourself so you can reach that goal. Sign up as early as you can to get the most from the program. To enroll in the Future Moms, call Anthem at 1-800-828-5891. For additional information please refer to the **myAflac.com > Employee Services > Benefits** and see **Future Moms** section (bottom left of page).



Prescription Drug Benefits

Under the Aflac Health Plan

You Should Know

- To further encourage the use of generics when available, no deductible will be required when purchasing a generic drug either at retail pharmacies or through the CVS mail-order pharmacy. Additionally, to encourage use of the mail-order pharmacy (where the discounts are much better), any maintenance medications filled by mail will not require a deductible.
- Prescription drug benefits under the Aflac Health Plan are provided through the CVS/Caremark network.
- Retail prescriptions are covered only when purchased through in-network pharmacies that participate in the CVS/Caremark network and through the CVS/Caremark Mail-Order Pharmacy. See the directory of providers at **caremark.com**. To register for access, use the member ID number on your Anthem ID card.
- Under Aflac's health plan, drugs are classified as:
  - Generic (Tier 1).
  - Formulary brand-name (Tier 2).
  - Non-formulary brand-name (Tier 3).

The classification of each drug is identified on the Preferred Drug List, also known as a formulary. This list is available on **myAflac.com > Employee Services > Benefits**.

Coverage	You Pay:		
Annual deductibles			
➤ Individual: $100 – Waived for generic medication at retail pharmacies and for any medication ordered from the mail-order pharmacy.			
➤ Family: $200 – See note below chart. Waived for generic medication at retail pharmacies and for any medication ordered from the mail order pharmacy.			
Prescription Purchases	Generic Tier 1	Formulary Tier 2	Non-formulary Tier 3
➤ In-network retail (30-day supply)	$10	$30	$70
➤ Mail order (90-day supply)	$20	$60	$140

Note that the family deductible is for the entire family—no individual in your family will pay more than $100 in deductibles, and the family as a whole will not pay more than $200 in deductibles.

For more information and to determine whether mail-order or retail pharmacy is best for you, visit **myAflac.com > Employee Services > Benefits.**

Requesting Lower-Cost Generic Medications

Want to save money? You may ask the pharmacist to substitute an exact generic medication for your prescribed brand medication if a generic is available. This is allowed if your doctor does not specify dispensing only the brand -name medication, because pharmacies must fill prescriptions exactly as written.

Generic drugs are less expensive than brand-name medications because manufacturers don't have to bearthe costs of developing and bringing a new drug to market. Today, almost half of all prescriptions are filled with generic drugs.

Using the Mail-Order Pharmacy

- **Mail-Order Pharmacy**
  To use the mail-order service, ask your doctor to write a prescription for a 90-day supply (with any appropriate refills). Mail the prescription to CVS/Caremark with a completed order form available at **myAflac.com > Employee Services > Benefits**.
- Need a prescription filled right away? Ask your doctor to write two prescriptions for your long-term medicines: the first for a short-term supply to be filled quickly at a retail pharmacy, and the second for the maximum 90-day mail-order supply with any appropriate refills.
- **Mail-Order Conveniences**
  - Extended supply of medicine.
  - Lower cost compared to multiple retail refills.
  - Delivered where you want; home, local pharmacy or even vacation address.

Prior Authorization for Specific Drugs and Medical Conditions

Your doctor must receive prior authorization from CVS/Caremark when prescribing certain covered drugs approved by the Food and Drug Administration for specific medical conditions. The approval criteria are based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations. Approval of a prescription is good for one year, after which your doctor may submit a new approval request.

Specialty Rx Program

Some chronic or genetic conditions require injected or infused medicines, and sometimes oral bio-chemical medications. CVS/Caremark provides such products—as well as special patient support—directly to plan participants through its Specialty Rx Program. Specialty Rx prescriptions are not filled at retail pharmacies. For coverage on these products, you must be pre-approved by and participate in the Specialty Rx Program.

For a comprehensive list of specialty prescription drugs, go to **www.cvscaremarkspecialtyrx.com.**

If you or an enrolled family member is being treated for any of the following conditions, call CVS/Caremark at 866-818-6911 to find out if a prescription from your doctor requires prior authorization through the Specialty Rx Program.

- Alzheimer's
- Amphetamines for ADD or ADHD (over age 18 only)
- Growth hormone deficiency (Step therapy and use of preferred brand for growth hormones is required)
- Hemophilia
- Hepatitis C
- Multiple sclerosis

For More Information About:

- The Aflac Health Plan:
  Visit **anthem.com** or call 888-893-6366.
- Prescription drug coverage:
  Visit **caremark.com** or call 866-818-6911.
- All of your Aflac benefits:
  Go to **myAflac.com > Employee Services > Benefits**.

Dental Plan Options

Eligibility:

Dental plan options are available to all full- and part-time employees, their legal spouses or registered domestic partners, and eligible dependents on first day of employment. Part-time employees must work at least 20 hours per week to be eligible for coverage.

You Should Know

- Dental coverage is offered by Ameritas Group.
- There are two dental plan options: The **Network Only Dental Plan** and the **Choice Dental Plan**.

	Network Only Dental Plan	Choice Dental Plan
What's the same	Benefits are the same under both options **when you use in-network dental care providers**.	
How the options differ	• Covers eligible services **only when you use in-network** dental care providers. Treatment provided by out-of-network providers is not covered. • Because exclusively using in-network providers holds down costs through negotiated rates, Aflac pays the majority of the premiums.	• Offers you the **choice of using in-network or out-of-network** dental care providers, with eligible services covered at the same benefit levels. • Because this option offers access to out-of-network providers who have not agreed to negotiated (discount) rates, premium rates are higher than those for the Network Only Dental Plan. Aflac subsidizes a portion of the premiums.
Keep in mind	• Using an in-network dentist results in lower out-of-pocket expenses and an average 25 percent discount on services under both plan options. • Always seek approval from Ameritas Group prior to having major dental services. This will ensure you understand the total cost of care and how the maximum annual benefit applies. To reach Ameritas Group, call 800-487-5553. • If your dentist isn't a member of the network, talk to him or her about joining. • The directory of in-network dental care providers is available at **ameritas.com/member/index.asp**.	

Coverage		Network Only Dental Plan	Choice Dental Plan
In-network services	Services from dental care providers who participate in the Ameritas Group network. See the directory of providers at **ameritas-dental.prismisp.com**	✓	✓
Out-of-network services	Services from dental care providers who do not participate in the Ameritas Group network.		✓

Deductibles (per calendar year)	• **Preventive and diagnostic services:** No deductible.
	• Basic and major services:
	  • $50 for individual
	  • $100 for family
		✓	✓

Co-pays and coinsurance (per calendar year)	• **Preventive and diagnostic services:** No co-pay or coinsurance Plan pays 100%. • **Basic services:** You pay 20% coinsurance • **Major services:** You pay 50% coinsurance	✓	✓
Maximum annual benefit	$1,000 per person (excluding orthodontia benefits paid)	✓	✓
Dental Rewards*	Allows qualifying plan members to carryover part of their unused annual maximum.	✓	
Preventive and diagnostic Services	• Oral exams: Up to two per calendar year • Fluoride treatments: Up to one per calendar year through age 18 • Dental prophylaxis (cleaning): Up to two per calendar year • X-rays	✓	✓
Basic services	• Simple extractions • Surgical services • Root canal therapy • Osseous surgery • Periodontal scaling and root planing • Denture relining • Replacement of broken tooth on complete or partial denture • Amalgam, silicate, acrylic or plastic fillings	✓	✓
Major services	• Crowns or crown restoration as a result of tooth decay or trauma (when the tooth can't be restored with amalgam, silicate, acrylic or plastic fillings) • Gold inlay fillings • Complete or partial dentures • Bridge pontics and abutments	✓	✓

Orthodontia – child only	• Only for new banding • Coverage ends at age 19 • $1,500 lifetime maximum per person • 50% coinsurance • After banding, remaining benefits paid quarterly	✓	✓
Your cost for coverage	• You and Aflac share the cost of coverage, with Aflac paying the greatest share.		

Dental Rewards

This dental plan includes a valuable feature allowing qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. If you visit one of our network providers, you are eligible for an additional PPO bonus carryover amount. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. He or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$350	Dental Rewards amount is added to the following year's maximum
Maximum Carryover	$1,000	Maximum possible accumulation for Dental Rewards

For More Information About:

- The dental plan: Visit **ameritas.com/member/index.asp** or call Ameritas Group at 800-487-5553.
- All your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

The plan considers only covered services, and reasonable and customary charges. Charges for all covered services received in-network are considered reasonable and customary. For out-of-network services, you pay the full amount of any expenses that are not covered and any portion of charges that exceed reasonable and customary.

Vision Plan

Eligibility:

All full- and part-time employees, their legal spouses or registered domestic partners, and eligible dependents are eligible for coverage on first day of employment.

You Should Know:

- Vision plan coverage is offered by VSP.
- From annual eye exams to benefits for glasses and contacts, the Aflac vision plan expands the scope of benefits for you and your family. This stand-alone plan offers options and services that may not be available through your health plan coverage. You may enroll in the vision plan even if you do not participate in the Aflac Health Plan coverage available to you.
- **Freedom of choice:** The vision plan offers you the freedom to use in-network or out-of-network care providers. **Benefits are greater when you use providers who participate in the VSP Choice Network.** See the directory of vision care providers under **Find a VSP Doctor at vsp.com/cms/home.html.**
- **Service frequency:** The plan covers an annual eye exam and lenses (including contacts) once every 12 months, and frames once every 24 months. Benefit periods are measured from the date you last had the same type of service.
- **Winning team:** The plan is administered by Ameritas in partnership with VSP Vision Care, the nation's largest provider of eye-care coverage.

Coverage	VSP Choice Network	
	In-Network	Out-of-Network
Deductibles	• $10 per exam • $25 for eyeglass lenses or frames[1]	• $10 per exam • $25 for eyeglass lenses or frames[1]
Maximum benefit (per calendar year)	None	None
Frequency of coverage		
➤ Exam	Once every 12 months[2]	Once every 12 months[2]
➤ Lenses	Once every 12 months[2]	Once every 12 months[2]
➤ Frames	Once every 24 months[2]	Once every 24 months[2]
Plan Pays:		
Eye exam (each 12 months)	Covered in full[3]	Up to $52[4]
Lenses (one pair, each 12 months)		
➤ Single vision	Covered in full[3]	Up to $55[4]
➤ Bifocal	Covered in full[3]	Up to $75[4]
➤ Trifocal	Covered in full[3]	Up to $95[4]
➤ Lenticular	Covered in full[3]	Up to $125[4]
➤ Progressive	See lens options on the next page.	Not covered
➤ Contacts		
• Elective	Up to $150[3] (See Benefits for Contact Lenses on the next page.)	Up to $105[4]
• Medically necessary		Up to $210[4]
• Fit and follow-up exams	Covered in full[3]	Not covered
	15% discount	
Frames (each 24 months)	$150,[3] plus 20% discount off any remaining cost	Up to $70[4]
Additional pair of glasses	20% discount	Not covered
Low vision (every 24 months)	75% of pre-approved amount,[5] up to $1,000 max. benefit	Not covered

[1] The deductible applies to a complete pair of glasses or frames, whichever is selected.
[2] Beginning from your previous use of this service.
[3] After you meet the applicable in-network annual deductible.
[4] After you meet the applicable out-of-network annual deductible.
[5] Call VSP for pre-approval requirements.

Coverage	VSP Choice Network	
	In-Network	Out-of-Network
	You Pay:	
Lens options		
➤ Progressive	$60–$119[6]	Not covered
➤ Standard polycarbonate	Covered in full for children, $25-$35 for adults[6]	Not covered
➤ Scratch resistance	$15–$29[6]	Not covered
➤ Coatings		Not covered
• Anti-reflective	$39–$61[6]	Not covered
• Ultraviolet	$15	Not covered
➤ High-luster edge polish	$14	Not covered
➤ Solid plastic dye (except Pink I and II)	$13	Not covered
➤ Plastic gradient dye	$15	Not covered
➤ Photochromic (glass and plastic)	$27–$76[6]	
LASIK or PRK	Average discount of 15%. Maximum out-of-pocket expense is $1,800 ($2,300 maximum for custom LASIK using Wavefront technology; $1,500 maximum for PRK). Certain restrictions may apply.[7]	Not covered
Your cost for coverage	You pay the full cost of coverage at group rates.	

➤ **Benefits for Contact Lenses:** The plan covers eyeglass lenses or contacts, but not both, every 12 months. The contact lens benefit includes your fitting and exam, and these charges are paid first. Any remaining benefit balance is applied toward the contact lenses. If you purchase disposables, the available benefit amount must be used all at once. Your provider will order a three- or six-month supply for you.

If you wear soft contacts, you may be eligible for a program that includes an initial contact lens evaluation and supply of lenses. Call VSP or your in-network provider for details.

For More Information About:

The vision plan: Visit **vsp.com/cms/home.html** and select VSP Choice when prompted for network, or call **800-877-7195.**

All your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

[6] Costs vary depending on your prescription and the option you choose.
[7] For the out-of-pocket maximum to apply, a VSP in-network provider must coordinate the procedure.

ADDITONAL BENEFITS

Employee Assistance Plan

Eligibility:

All full- and part-time employees, their legal spouses or registered domestic partners, and qualified dependents over age 16 are eligible.

You should know:

- The Employee Assistance Plan is served by Bensinger, DuPont & Associates.
- Personal problems have a serious effect on work and family life. Help is available through professional counseling for any issue.
- Services are confidential. The Employee Assistance Plan does not report the names or any identifying data of service users to Aflac. You pay nothing. Services are company-paid and easy to use.
- Help is available 24 hours a day, 7 days a week by calling 800-807-1535.

Continued Services Under The Health Plans:

The Employee Assistance Plan provides free counseling services for up to five visits per covered issue. If you need to continue counseling beyond the five free visits provided under the Employee Assistance Plan, the additional counseling may be covered through your health benefit plan. You would be responsible for the health plan's applicable co-payments and/or deductibles, subject to the in-network and out-of-network benefit levels.

Coverage	
How it works	➤ The Employee Assistance Plan is offered through Bensinger, DuPont & Associates at 800-807-1535. Calls are answered 24 hours a day, 7 days a week. ➤ You and your family members may use Employee Assistance Plan services each time any of you needs help dealing with a concern. ➤ Callers will be immediately connected to a qualified counselor who will assess the caller's needs, provide immediate assistance in dealing with the issue and refer the caller to a local resource for the appropriate service. The same counselor will follow up with the caller to ensure his or her needs are met. ➤ Callers may receive up to five face-to-face counseling sessions per covered issue, plus referral to legal assistance, financial counseling or child care or elder care resources. ➤ Supervisors may call the Employee Assistance Plan at any time for consultation on how to manage troubled employees in the workplace.
Who can use EAP Services	Employees and all immediate family members, defined as: ➤ Any adults in the home (spouse, adult children, older relatives), or ➤ Any dependent children living away from the home, such as children away at college.
Children under 16	If needed, children under age 16 will be referred to an appropriate child specialist who is an in-network provider in the employee's Aflac health benefit plan, or to a low-cost or free community resource.
Chronic conditions	If the caller is dealing with a long-term issue, the counselor will coordinate longer-term treatment with an in-network provider in the employee's Aflac health benefit plan, or with a low-cost or free community resource. *Copay for office visit $25.
Online resources	The Employee Assistance Plan website at **bensingerdupont.com** (password: Aflac) offers helpful resources, such as articles to help you recognize and understand many personal issues, legal and financial information, assessment tools and child/eldercare searches.
Your cost	There is no cost to you or your family member for coverage for the maximum of five counseling sessions per issue. Aflac pays for Employee Assistance Plan services.

For More Information About:

- Employee Assistance Plan services: Call Bensinger, DuPont & Associates at 800-807-1535.
- Resources to help you deal with and resolve personal issues: Visit **bensingerdupont.com** and use the password "Aflac."
- Continued counseling services under your Aflac health benefits: Call your health plan at the number on your health benefits ID card or as listed on the Quick Reference chart at the end of the guide.
- All of your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

Flexible Spending Accounts *(Not available for residents of Puerto Rico)*

Wage Works provides third-party administration for flexible spending accounts. WageWorks brings to you and our policyholders simple-to-use technology solutions for requesting reimbursement for eligible expenses. We encourage you to explore how flexible spending accounts can benefit you and your family.

Eligibility

Full- and part-time employees; however, officers of Aflac or any wholly owned subsidiary are not eligible to participate in the dependent care flexible spending account. Part-time employees must work at least 20 hours per week to be eligible to participate.

About the Accounts:

Aflac offers three types of flexible spending accounts. Money in each account may be used only for that account's designated purposes. During 2015, you may defer between $100 and $2,500 into the medical flexible spending account, between $100 and $5,000 into the dependent care flexible spending account, and up to $250 per month for parking costs and up to $130 per month for mass transit or vanpooling in the commuter benefit plan.

Your enrollment in a flexible spending account is for one calendar year only. To continue participating, **you must make a new election each calendar year**.

Plan carefully as the Internal Revenue requires that unused money in each year's flexible spending account be forfeited, known as the "use it or lose it" rule. You do have the ability to rollover up to $500 in your medical flexible spending account to the next year. When deciding how much money to contribute to your accounts, be conservative but realistic with estimating your 2015 expenses.

You Should Know:

- **Save up to 40 percent on everyday expenses.**
  Open a WageWorks flexible spending account during open enrollment and good things happen. You have money ready for eligible expenses not covered by your insurance, saving you up to 40 percent.
- **How Flexible Spending Accounts Work.**
  You can sign up for a flexible spending account during open enrollment. You set aside some of your pay, before taxes, from each paycheck to use for eligible expenses. This is how you save money: $100 put into your flexible spending account is $100 to spend on eligible expenses. Without a flexible spending account, you pay taxes, leaving up to $80 to pay for the same eligible expenses.
- **Use the WageWorks Debit Card.**
  Use your WageWorks Debit Card instead of cash or credit at health care providers and pharmacies for eligible services, goods and prescriptions. Typical expenses include co-payments for doctor visits and prescriptions, dental and orthodontia expenses, vision care, and prescribed over-the-counter drugs and medications. Remember to keep your card – a new card is not issued each year.
- **Using Your Flexible Spending Account Is Easy.**
  When you elect a health care flexible spending account, your account is funded with the full amount you choose at the beginning of the year. As soon as that happens, it's ready to use for eligible expenses. Throughout the year, you pay your account back with pre-tax contributions from your paycheck. Accessing your account is easy:
  - ***WageWorks Debit Card.*** Use it instead of cash at health care providers and wherever accepted for health-related services and health expenses.
  - **Pay Me Back.** File a claim online or by fax or mail for reimbursement.
  - ***On the Go.*** Use our mobile website to view your account information.
- **Download the EZ Receipts™ mobile application.**
  Use your smartphone to file claims and take care of your account paperwork from anywhere. Go to **wageworks.com/aboutmobile** to learn more.

You can also choose a WageWorks Dependent Care FSA to help with the cost of care for eligible children or aging parents while you are at work. A dependent care FSA works a lot like a health care FSA, but your account is funded each payroll period, making funds available as contributions are taken from your paycheck.

Estimating Your Savings

How much you save depends on how much you spend on health and dependent care, and on your tax situation. For every $100 of eligible expenses, you could save up to $40 in taxes. To estimate your expenses and see for yourself how your savings can add up, use the savings calculator at: **FSAWorks4Me.com/takecare**.

Health Care Flexible Spending Account			
Estimated Eligible Expenses	Example	Your Estimate	
Prescription drugs	$270		
Doctor visits, co-payments	$180		
Dental fillings, crowns	$150		
Orthodontia (braces)	$1,600		
Prescription glasses	$150		
Eye exams, LASIK	$150		
Other	$0		
Suggested plan year election	= $2,500	=	
Taxes (20%[1])	x 0.20	x	(20% to 40% is typical)
Estimated savings[1]	= $500	=	

Dependent Care Flexible Spending Account			
Estimated Eligible Expenses	Example	Your Estimate	
Day care, nursery school	$3,600		
Before- or after-school care	$700		
Summer day camp, summer day care	$700		
Suggested plan year election	= $5,000	=	
Taxes (20%[1])	x 0.20	x	(20% or 40% is typical)
Estimated savings[1]	= $1,000	=	

[1] Tax savings amounts are examples provided for illustrative purposes only. They are based on federal, state, and FICA (Social Security) taxes that you do not have to pay through payroll deductions on amounts used to fund your account. Your actual savings may vary depending on your marginal income tax rate, whether you pay state income taxes, and other factors. Some states do not recognize tax exclusions for FSA contributions.

Coverage:

You can use your flexible spending account to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer. For details and hundreds more eligible expenses, visit: **FSAWorks4Me.com/takecare**.

Medical Flexible Spending Account

You Should Know:

- **Eligible expenses:** The medical flexible spending account allows you to redirect portions of your pre-tax compensation to pay for eligible, unreimbursed health care expenses (see the Coverage section on next page). Expenses may be for services received by you, your spouse, your children as defined in the health plan section of this guide, and anyone who qualifies as your dependent for income tax purposes.
- For details, see the Summary Plan Description at **myAflac.com > Employee Services > Benefits > Summary Plan Descriptions**. For eligible expenses and qualifying dependents, go to **IRS.gov>Forms and Publications>Publication 502**.
- **Immediate availability:** You can receive reimbursement up to your full annual contribution amount from the first day of the calendar year (as long as services have already been provided).
- **Rollover:** Up to $500 of your unused medical flexible spending account balance can be carried over into the next plan year instead of forfeiting it. Please note that medical expenses incurred by Dec. 31 must be submitted by March 31 of the next year.

Newly Hired?

If you enroll after Jan. 1, 2015, you may only claim reimbursement for services provided on or after your eligibility date.

Coverage	
Examples of out-of-pocket expenses eligible for reimbursement	➤ Medical, prescription drug, dental and vision co-payments, and deductibles ➤ Eyeglasses, contact lenses, and contact lens solutions not covered under another plan ➤ Hearing aids ➤ Certain over-the-counter drugs and medicines prescribed by a physician ➤ Orthodontic care (braces) ➤ Chiropractic
Examples of out-of-pocket expenses NOT eligible for reimbursement	➤ Vitamins ➤ Over-the-counter drugs and non-prescription medicines ➤ Drugs for cosmetic use ➤ Non-medical-related counseling ➤ Elective cosmetic surgery ➤ Health-club membership fees ➤ Weight-loss foods that substitute for normal foods or nutritional needs
Your maximum contribution amount	$2,500 per year

For details and hundreds more eligible expenses, visit **FSAWorks4Me.com/takecare**.

Always Keep Receipts for Medical Flexible Spending Account Expenses.

This is an IRS requirement. Plus, receipts may be needed to document expenses for reimbursement or if your tax return is audited.

The IRS requires a legible receipt showing the information below to substantiate a flexible spending account claim. Cash register or credit card receipts that do not include all of this information will not fulfill IRS requirements:

- Nature of service (type of service provided or name of prescription).
- Date of service.
- Provider name (doctor, pharmacy, hospital, etc.).
- Name of person who received the service.
- Purchase amount.

Dependent Care Flexible Spending Account

You Should Know:

- **Eligible expenses:** A dependent care flexible spending account allows you to redirect portions of your pre-tax compensation to pay eligible day-care costs for qualifying dependents. Expenses are eligible only for day-care services that allow you—and your spouse if you are married—to work full or part time and/or to attend school full time. Expenses for babysitting and other miscellaneous care unrelated to work or school attendance are not eligible. Qualifying dependents must be your dependents for federal income tax purposes, but they need not be covered by any other Aflac benefits. See chart below.
- For details, see the Summary Plan Description at **myAflac.com > Employee Services > Benefits > Summary Plan Descriptions**. For eligible expenses and qualifying dependents, go to **IRS.gov > Forms and Publications > Publication 503**. *Officers of Aflac, or any wholly owned subsidiary, are not eligible to participate in the dependent care flexible spending account.*
- **Availability of funds:** Unlike the medical flexible spending account, the dependent care account can reimburse only up to the amount in your account at the time you file your claim. This means if your claim exceeds your dependent care flexible spending account balance, the unpaid amount will be pended and paid after additional contributions are added to your account.
- **Grace period:** To reduce the pressure on you to spend dependent care flexible spending account money by the end of the calendar year, you'll have an extra two months and 15 days after the end of 2015 (Jan. 1, 2015 through March 15, 2016) to incur eligible expenses before the **"use it or lose it"** rule applies.
- **Run-off period:** If you do not use all the funds in your account for eligible expenses by March 31, 2016, you'll forfeit any remaining balance (the "**use it or lose it**" rule).

Coverage	
Covers the cost of day-care services in or out of your home	Qualifying dependents include: ➤ Children under age 13. ➤ Elderly dependents who live with you. ➤ Anyone you claim as a tax dependent because of physical or mental inability to care for himself or herself.
Your maximum contribution amount	➤ $5,000 per year (or the lesser of your or your spouse's income). ➤ $2,500 per year if married and filing separate tax returns.

Commuter Benefit Plan

A Commuter Benefit Plan, allowed by §132f of the Internal Revenue Code, allows employees to have their parking and commuter expenses deducted on a pre-tax basis. Employees can deduct up to $250 per month for parking costs or up to a maximum of $130 per month for mass transit or vanpooling costs. For details, see the Summary Plan Description at **myAflac.com > Employee Services > Benefits > Flexible Spending Accounts > Plan Summary**.

Questions?

Helpful tips, guides, video tutorials and FAQs are available online at **takecarewageworks.com.**

WageWorks

Customer service professionals also are standing by to help you. Just call 800-950-0105, Monday through Friday from 8 a.m. to 7 p.m. Central time.

This program is sponsored by your employer and brought to you by WageWorks—the nation's leading provider of consumer-directed savings and spending accounts. WageWorks sets the standard for convenience and flexibility with easy access to your account, no-hassle payment options, comprehensive online tools and expert support. Millions of employees nationwide enjoy the WageWorks advantage to save money and make smart choices about their health care, dependent care and commuter expenses.

WageWorks is a preferred vendor for the administration of Aflac cafeteria plans (health flexible spending accounts and dependent care accounts), commuter spending accounts, and health savings account products and services. WageWorks is a separate entity from Aflac, and WageWorks will guarantee and warrant any products and services they offer based upon their own service policies.

Group Term Life Insurance

Eligibility:

All full- and part-time employees are eligible for basic and supplemental life insurance following 30 days of employment. Employees may also enroll legal spouses or registered domestic partners and eligible dependents. Part-time employees must work at least 20 hours per week to be eligible for coverage.

You Should Know:

- Group term life insurance is provided by Lincoln Financial Group.
- Aflac pays the premiums for employee basic life insurance coverage. There is no cost to you.
- You pay premiums for supplemental coverage for yourself and for spouse or dependent life insurance.

Coverage	
Employee Basic Life Insurance	
Basic insurance coverage	➤ Term life insurance equal to 1.5 times your annual base salary (as of each pay date), up to a maximum of $500,000. Coverage is rounded up to the next whole $1,000. ➤ The accelerated benefit option permits you to take an advance payment of up to 75 percent of the coverage amount, up to a maximum of $250,000, when you have a terminal illness and an expected life span of 12 months or less.
Reduced coverage at age 70 and older	➤ From age 70 through 74, coverage is reduced to 75 percent of your basic coverage amount (1.125 or one and one-eighth times your annual base salary, up to the coverage maximum). ➤ At age 75 and older, coverage is reduced to 50 percent of the basic coverage amount (0.75 times your annual base salary, up to the coverage maximum).
Your cost	There is no cost to you. Aflac covers 100 percent of the cost.
Employee Supplemental Life Insurance	
Coverage options	You may choose coverage levels of 1 to 8 times your annual base salary (as of each pay date), up to a maximum of $1,000,000. Coverage is rounded up to the next whole $1,000.
Reduced coverage at age 70 and older	➤ From age 70 through 74, coverage is reduced to 75 percent of the supplemental coverage amount in effect. ➤ At age 75 and older, coverage is reduced to 50 percent of the supplemental coverage amount that was in effect at age 70.
If you increase coverage or begin coverage	➤ If you are **currently enrolled** in supplemental life insurance and you choose to: • Increase your coverage by one level, you are not required to submit an Evidence of Insurability form. • Increase your coverage by more than one level, you must submit an Evidence of Insurability form. • If you are enrolling for the first time during open enrollment and are not a new hire, you must submit an Evidence of Insurability form during the enrollment period for underwriting purposes. For an Evidence of Insurability form, go to **myAflac.com > Employee Services > Benefits**.
Your cost	You pay 100 percent of the cost at group rates.

Newly Hired?

You aren't required to complete the Evidence of Insurability form if you elect supplemental coverage when you first become eligible unless coverage exceeds 5 times salary or $500,000 for employee or $25,000 for spouse.

Spouse Life Insurance	
Coverage options	You may choose from the following levels: ➤ Level 1 – $15,000 ➤ Level 2 – $25,000 ➤ Level 3 – $50,000 ➤ Level 4 – $100,000
To begin coverage	If you didn't enroll your spouse for coverage when the spouse first became eligible, he or she must submit an Evidence of Insurability form during the enrollment period for underwriting purposes. For an Evidence of Insurability form, go to **myAflac.com > Employee Services > Benefits**.
If both spouses are employed by Aflac	➤ If both you and your spouse are employed by Aflac or a wholly owned subsidiary, neither of you may elect spouse life insurance coverage. ➤ If you marry another Aflac employee, or your spouse becomes an Aflac employee, all spouse life insurance coverage will automatically end.
Your cost	You pay 100 percent of the cost at group rates.
Dependent Life Insurance	
Coverage options	Each eligible dependent is insured for the coverage amount you select, with no limit on the number of eligible dependents. You may choose from the following levels: ➤ Level 1 – $5,000 ➤ Level 2 – $7,500 ➤ Level 3 – $10,000
Newborns	If you already have dependent life insurance coverage when a child is born, coverage for the newborn begins at birth.
If both parents are employed by Aflac	➤ If both you and any dependent's other parent are employed by Aflac or a wholly owned subsidiary, only one parent may elect dependent life insurance coverage. ➤ If you already have dependent life insurance coverage and your spouse becomes an Aflac employee, your spouse will not be eligible to elect dependent life insurance coverage.
Your cost	You pay 100 percent of the cost at group rates.

For More Information About:

- Employee, spouse, or dependent life insurance coverage: See it on **myAflac.com > Employee Services > Benefits**, or call 706-317-0770.
- All of your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

Evidence of Insurability (EOI), if required, must be submitted to Lincoln Financial Group by November 30, 2014 for Open Enrollment. Evidence of Insurability means you must complete and submit the medical questionnaire ***directly*** to the group life carrier. The questionnaire is located on the Benefits portal. (PATH: Employee Services/Benefits/Group Life/Evidence of Insurability (EOI)). The carrier may request additional information from you after the initial form is submitted. Once an underwriting decision is made, the group life carrier will send you a letter if the additional life coverage has been approved or declined. Your current coverage will remain in effect until the additional coverage is approved.

Accidental Death and Dismemberment Insurance

Eligibility:

All full- and part-time employees are eligible following 30 days of employment. Part-time employees must work at least 20 hours per week to be eligible for coverage.

You Should Know:

- Accidental Death and Dismemberment coverage is provided by Arch Insurance Group.
- Aflac pays the premiums for basic accidental death and dismemberment insurance coverage. There is no cost to you. You pay for any voluntary coverage you choose for yourself. Spouse and dependent coverage is not available.
- Accidental death and dismemberment insurance differs from life insurance. It pays a benefit if you sustain specific loss-of-function injuries due to a covered accident or if you die due to a covered accident. Additional benefits are paid in specific situations, such as if you die while wearing a seat belt, and to help pay a surviving child's college expenses.

Coverage				
Employee Basic Accidental Death and Dismemberment Insurance				
Basic insurance coverage	Accidental death and dismemberment insurance equal to 1.5 times your annual base salary (as of each pay date), up to a $1,000,000 maximum. Coverage is rounded up to the next whole $1,000.			
Benefits for covered losses	Resulting Condition/Loss	% of Coverage Amount Paid	Resulting Condition/Loss	% of Coverage Amount Paid
	➤ Life	100%	➤ Quadriplegia	200%
	➤ Brain Death	100%	➤ Paraplegia	50%
	➤ 2 or more members	100%	➤ Hemiplegia	50%
	➤ One member	50%	➤ Uniplegia	25%
			➤ Thumb and index finger of same hand	25%
			➤ Four fingers or four toes of the same hand or foot	25%
Additional benefits	➤ Burial/Cremation Benefit, up to $20,000 ➤ Seatbelt/Airbag Benefit, $25,000 each ➤ Rehabilitation Benefit, up to $25,000 ➤ Home alteration and vehicle modification, up to $25,000		➤ Coma, 1% for up to 100 Months ➤ Higher education, up to $15,000/4 Years ➤ Paralysis, per schedule	
Your cost	There is no cost to you for basic coverage. Aflac covers 100 percent of the cost.			
Employee Voluntary Accidental Death and Dismemberment Insurance				
Coverage options	You may choose increments of 1 to 8 times your annual base salary (as of each pay date), up to $1,000,000 maximum in addition to your basic coverage. Voluntary coverage is rounded up to the next whole $1,000.			
Your cost	You pay 100 percent of the cost of voluntary coverage at group rates.			

For More Information About:

Employee accidental death and dismemberment insurance coverage: See the Summary Plan Description on **myAflac.com > Employee Services > Benefits**, or call 706-317-0770.

All of your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

Short- and Long-Term Disability Coverage

Eligibility:

Enrollment is automatic for all full-time employees. Part-time employees are not eligible.

You Should Know:

- Short- and long-term disability coverage is provided by Reliance Standard.
- If you are unable to work because of illness or injury, you may become eligible for benefits that pay you a continuing income of at least 60 percent of your basic weekly pay, up to the plan's benefit maximums.
- Aflac provides these valuable income-continuation benefits at no cost to you.

Hired in the Last 12 Months?

You become eligible for coverage after one year of employment, unless an alternative effective date is required because you are considered eligible by applicable state law.

How the benefits work	➤ You become eligible for short-term disability benefit payments after you have been disabled due to illness or injury and unable to work for eight consecutive days. Benefits may continue for up to 25 weeks, until you are no longer disabled, or until the date you reach your Social Security Normal Retirement Age, whichever is sooner. ➤ You become eligible for long-term disability benefit payments if you are totally disabled as defined by the plan. ➤ Benefit payments begin after 180 days of total disability (non-exempt employees) or after 90 days of total disability (exempt employees). Long-term disability benefits may continue for a specified period, until you are no longer disabled or you reach age 65 or normal retirement age. ➤ The plans consider any benefits payable from other sources, such as other group disability policies, Social Security, workers' compensation and state disability, then pay any additional amount needed to ensure your income from all sources is at least 60 percent of your pre-disability basic weekly pay. ➤ Any disability must be certified by a licensed physician and approved by the claims administrator.
Your cost	There is no cost to you. Aflac covers 100 percent of the cost.

For More Information About:

- Short- and long-term disability coverage: Call the claims administrator at 877-202-0055.
- All of your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

Aflac 401(k) Plan

Eligibility:

Full- and part-time employees may participate in the plan after receiving their first Aflac paycheck. Temporary employees aren't eligible to participate unless they have:

- Completed 1,000 hours of service in their first year of employment, or in any calendar year thereafter, and
- Reached 21 years of age.

Leased employees, union employees, individuals classified by Aflac as independent contractors, nonresident aliens with no U.S. income, interns and employees who participate in Aflac Japan's retirement plans are not eligible to participate.

You Should Know:

- **The Aflac 401(k)** plan is managed by T. Rowe Price.
- **Pre-tax and Roth accounts:** Through the 401(k) plan you may invest a portion of your pre-tax pay—meaning before federal and state income taxes (where applicable) are deducted. You may also contribute a portion of your after-tax pay as a Roth contribution (see Roth Deferrals below).
  - Pre-tax contributions are taxed upon withdrawal.
  - Roth contributions are taxed at the time they are made but are not subject to federal income taxes when distributed to you.
- **Make changes any time:** You may change your contribution amounts and investment choices any time by logging in to your account at **rps.troweprice.com** or by calling T. Rowe Price, the plan recordkeeper, at 800-922-9945. Your changes will be put into effect as soon as administratively feasible.
- **More to learn:** The information in this summary is intended to provide a brief overview to familiarize you with the plan, but does not include all the details of your rights and responsibilities under the plan. Consult the current Summary Plan Description and the official plan document for more complete information about the plan.

Your Contributions:

New participants will be automatically enrolled at 6 percent deferral rate (subject to the annual limit set by the Internal Revenue Service). All participants deferring less than 6 percent will have their deferral rate increased by 1 percent annually with the Auto Increase feature until 6 percent deferral is reached. You may change your contribution rate or opt out of the automatic enrollment at any time. You may elect:

- Up to 75 percent of your compensation. For this purpose, your compensation is:
  - Amounts reported on your Form W-2, plus pre-tax deductions for this plan and certain other Aflac plans; but
  - Minus reimbursements, expense allowances, fringe benefits, moving expenses, gifts, deferred compensation and welfare benefits.
- Up to 75 percent of your profit-sharing bonus (subject to required withholdings for Roth contributions).

Company Matching:

For every dollar you contribute, up to 6 percent of your gross compensation (subject to IRS limitations), Aflac will match your contribution at 50 percent.

Newly Hired?

During New Employee Orientation, you'll receive information explaining plan provisions, investment choices, investment performance and general information.

Roth Deferrals:

You may designate all or a portion of your contributions as Roth contributions. These contributions are withheld from your pay and deposited to the plan on an after-tax basis.

- Roth contributions and any earnings on those contributions, if allowed to stay in the plan for at least five years, may be completely tax-free at the time of distribution. See your personal tax advisor or a tax professional to decide whether Roth contributions to the 401(k) plan are right for you.
- As far as the company's matching contribution or Internal Revenue Service limitations are concerned, there are no differences between normal pre-tax 401(k) contributions and Roth post-tax contributions.

IRS Limitations:

The Internal Revenue Service sets limits on your contributions each year and will announce the 2015 limits in the fourth quarter of 2014. As examples:

- If you're under age 50, the 2014 limit on your total before-tax and Roth contributions is $17,500. ($15,000 for Puerto Rico residents).
- If you will be age 50 or older during 2014, the IRS allows you to make additional catch-up contributions of up to $5,500. ($1,500 for Puerto Rico residents).

Vesting:

Vesting means your ownership of your 401(k) account balance.

- You're always 100 percent vested in any contributions you make to the plan, as adjusted for earnings or losses.
- You become vested in your company matching contributions account as follows:
  - After 1 year of service – 20 percent
  - After 2 years of service – 40 percent
  - After 3 years of service – 60 percent
  - After 4 years of service – 80 percent
  - After 5 years of service – 100 percent

For More Information About:

The 401(k) plan:

- Visit **rps.troweprice.com** or call T. Rowe Price, the plan record keeper and investment administrator, at 800-922-9945.
- See the Summary Plan Description at **myAflac.com > Employee Services > Benefits > Summary Plan Descriptions**.

All of your Aflac benefits: Go to **myAflac.com > Employee Services > Benefits**.

Managing Your Retirement

Have you ever wondered: *When can I afford to retire?*, *How much money will I need?* or *How much will my Aflac benefits provide?*

Congratulations! You're asking the right questions. To answer them and positively shape your financial future, you need to think about how you'll spend your time in retirement and chart a plan for reaching your goals. It's not difficult, plus help is readily available: You have access to some great estimator tools and expert information online.

Retirement Resources – The Big Picture:

For most people, income for retirement comes from just three sources:

- Personal savings and investments
- Social Security benefits
- Employer-sponsored retirement plans (at Aflac, the pension and/or 401(k) plans)

A Closer Look:

- **Social Security benefit:** Income-based taxes paid by you and your employer throughout your working career fund your Social Security retirement benefit. Paid as monthly income, the Social Security benefit usually is significantly less than your pre-retirement income. Your Social Security benefit varies depending on your income during your working career and when you begin receiving payments. For example, the earlier you begin receiving Social Security, the lower the monthly payments.
- **Pension benefit:** If you were hired prior to Oct. 16, 2013 and elected to remain in the pension plan, a formula based on your pay and years of service with Aflac determines your pension benefit. The pension plan is a basic supplement to your other retirement income sources. Like Social Security, the pension plan's monthly benefit varies depending on when you start receiving payments.
- **Saving and investing over time:** Aflac's 401(k) plan and your personal investments offer you the greatest opportunity to build the financial resources needed to maintain your pre-retirement lifestyle after your working days have ended.

The Answers Are Within Reach:

You can chart a personal course to retirement security by taking an hour—or maybe two—to answer these questions:

- **How much money will I need in retirement?** Financial experts generally agree you'll need 70 to 90 percent of your monthly preretirement income to maintain your lifestyle. But you may need even more income to cover age-related health-care expenses. Keep in mind your income needs will be driven by your personal situation and choices.
- **How much money will I have in retirement?** There's an app for that! T. Rowe Price offers an easy, personalized Retirement Income Calculator at **www3.troweprice.com/ric/ricweb/public/ric.do**. To estimate your retirement income, you'll need to find out how much to expect from your current retirement-income sources.
- Here's where you'll find easy-to-use tools:
  - Social Security benefit calculator: **ssa.gov/estimator/**.
  - Aflac pension calculator: **millimanbenefits.com**, or request a mailed estimate by calling the Milliman Benefit Service Center at 866-767-1212.
  - Aflac 401(k) account balance at T. Rowe Price: **rps.troweprice.com**.

In addition, you'll need to enter the estimated or exact value of any accounts you may have with prior employers, along with your personal savings and investment information.

- **How much will my Aflac benefits provide during retirement?** With the Milliman pension calculator at **millimanbenefits.com** and the T. Rowe Price Retirement Income Calculator at **www3.troweprice.com/ric/ricweb/public/ric.do**, you can model various retirement dates, 401(k) contribution amounts, and salary levels.
- **What can I do to make sure I have enough retirement income?**
  - Estimate your potential monthly pay and income from other sources for the year you want to retire. What percentage of that amount do you think you'll need to maintain your lifestyle and meet your financial obligations?
  - Use the estimator tools to calculate how much your current retirement income resources will provide.
  - If the amount you'll need is greater than the amount your current sources will provide, you'll see the gap you must fill through saving and investing prior to retirement.
  - Talk to a financial advisor. If you don't have a trusted financial advisor, ask friends and family members for recommendations. Schedule appointments to meet the recommended advisors and determine which one is right for you. Note: Some advisors will help you analyze your needs and opportunities without obligation.

Tools You Can Use

For interactive tools provide professional retirement information in "layman's terms," visit **rps.troweprice.com > Planning & Research tab > Tools & Resources**. Milliman offers similar tools at **millimanbenefits.com > Investment Tools**.

Salary Redirection Agreement

Aflac Employee Flexible Benefits Plan Salary Redirection Agreement:

Aflac offers some benefit options on a pre-tax basis. During each open enrollment period, you may choose to retain, change, add or delete the stated pre-tax benefits listed in this benefits guide through the online open enrollment process.

Once you authorize your benefit elections through the online annual benefits process during the open enrollment period set by Aflac, you're acknowledging that you understand the insurance premiums and/or flexible spending account election amounts that will be deducted beginning with your Jan. 15, 2015, paycheck.

You also acknowledge that you understand these deductions will be continuous and in an amount equal to the insurance premiums and/or flexible spending account election amounts for each payroll period throughout the year (January – December), unless you experience a change in status as governed by federal regulations.

The amount of your required contribution is based on a schedule found on **myAflac.com > Employee Services > Benefits**.

If there is an insignificant rate change during the plan year (same as calendar year), by submitting your benefit elections through the online annual benefits process, you authorize Aflac to make a corresponding change in the amount deducted from your salary without your signing a new Salary Redirection Agreement.

You Also Acknowledge That:

1. Your pre-tax contributions for payment of benefits reduce your compensation for Social Security tax purposes and, therefore, your Social Security benefits may be decreased.
2. You cannot change or revoke your Salary Redirection Agreement for premiums between the first day of the plan year (Jan. 1) and the plan's next anniversary date (Dec. 31), unless a change in status occurs. The Salary Reduction Agreement change must be caused by and consistent with the change in status.
3. Coverage under a selected benefit plan or insurance policy does not begin when the benefits enrollment form is submitted. The terms, conditions and coverage effective date are determined under the separate benefit plan or insurance policy chosen.
4. As a medical flexible spending account participant, you understand that reimbursement is made only for eligible expenses. If you do not incur an eligible expense before the end of each calendar year (and submit a claim for reimbursement for such an expense within 90 days following the end of each calendar year), you will forfeit any amount over $500 you requested to be withheld from your salary in anticipation of such an expense (you are allowed to rollover up to $500). This is known as the "use it or lose it" rule for medical flexible spending accounts.
5. As a dependent care flexible spending account participant, you understand that reimbursement is made only for eligible expenses. If you don't incur an eligible dependent-care expense within 2½ months following the end of each calendar year (and submit a claim for reimbursement for such an expense within 90 days following the end of each calendar year), you will forfeit the amount you requested withheld from your salary in anticipation of such an expense. This is known as the "use it or lose it rule" for dependent care flexible spending accounts.

REFERENCE

Appendix and Legal Notices

Summary Plan Descriptions

Summary plan descriptions ("SPDs") for the Aflac Incorporated ("Aflac" or the "Company") health, welfare and retirement plans (collectively the "Plans") are available on **myAflac.com > Employee Services > Benefits**. These SPDs are accessible to participants and eligible employees in compliance with ERISA.

If you're unable to access **myAflac.com**, or if you would like a paper copy of any of the SPDs, you may request printed copies from Aflac's Benefits Department. For more information, please call the Benefits Department at 706-317-0770.

This guide provides an overview of Aflac's employee benefit plans. It does not replace legal plan documents, SPDs, group policies or certificates of coverage describing specific benefits, limitations and exclusions. These documents are available on **myAflac.com > Employee Services > Benefits**. If there are discrepancies in this guide, your benefits will be determined in accordance with the official plan documents.

Receipt of this guide should not be considered to mean that you are a participant or eligible to participate in the Plans or benefit programs described in this guide if you do not otherwise meet the eligibility requirements set forth in the documents which govern the Plans or you fail to enroll as described in this guide.

Where the following notices refer to a spouse, it is Aflac's intent for the word spouse to mean legal spouse or registered domestic partner.

Status Changes

Benefit elections for the health and welfare benefit options made during the annual enrollment period are for the next calendar year and become effective Jan. 1, 2015 The benefits you elect remain in effect through Dec. 31, 2015. You may not make changes to your elections under the health and welfare benefit options unless you experience one of the following events, known as a "status change":

- Marriage, registration of a domestic partnership, divorce, legal separation, cessation of a domestic partnership, annulment, birth, adoption or placement for adoption of a child, or death of a spouse/child;
- Termination/beginning of employment for employee/spouse;
- Any of the following events that change your employment status, or that of your spouse or dependent: termination or commencement of employment; a strike or lockout; going on or return from an unpaid leave of absence; a change in worksite; or if a change in your employment status affects your plan eligibility due to an eligibility provision that is based on your employment status;
- Significant change in health benefits coverage attributable to the employment of a spouse;
- Entry of a Qualified Medical Support Order resulting from divorce, legal separation or change in legal custody that requires you to add group health coverage for your dependent child under the health and welfare benefit options or requires your former spouse or another person to provide health care coverage for the dependent child;
- Dependents becoming eligible for coverage or losing eligibility;
- Eligibility for coverage under Medicare and/or Medicaid;
- Loss of coverage under Medicare, Medicaid, PeachCare, AllKids, Child Health Plus or any other state child health program;
- Eligibility for a premium subsidy under Medicaid or the Children's Health
- Relocation to an area in which the current health plan is unavailable

Please note a dependent's new eligibility for PeachCare for Kids, AllKids, Child Health Plus or any other state child health program does not constitute a status change.

If you experience one of the status changes listed above, immediately go to **myAflac.com > Employee Services > Benefits** to complete a Status Change form, or call the Benefits Department at 706-317-0770 if you have questions. You generally must complete and submit a Status Change form to the Benefits Department within 30 days of the date the status change occurred. The health and welfare benefit options generally prohibit status changes more than 30 days after the status change event occurs. However, you will have up to 60 days after a loss of coverage under Medicaid or CHIP because of loss of eligibility or after you are determined to be eligible for premium assistance to request medical coverage under the Aflac Employee Health Plan.

In addition, your requested election change must be consistent with your status change event. For example, if one of your eligible dependents no longer qualifies as an eligible dependent, you may cancel coverage for that dependent, but you may not cancel coverage for your other eligible dependents. If you are not sure the election change you would like to make is consistent with the status change event, you should contact the Benefits Department.

Continuous Coverage Rights Under COBRA

If you're participating in an Aflac employee group health plan benefit such as medical, dental, vision, health flexible spending accounts or the employee assistance plan (collectively referred to as the "Plan"), this notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, more commonly known as COBRA. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, please review the Plan's SPD or call the Benefits Department at 706-317-0770 and ask for the plan administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end due to what is known as a "qualifying event" (specific qualifying events are listed later in this section). After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary. You, your legal spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost as a result of the qualifying event. Continuation coverage will also be offered to your registered domestic partner if his or her coverage under the Plan is lost because of a qualifying event. Under the Plan, individuals who elect COBRA continuation coverage must pay for the coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan for either of these reasons:

- Your hours of employment are reduced or
- Your employment ends for any reason other than your gross misconduct.

If you're the legal spouse or registered domestic partner of an Aflac employee, you'll be offered continuation coverage if you lose your coverage under the Plan for any of these reasons:

- Your legal spouse or registered domestic partner dies.
- Your legal spouse's or registered domestic partner's hours of employment are reduced.
- Your legal spouse's or registered domestic partner's employment ends for any reason other than his or her gross misconduct.
- Your legal spouse or registered domestic partner is retired and becomes entitled to Medicare benefits (under Part A, Part B or both).
- You are divorced or legally separated from your legal spouse or you terminate your domestic partnership.

Your dependent children will be offered continuation coverage if they lose group health coverage under the Plan for any of these reasons:

- Parent-employee dies.
- Parent-employee's hours of employment are reduced.
- Parent-employee's employment ends for any reason other than his or her gross misconduct.
- Parent-employee becomes entitled to Medicare benefits (Part A, Part B or both).
- Parents become divorced or legally separated or terminate their domestic partnership.
- Child is no longer eligible for coverage under the Plan as a dependent child.

Filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to Aflac, and that bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's legal spouse

or registered domestic partner, surviving legal spouse or registered domestic partner and dependent children will also be offered continuation coverage if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction in the hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Company, or the employee's entitlement to Medicare benefits (under Part A, Part B or both), the Company must notify the plan administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

You are responsible for notifying the plan administrator within 60 days of a qualifying event that is not listed in the "When is COBRA Coverage Available?" section of this notice. These events include divorce, legal separation or the termination of a domestic partnership and the termination of a child's dependent status. Provide notice to:

Benefits Department
Aflac Incorporated
P.O. Box 5248
Columbus, Georgia 31906-0248
706-317-0770

Here's a sample of the notice and information you should provide to the Benefits Department:

To: Benefits Department
Aflac Incorporated
P.O. Box 5248
Columbus, Georgia 31906-0248

From: Name and address of covered employee, legal spouse, registered domestic partner and/or child

Telephone number: _____

Date of this notice: _____

Re: Aflac Employee Health Plan

In accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this notice is given to inform you of the occurrence of the event(s) indicated below with respect to the health coverage provided by the Aflac Employee Health Plan:

- Divorce, legal separation or termination of the domestic partnership of the covered employee and legal spouse or registered domestic partner.
- Termination of a child's dependent status under the terms of the health plan.

_____

Date the event occurred

_____

Signature of covered employee, legal spouse or registered domestic partner

How Is COBRA Coverage Provided?

Once the plan administrator is notified that a qualifying event has occurred, COBRA continuation coverage will be offered to each eligible individual. These individuals will each have the independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their legal spouses or registered domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

Premium Payments

COBRA continuation coverage is at your expense. The monthly cost of COBRA continuation coverage will be included in the election notice sent to you. The amount you must pay for COBRA continuation coverage will not exceed 102 percent of the cost for this coverage to the Plan (including both the Company's and your contributions) for a similarly situated participant or beneficiary who is not receiving COBRA continuation coverage, (or in the case of an extension of COBRA continuation coverage due to a disability, 150 percent of that cost). You will have to pay COBRA premiums on an after tax basis.

For coverage to continue, the first premium must be received by the date stated in the notice sent to you. Normally, this date will be 45 days after COBRA continuation coverage is elected. Premiums for every following month of COBRA continuation coverage must be paid monthly on or before the premium due date stated in the notice sent to you. There is a 30-day grace period for these monthly premiums. If they are not paid within 30 days after their due date, COBRA continuation coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA continuation coverage will end as of the first day of that monthly period of coverage.

Period of COBRA Coverage

COBRA continuation coverage is temporary. The length of time for which COBRA continuation coverage will be available (the "maximum period" of continuation coverage) depends on the type of qualifying event, as shown in the following chart:

Qualifying Event	Maximum Period of COBRA Continuation Coverage
Your termination of employment and/or reduction in hours of employment	18 months
You or your covered legal spouse, registered domestic partner or child qualify for a disability extension	29 months
Your divorce, legal separation, termination of domestic partnership, death or becoming entitled to (enrolled in) Medicare benefits	36 months
Your covered dependent child's loss of dependent status	36 months

However, you or your covered legal spouse's, registered domestic partner's or child's COBRA continuation coverage period may be terminated before the maximum period of coverage to which you were entitled if one of the following events occur; in this case your coverage will end on:

- The date on which a premium payment was due but not paid.
- The date after you or your legal spouse, registered domestic partner or child first becomes covered under another employer's group health plan without an exclusion or limitation affecting coverage of his or her pre-existing condition, if any, provided he or she becomes covered after his or her election of COBRA continuation coverage.
- The date after you or your legal spouse or registered domestic partner first becomes entitled to Medicare benefits (under Part A or Part B, or both), provided you or he or she becomes covered after his or her election of COBRA continuation coverage.
- The date the Company terminates all of the group health plans.
- For the health flexible spending account, the last day of the plan year in which the qualifying event occurs.

  If you or your covered legal spouse's, registered domestic partner's or child's COBRA continuation coverage is terminated for any reason before the maximum period of coverage to which you were entitled, you or your covered legal spouse, registered domestic partner or child will be notified of that fact and provided with an explanation of why COBRA continuation coverage was terminated.

Special rule for Medicare entitlement: If you become entitled to Medicare (Part A or B) while you are still employed by the Company (but not more than 18 months before the qualifying event) and you then lose your health coverage because of a qualifying event that is a termination or reduction in your hours of employment, then your covered legal spouse or registered domestic partner and children may elect COBRA continuation coverage for the balance of the 36 month period starting when you became entitled to Medicare, or 18 months from your later termination or reduction in hours of employment, whichever period is longer.

You or your covered legal spouse, registered domestic partner or child, or a person acting on your or their behalf must provide notice of your entitlement to Medicare benefits (under Part A, Part B, or both) within the time limit and in the manner described below for second qualifying events.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for his or her covered legal spouse or registered domestic partner and children remains in effect for up to 36 months after the date of Medicare entitlement. This is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as explained below.

Special Rule for Health Flexible Spending Account Coverage

The COBRA continuation coverage you may elect with respect to the health flexible spending account ("HFSA") is only available until the end of the plan year in which the qualifying event occurs. The Company does not have to offer you COBRA continuation coverage for the HFSA if, at the time of the qualifying event, the premium you must pay for this coverage exceeds the remaining coverage available to you for the plan year under the HFSA.

Disability extension of 18 month period of continuation coverage.

When the Qualifying Event for COBRA continuation coverage is your termination of employment or the reduction in hours of employment, the 18-month period of COBRA continuation coverage is extended for an additional 11 months (to a total of 29 months) if these two conditions are met:

- The Social Security Administration determines that you or your covered legal spouse, registered domestic partner or child is disabled, and the date on which the disability began was either:
  - within the first 60 days of COBRA continuation coverage (in the case of a child born to or placed for adoption with you and your legal spouse or registered domestic partner, the 60-day period is measured from the date of birth or placement for adoption); or
  - before the qualifying event and the Social Security Administration considers that you or your covered legal spouse, registered domestic partner or child remains disabled as of the date of the qualifying event.
- You or a covered legal spouse, registered domestic partner or child, or a person acting on your or his or her behalf, provide written notice to the plan administrator of the Social Security Administration's disability determination before the end of the original 18-month period of continuation coverage and within 60 days after the latest of:
  - The date of the disability determination by the Social Security Administration,
  - The date on which the qualifying event occurred, or
  - The date on which you or a covered legal spouse, registered domestic partner or child loses (or would lose) coverage under the Plan as a result of the qualifying event.

If you or a covered legal spouse, registered domestic partner or child, or a person acting on your or his or her behalf, do not provide the notice to the plan administrator within the limit explained above, the maximum period for continuation coverage will not be extended beyond the original 18-month coverage period.

Provide notice to:

Benefits Department
Aflac Incorporated
P.O. Box 5248
Columbus, Georgia 31906-0248
706-317-0770

Second qualifying event extending the 18-month period of continuation coverage. If COBRA continuation coverage was elected by your covered legal spouse, registered domestic partner or children because your employment ended or your hours were reduced (including COBRA continuation coverage during a disability extension period) and your family experiences a second qualifying event during the 18 months of COBRA continuation coverage, your covered legal spouse or registered domestic partner and dependent children may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if proper notice of the second qualifying event is provided to the plan administrator. This extension may be available to your legal spouse or registered domestic partner and dependent children who are receiving continuation coverage if you – the employee or former employee – die, divorce, legally separate or terminate your domestic partnership, or if a child no longer qualifies as a dependent under the Plan. The extension is applicable only if the second qualifying event would have resulted in a loss of coverage for your legal spouse, registered domestic partner or children if the first qualifying event had not occurred.

You or your covered legal spouse, registered domestic partner or child, or a person acting on your or his or her behalf, must provide written notice of the second qualifying event within 60 days after the latest of:

- the date of the second qualifying event; or
- the date on which your covered legal spouse, registered domestic partner or child would lose coverage under the Plan as a result of the second qualifying event.

If you or your covered legal spouse, registered domestic partner or child, or a person acting on your or his or her behalf, do not provide this notice within the time limit explained above, the maximum period for continuation coverage will not be extended beyond the original 18-month coverage period.

You must provide notice of the second qualifying event to:

Benefits Department
Aflac Incorporated
P.O. Box 5248
Columbus, Georgia 31906-0248
706-317-0770

Health Insurance Marketplace

You and your enrolled dependents may have additional coverage options available to you if you lose coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace established under the Patient Protection and Affordable Care Act. In the Marketplace, you could be eligible for a tax credit that lowers your monthly insurance premiums, and you will be able to see what your deductibles and out-of-pocket costs will be before you decide to enroll. For more information about the Marketplace, visit **www.HealthCare.gov**. Being eligible for COBRA continuation coverage will not limit your eligibility for coverage or a tax credit through the Marketplace.

If You Have Questions

Questions about the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health insurance plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit **dol.gov/ebsa.** Addresses and phone numbers of regional and district Employee Benefits Security Administration offices are available through its website.

Keep Your Plan Administrator Informed of Address Changes

Protect your family's rights by keeping the plan administrator informed of any changes to family members' addresses. You should also keep copies of notices sent to the plan administrator for your records.

Plan Contact Information

Information about the Plan and COBRA continuation coverage may be obtained at the address and phone number below. Please provide the plan name, number and administrator information when requesting information.

Address:
Aflac Incorporated
P.O. Box 5248
Columbus, Georgia 31906-0248
706-660-7551

Plan Name: Aflac Employee Health Plan
Employee Health Plan Number: 501
Plan Administrator: Benefits Manager

Aflac Incorporated 401(k) Savings and Profit Sharing Plan

The Aflac Incorporated 401(k) Savings and Profit Sharing Plan (the "401(k) Plan") includes features that allow you and Aflac, as well as other participating companies (the "Company"), to make contributions to the 401(k) Plan. This notice is provided to meet certain legal requirements and to help you make more informed decisions about your contributions. Any covered employee who is not classified as a temporary employee is eligible to begin making contributions to the 401(k) Plan after receiving his or her first paycheck. Temporary employees in covered positions are eligible after reaching age 21 and completing 1,000 hours of service in the first year of employment or any calendar year thereafter.

Automatic Plan Contributions

You may make before-tax and/or Roth contributions to the 401(k) Plan of up to 75 percent of your compensation other than annual bonuses, and up to 75 percent of your annual bonus after required taxes are deducted. However, your total before-tax and Roth contributions for the year may not exceed a dollar limit imposed by the IRS ($17,500 in 2014). If you will be age 50 by the end of 2015, you may contribute an additional amount for the year as a catch-up contribution. During the 2014 plan year, the maximum catch-up contribution was $5,500.

If you're eligible to participate in the 401(k) Plan and don't make an affirmative election, you will be automatically enrolled in the 401(k) Plan 30 days after your hire or re-hire date (or, if you are a temporary employee, 30 days after you meet the age and service requirements for participation). If you are automatically enrolled, 6 percent of your compensation other than annual bonuses will be contributed to the 401(k) Plan on a before-tax basis. If you don't want to contribute to the 401(k) Plan, if you want to contribute at a rate other than 6 percent, if you want to make contributions from your bonuses, or if you want to make Roth contributions, you must contact T. Rowe Price by telephone at 800-922-9945 or log on to **rps.trowprice.com**. You have the right to elect not to make automatic contributions or to change your before-tax and/or Roth deferral amount under the 401(k) Plan at any time, and any changes you elect will be implemented as soon as administratively feasible after your directions are received.

The 401(k) Plan also includes an automatic increase feature to help you get the most out of the 401(k) Plan's retirement savings opportunity. Under this feature, unless you elect otherwise, each year in January (i) your before-tax contribution rate will be

increased by 1 percent, unless you are already contributing either 0 percent or more than 5 percent as before-tax contributions; and (ii) your Roth contribution rate will be increased by 1 percent, unless you are already contributing either 0 percent or more than 5 percent as Roth contributions.

Like other contributions you make to the 401(k) Plan, your automatic contributions will be eligible for Company matching contributions. The Company will match, at 50 cents on the dollar, the first 6 percent of your compensation you contribute to the 401(k) Plan as either before-tax or Roth contributions.

The Company will also make nonelective contributions for some participants under the 401(k) Plan, equal to 2% of the participant's eligible compensation. In order to receive the nonelective contributions, you must not be eligible for future accruals in the Aflac Incorporated Pension Plan, and you must have reached age 21 and completed one year of service, which generally is a 12-month period of employment beginning on your hire date. Nonelective contributions will begin on the first January 1 or July 1 when you meet these eligibility requirements. You do not have to make before-tax or Roth contributions to receive the nonelective contribution.

The amount of before-tax, Roth and matching contributions made to your 401(k) Plan account will be determined based on your compensation, as defined in the 401(k) Plan. Compensation includes amounts paid to you that are reported on IRS Form W-2, and before-tax elective deferrals made under the 401(k) Plan or under certain other benefit plans, but excludes reimbursements, expense allowances, fringe benefits, moving expenses, gifts, deferred compensation, welfare benefits, and, for temporary employees, amounts paid to you while you are not eligible for the 401(k) Plan. Compensation under the 401(k) Plan is limited by the IRS each year. For 2014, the limit was $260,000.

Investment and Default-Fund Provisions

You may direct the investment of your 401(k) Plan account among an array of available investment funds. You may change your investment elections at any time. Your investment elections will continue to apply until you change them. If you don't make an investment election, your 401(k) Plan account will be invested in a default fund. Any distribution checks over $10 that remain outstanding for more than 180 days will be deposited back into your account and invested in the 401(k) Plan's default investment fund.

The current default investment fund under the 401(k) Plan is the T. Rowe Price Retirement Date Fund with the target date closest to the year in which you turn 65. A description of the default fund's investment objectives, risk and return characteristics and fees and expenses is available from T. Rowe Price. If you need additional information about the default fund or any other investment funds available under the 401(k) Plan, please call T. Rowe Price at 800-922-9945 or go to **rps.troweprice.com**.

Diversification Rights

One of the funds into which you may invest through your 401(k) Plan account is the Aflac Incorporated Stock Fund (the "Aflac Stock Fund"), which is invested primarily in shares of Aflac common stock. Because you decide how to invest all amounts in your 401(k) Plan account, you are not required to keep any portion of your 401(k) Plan account invested in the Aflac Stock Fund. As stated above, you may change the way your current and/or future contributions (including Company matching contributions) are invested at any time by contacting T. Rowe Price at 800-922-9945 or going to **rps.troweprice.com**.

Importance of Diversification

A well-balanced and diversified portfolio is important to the long-term financial security of you and your beneficiaries. Broadly defined, diversification means having an investment portfolio mixed among different asset classes, such as stocks, bonds and cash. Funds invested primarily in the stock of a single company, such as the Aflac Stock Fund, are subject to greater risk than diversified funds. Most financial planners agree that having more than 20 percent of your total investment portfolio in any individual stock results in unnecessary risk-taking and would not be considered adequate diversification. You may want to take this opportunity to evaluate your portfolio allocations.

Contact Information

This notice is a brief overview of a few important features of the 401(k) Plan. If there are discrepancies between the contents of this notice and the 401(k) Plan document, the terms of the 401(k) Plan will govern. If you would like more information about the 401(k) Plan, please refer to the summary plan description at **myAflac.com > Employee Services > Benefits > Retirement**

If you'd like a printed copy or need more information, please call the Benefits Department at 706-317-0770.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective September 23, 2013

This notice describes the ways your medical information may be used and disclosed by the group health benefit programs sponsored by Aflac (collectively the "Plan"). The Plan is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of protected health information and to provide you with this notice of the Plan's legal duties and privacy practices. This notice also provides information about how you may access your health information. Please review it carefully.

Protected health information ("PHI") means individually identifiable health information that is created or received by the Plan that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you; and that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In addition to HIPAA, special protections under state or other federal law may apply to the use or disclosure of your PHI. The Plan will comply with other federal laws where they are more protective of your privacy. If state law provides privacy protections that are more stringent than those provided by HIPAA, the Plan will maintain your PHI in accordance with the more stringent state-law standard only to the extent the law is not preempted by ERISA or other federal law.

In general, the Plan receives and maintains health information only as needed for claims or Plan administration. The primary source of your health information continues to be the healthcare provider (for example, your doctor, dentist or hospital) that created the records. Some health benefits are provided through insurance where the Plan sponsor does not have access to PHI. If you are enrolled in any insured arrangements, you will receive a separate privacy notice from the insurer. Please note that the group health benefit programs covered by this notice are part of an organized health care arrangement because they are all sponsored by Aflac. This means that the benefit programs may share your PHI with each other, as needed, for the purposes of payment and health care operations.

The Plan is required to operate in accordance with the terms of this notice. The Plan reserves the right to change the terms of this notice. If there is a material change to the uses or disclosures, your rights or the Plan's legal duties or privacy practices, the notice will be revised and you'll receive a copy. The new provisions will apply to all PHI maintained by the Plan, including information that existed prior to revision.

Uses and Disclosures Permitted Without Your Authorization or Consent

The Plan is permitted to use or disclose PHI without your consent or authorization in order to carry out treatment, payment or health-care operations. Information about **treatment** involves the care and services you receive from a health-care provider. For example, the Plan may use information about treatment of a medical condition by a doctor or hospital. Information about **payment** involves activities by the Plan to provide coverage and benefits. Payment activities include determinations of eligibility and claims management. (For example, claims are made for services you receive from a doctor.) The Plan may use and disclose your PHI for **health care operations** to make sure the Plan is well run, administered properly and does not waste money. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions. The Plan may also disclose your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information (e.g. family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums and any other activities related to the creation, renewal or replacement of a health insurance contract or health benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits that may be of interest to you.

The Plan may disclose health information to the Company, if the information is needed to carry out administrative functions of the Plan. In certain cases, the Plan, insurers or HMOs may disclose your PHI to the Company. Some of the people who

administer the Plan work for the Company. Before your PHI can be used by or disclosed to these employees, the Company must certify that it has: (1) amended the Plan documents to explain how your PHI will be protected, (2) identified the Company employees who need your PHI to carry out their duties to administer the Plan, and (3) separated the work of these employees from the rest of the workforce so that the Company cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, these designated employees will be able to contact an insurer or third party administrator to find out about the status of your benefit claims without your specific authorization.

The Plan may disclose information to the Company that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get new benefit insurance or to change or terminate the Plan. For example, if the Company wants to consider adding or changing organ transplant benefits, it may receive this summary health information to assess the costs of those services.

The Plan may also disclose limited health information to the Company in connection with the enrollment or disenrollment of individuals into or out of the Plan.

The Plan may also use or disclose your PHI for these additional purposes without your written consent or authorization:

- To business associates of the Plan that perform certain administrative services for the Plan and agree in writing to protect the privacy of your information. In addition to performing services for the Plan, business associates may use PHI for their own management and legal responsibilities and for purposes of aggregating data for Plan design and other health care operations.
- The Plan and its business associates may disclose PHI to certain other entities (including other health plans and health care providers) for the other entity's treatment, payment or health care operations purposes.
- To individuals involved with your care or payment for your care. The Plan may disclose your PHI to adult members of your family or another person identified by you who is involved with your care or payment for your care if: (1) you authorize the Plan to do so, (2) the Plan informs you that it intends to do so and you do not object, or (3) the Plan infers from the circumstances based upon professional judgment that you do not object to the disclosure. The Plan will, whenever possible, try to get your written objection to these disclosures (if you wish to object), but in certain circumstances it may rely on your oral agreement or disagreement to disclosures to family members.
- To personal representatives. The Plan may disclose your PHI to someone who is your personal representative. Before the Plan will give that person access to your PHI or allow that person to take any action on your behalf, it will require him/her to give proof that he/she may act on your behalf; for example, a court order or power of attorney granting that person such power. Generally, the parent of a minor child will be the child's personal representative. In some cases, however, state law allows minors to obtain treatment (e.g. sometimes for pregnancy or substance abuse) without parental consent, and in those cases, the Plan may not disclose certain information to the parents. The Plan may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.
- For any purpose required by law, such as responding to a court order.
- For public health activities as authorized by law or to comply with law, such as reporting disease, injury, birth, death or public-health surveillance, investigations and interventions.
- To the proper government authorities if child abuse or neglect is reported, or if the Plan reasonably believes an individual is a victim of abuse, neglect or domestic violence.
- To a health oversight agency for oversight authorized by law for audits, investigations, proceedings and actions.
- In the course of any judicial or administrative proceeding (for example, responding to a subpoena or lawful request).
- To a law enforcement official (for example, a court order, warrant, subpoena, or summons).
- To a coroner, medical examiner or funeral director (for example, to identify the deceased).
- To facilitate organ, eye or tissue donation and transplantation.
- For research purposes as permitted and provided for by law.
- To avert a serious threat to the health or safety of a person or the public, if consistent with law and ethical standards.

- For activities deemed necessary by military command authorities, if you are in the armed forces.
- To comply with workers' compensation or similar laws.
- To the Secretary of the Department of Health and Human Services, if required by law, to investigate or determine the Plan's compliance with the law.

Uses and disclosures other than those listed will be made only with your written authorization. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions); use or disclosure for marketing purposes (with limited exceptions); and use or disclosure that constitutes the sale of your PHI.

If you authorize a use or disclosure, you have the right to revoke that authorization. Your decision to revoke an authorization must be timely, submitted in writing and delivered to the Benefits Manager. Your authorization revocation will apply only to future disclosures of PHI. Once the Plan has taken action with respect to your authorization, the authorization can no longer be revoked for PHI already released.

The privacy of health information that can be used to identify you or provides information about you is protected. Not all health information is protected. Health information that doesn't identify you or cannot be used to identify you is not protected. In addition, the protections described in this notice do not apply to health information that Aflac can have under applicable law (e.g., the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation laws, federal and state occupational health and safety laws and other state and federal laws), or that Aflac properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (e.g., pre-employment physicals, drug testing, fitness for duty examinations, etc.).

You have the following rights:

You may request restrictions on certain uses and disclosures of your PHI.

You may request a restriction on use or disclosure for the purposes of treatment, payment or health-care operations. Your request must be in writing. The Plan is not required to agree to this restriction if it would prevent the Plan from carrying out payment or health-care operations. Even if the Plan agrees to your request for restriction, there are exceptions. For example, if you need emergency treatment, restricted information may be used or disclosed if it is needed for your treatment. Additionally, there are certain instances in which uses and disclosures cannot be restricted. For example, if disclosure is required by law, a restriction would not apply. You may terminate any restriction that you have requested. The Plan may terminate any restriction it agreed to without your approval. A termination by the Plan will affect only new information – in other words, information created or received by the Plan after the termination.

You may also request that your health care provider not disclose your PHI to the Plan for a health care item or service if you have paid for the item or service out-of-pocket in full. Please note that if your health care provider does not disclose the item or service to the Plan, the amount you paid for the item or service will not count toward your annual deductible or any out-of-pocket maximums under the Plan. The provider may also charge you the out-of-network rate for the item or service.

You have a right to receive confidential (alternative) communications of PHI.

You may request that PHI be communicated to you at an alternate address or by alternate means if your request clearly states that you could be endangered by disclosure of all or part of your PHI. Your request must be made in writing and must specify an alternate address or method of contact. The Plan will accommodate reasonable requests.

You have the right to access or copy your PHI.

You have a right to inspect and copy certain PHI maintained by the Plan. Remember that your health-care provider has the most complete records of your health care, including information the Plan does not have, use or maintain. We recommend that you contact your provider to review your health information. If you want to see the information maintained by the Plan, you must make the request in writing to the Aflac Benefits Manager. The Plan may charge a cost-based fee for supplies, labor and postage. If you ask for a summary or explanation of your personal health information, the Plan may charge you for the cost of preparing the summary or explanation. Your right of access is limited. For example, you do not have the right of access to psychotherapy notes, to information used in judicial or administrative proceedings or to information that is subject to the federal Privacy Act or under a promise of confidentiality.

The Plan may deny you access to your PHI in the Plan's records. You may, under some circumstances, request a review of that denial. If the Plan or its business associates maintain electronic records of your PHI, you may request an electronic copy of your PHI. You may also request that your electronic records be sent to a third party.

You have a right to amend PHI about you that is maintained by the Plan.

Your request must be in writing and you must give a reason for the request. Your right to amend is limited. For example, you can only amend information that is available to you under your right of access. The Plan may deny your request if the information was not created by the Plan and the creator of the information is available to respond to your request. The Plan may deny your request if the information is accurate and complete.

You have a right to receive an accounting of some (but not all) disclosures made by the Plan.

You may request an accounting of disclosures of your PHI made within the six-year period just before the date of your request. Your request must be in writing. The accounting will not include disclosures the Plan is permitted to make for treatment, payment and health-care operations, or those made with your authorization. The accounting will not include disclosures made to you or close family members involved in your care. The accounting will not include disclosures made for purposes of national security, incidental to otherwise permitted or required disclosures, as part of a limited data set or to correctional institutions or law enforcement officials. Your right to an accounting may be suspended in the event of certain government activities. If you request more than one accounting within a 12-month period, the Plan may charge you a cost-based fee for the additional requests.

You have a right to receive a paper copy of this notice.

If you have agreed to receive this notice by email, you also have a right to receive a paper copy upon request.

You have a right to receive notification of a breach of your PHI.

You will be notified if your unsecured PHI is acquired, accessed, used or disclosed in a manner that is not permitted under HIPAA and the security or privacy of your PHI is compromised.

Complaints

You may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. Complaints to the Plan should be made using the form provided by the Benefits Manager. If your complaint is with an insurer or HMO, you may file a complaint with the individual named in the insurer's or HMO's notice of privacy practices to receive complaints. Retaliation against a person who files a complaint is prohibited.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, you must submit your complaint in writing, either on paper or electronically, within 180 days of the date you knew or should have known that the violation occurred. You must state who you are complaining about and the acts or omissions you believe are violations of HIPAA's privacy rules. Complaints sent to the Secretary of the U.S. Department of Health and Human Services must be addressed to the regional office of the U.S. Department of Health and Human Services' Office of Civil Rights for the state in which the alleged violation occurred. For information on the regional office at which you must file your complaint, and the address of that regional office, go to the Office of Civil Rights' web site at **hhs.gov/ocr/hipaa/**.

Contact the Plan about This Notice

For further information about the content of this notice or about filing a complaint, call the Benefits Department at 706-317-0770. Send written requests or other written communication to:

Benefits Department
Aflac Incorporated
P.O. Box 5248
Columbus, GA 31906-0248

Medicaid and the Children's Health Insurance Program (CHIP)

If you're eligible for health coverage from Aflac but can't afford the premiums, some states have premium-assistance programs that can help pay for coverage with funds from their Medicaid or CHIP programs. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.HealthCare.gov.**

If you or your dependents aren't currently enrolled in Medicaid or CHIP and you believe you might be eligible for one of these programs, contact your state Medicaid or CHIP office or dial 877-KIDS NOW or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask the state if it has a program that may help pay the premiums for an employer-sponsored plan.

If you or your dependents are deemed eligible for premium assistance under Medicaid or CHIP, the Aflac Employee Health Plan is required to allow you or your dependents to enroll in the medical benefit option – provided you or your dependents are eligible for but not already enrolled in this option. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

As of July 31, 2014, these states in which Aflac empoyees are located participated in premium-assistance programs. Contact your state for more information:

ALABAMA – Medicaid
http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

IDAHO – Medicaid
http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid
http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

COLORADO – Medicaid
http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

MONTANA – Medicaid
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid
www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid
http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Phone: 1-888-695-2447
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710

MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
www.ohhs.ri.gov
Phone: 401-462-5300

NEW YORK – Medicaid
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

UTAH – Medicaid and CHIP
http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924

CHIP Website: **http://www.coverva.org/programs_premium_assistance.cfm**
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
https://www.gethipptexas.com/
Phone: 1-800-440-0493

WEST VIRGINIA – Medicaid
www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To contact these states, for more information on enrollment rights or to see if a state has added a premium-assistance program since July 31, 2014, go to **myAflac.com > Employee Services > Benefits** or call:

U.S. Department of Labor Employee Benefits Security Administration **dol.gov/ebsa** 866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services **cms.hhs.gov** 877-267-2323, menu option 4, ext. 61565

Important Federal Health Care Reform Changes and Notices

Pre-existing Condition Exclusion Removed

The pre-existing condition exclusion no longer applies to any individuals.

Grandfathered Health Plan

The Aflac Employee Health and Welfare Benefits Plan believes its medical benefit option is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act") – commonly referred to as Health Care Reform.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions about which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Department at Aflac Incorporated, 1932 Wynnton Road, Columbus, Georgia, 31999, 706-317-0770. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

New Health Insurance Marketplace Coverage Options And Your Health Coverage

PART A: General Information

Under the health care law, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace for 2015 is scheduled to begin on November 15, 2014 and end on February 15, 2015.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about the coverage offered by Aflac, please check the summary plan description for the Aflac Employee Health and Welfare Benefit Plan or contact the Benefits Department at 706-317-0770.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1]An employer-sponsored health plan meets the "minimum value" standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Aflac

This section contains information about the health coverage offered by Aflac to eligible employees. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Aflac Incorporated	**4. Employer identification Number (EIN)** 58-1167100
5. Employer Address 1932 Wynnton Road	**6. Emplyer Phone Number** 706-317-0770
7. City Columbus	**8. State** GA
10. Who can we contact aabout employee health coverage at this job? Aflac Incorporated Benefits jDepartment	**9. ZIP Code** 31999
11. Phone Number 706-317-0770	**12. Email address** N/A

Here is some basic information about health coverage offered by Aflac:

➤ As your employer, we offer a health plan to:

- ☐ All employees.
- ☑ Some employees.

Please see the summary plan description for the Aflac Employee Health Plan for a description of the plan's eligibility requirements.

➤ With respect to dependents:

- ☑ We do offer coverage.
- ☐ We do not offer coverage.

Please see the summary plan description for the Aflac Employee Health Plan for a description of the plan's eligibility requirements.

Health Benefits Coverage Under Federal Law

Women's Health and Cancer Rights Act of 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical benefit option. Therefore, the deductibles and coinsurance as noted in your SPD may apply. If you would like more information on WHCRA benefits, call the claims administrator at the number listed on the back of your medical identification card.

Newborns' Act Disclosure

The medical benefits offered under the Aflac Employee Health and Welfare Benefits Plan and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Aflac Employee Health and Welfare Benefits Plan and insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment

You and your eligible dependents may enroll in the Aflac Employee Health and Welfare Benefits Plan's medical benefit option under the following circumstances:

- **Individuals Losing Other Coverage** – If you declined coverage under the medical benefit option when it was first available because of other health coverage, and that coverage is later lost on account of:
  - Exhaustion of COBRA continuation coverage,
  - Lost eligibility for other coverage, or
  - Termination of employer contributions towards the other coverage, you and your eligible dependents may enroll in the medical benefit option within 30 days after the date you lost that other coverage. Your enrollment will take effect on the date of your loss of coverage. The change in your benefit contributions will begin on the first payroll period following your election change request.

  "Lost Eligibility for Other Coverage" means a loss of other health coverage as a result of your legal separation or divorce, a dependent's loss of dependent status, death, termination of employment or reduction in number of hours of employment or you no longer reside, live or work in the service area of a health maintenance organization in which you participated.

- **Newly Eligible Dependents** – If you initially declined enrollment for yourself or your eligible dependents and you later have a newly eligible dependent because of marriage, registered domestic partnership, birth, adoption or placement for adoption, you may enroll yourself and your newly eligible dependents (including a previously eligible dependent spouse, if you have a newly eligible dependent child) as long as you request enrollment within 30 days after the marriage, registered domestic partnership, birth, adoption or placement for adoption. For example, if you and your previously eligible dependent spouse have a child, you may enroll yourself, your previously eligible dependent spouse and your new child in the medical benefit option, even if you were not previously enrolled. You will not, however, be able to enroll existing eligible dependent children for whom coverage has been waived in the past.

  You or your eligible dependent's participation will start as of the date of the birth, adoption or placement for adoption, or for marriage/domestic partnership, the date you submit your election change, so long as you timely request enrollment. You must provide proof of your

dependent's status as an eligible dependent. The change in your benefit contributions will begin on the first payroll period following your election change request.

You will need to enroll your new eligible dependents before the date that is 30 days after the event by which they became your eligible dependent (for example, a new spouse, after your marriage or your baby is born).

- **Medicaid and CHIP** – If you or your eligible dependent children are eligible for, but not enrolled in, the medical benefit option and you or your eligible dependent children:
  - Lose coverage under Medicaid or a state child health plan (CHIP) or
  - Become eligible for a premium assistance subsidy through Medicaid or CHIP,

you and your eligible dependent children may enroll in the medical benefit option as long as you request enrollment within 60 days after the loss of coverage or the date you or your eligible dependent children became eligible for the premium subsidy. You will need to provide proof of your dependent's status as an eligible dependent. Your enrollment will take effect no later than the date of the loss of coverage or premium assistance subsidy. The date of the change in your benefit contributions will begin on the first payroll period following your election change request.

These 30-day and 60-day periods are special enrollment periods. To request special enrollment or obtain more information, contact:

Benefits Department
Aflac Incorporated
P. O. Box 5248
Columbus, Georgia 31906-0248
(706) 317-0770

Important Notice About Your Prescription Drug Coverage and Medicare

(For Participants and Covered Spouses and Dependents Who Are Eligible for Medicare)

Please read this notice carefully and keep it where you can find it.

This notice contains information about your current prescription drug coverage with the **Aflac Employee Health and Welfare Benefits Plan** and prescription drug coverage available for those on Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are two important points you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage is available to everyone on Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Aflac has determined that the prescription drug coverage offered by the Aflac Employee Health and Welfare Benefits Plan is, on average for all plan participants eligible for Medicare, expected to pay as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Read this notice carefully: It explains your options under Medicare prescription drug coverage and can help you decide whether you want to enroll.

When Can You Join a Medicare Drug Plan?

- From Oct. 15 to Dec. 7 of each year, you will have the opportunity to enroll in a Medicare prescription drug plan. You may also join a Medicare drug plan when you first become eligible for Medicare.
- If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month special enrollment period to join a Medicare drug plan.
- If you enrolled in a Medicare prescription drug plan between Nov. 15, 2006 and May 15, 2007 or decide to enroll during an open enrollment period of any year thereafter, and you drop your Aflac Employee Health and Welfare Benefits Plan prescription drug coverage, you may not be able to be reinstated to the Aflac Employee Health and Welfare Benefits Plan.
- You should compare your current coverage, including covered drugs, to the coverage and cost of plans offering Medicare prescription drug coverage in your area.
- When the Medicare Part D benefit becomes available, two prescription drug coverage options are available. You may:
  - Retain your existing coverage with the Aflac Employee Health and Welfare Benefits Plan and choose not to enroll in a Part D Plan; or
  - Enroll in Medicare Part D as a supplement to, or in lieu of, other coverage.

Your current Aflac Employee Health and Welfare Benefits Plan coverage pays for other health expenses in addition to prescription drugs, and you'll still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you drop or lose your coverage with the Aflac Employee Health and Welfare Benefits Plan and have a break in Creditable Coverage of 63 days or more before enrolling in a Medicare prescription drug plan, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at by least 1 percent of the Medicare base beneficiary premium per month for every month you didn't have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than the Medicare base premium. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage, call the Benefits Department at 706-317-0770. Note: You will be provided this notice each year, and may request a copy at any time.

More detailed information about Medicare plans offering prescription drug coverage is available in the Medicare & You handbook. Call the number below to get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans is available by:

- Visiting **medicare.gov**, where you can receive personalized help.
- Calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for the telephone number). Or, call Medicare to request the number at 800-MEDICARE (800-633-4227).
- Calling 800-MEDICARE (800-633-4227). TTY users should dial 877-486-2048.

For those with limited income and resources, extra help is available to pay for the Medicare prescription drug plan. For more information, visit the Social Security Administration website at socialsecurity.gov or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep your copy of this benefits guide on hand, as this section titled Important Notice About Your Prescription Drug Coverage and Medicare serves as your Creditable Coverage notice. If you are enrolled in the Aflac Employee Health and Welfare Benefits Plan and in one of the plans approved by Medicare that offers prescription drug coverage, you may need to provide a copy of this notice when you join the plan providing Medicare prescription drug coverage to show that you aren't required to pay a higher premium amount.

Date:	Nov. 1, 2014
Name of Entity/Sender:	Aflac Employee Health and Welfare Benefits Plan
Contact—Position/Office:	Benefits Manager Human Resources Division P.O. Box 5248, Columbus, GA 31906-0248
Phone Number:	706-317-0770

Aflac: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-888-893-6366.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	• **$500** Individual/ **$1,000** Family for In Network providers. • **$1,000** Individual/ **$2,000** Family for Out of Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for others cost for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	• Yes. **$2,000** Individual/**$4,000** Family for In Network providers. • **$4,000** Individual/**$8,000** Family for Out of Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Copayments, Non-Covered Services, Services deemed not medically necessary by medical Management and/or Anthem, Penalties for non-compliance, Charges over the allowed amount, Pharmacy claims, Deductible.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a	Yes. See **www.anthem.com** or	If you use an in-network doctor or other health care **provider**, this plan will pay some or all.

Network of **providers**?	Call **1-888-893-6366** for a list of In Network providers.	Of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use In Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	**$25** Copay/Visit	**40%** Coinsurance	----------none----------
	Specialist visit	**$35** Copay/Visit	**40%** Coinsurance	----------none----------
	Other practitioner office visit	**$35** Copay/Visit	**40%** Coinsurance	Coverage is limited to 30 visits per calendar year for Chiropractor and 30 visits for Acupuncture combined In Network and Out of Network.
	Preventive care/screening/ immunization	**$25/$35** Copay	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**40%** Coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	**$50** Copay/Visit	**40%** Coinsurance	Copay applies to facility charges only.
If you need drugs to treat your illness or condition prescription drugs are covered by CVS Caremark. More information about prescription drug coverage is available at www.caremark.com or call toll-free at 1-866-818-6911.	Tier 1 - Generic drugs	$10 Retail $20 Mail	Not Covered	$100 per participant deductible; maximum family deductible $200. The deductible is waived if mail service or generic drugs are used. Contraceptives are covered at 100% as outlined by health care reform (Affordable Care Act). Standard flu shot injection is covered at $15.
	Tier 2 - Preferred brand drugs	$30 Retail $60 Mail	Not Covered	
	Tier 3 - Non-preferred brand drugs	$70 Retail $140 Mail	Not Covered	
	Specialty drugs More information about specialty drugs is available at www.cvscaremarkspecialtyrx.com	Same as Retail/Mail	Not Covered	$100 per participant deductible; maximum family deductible $200; CVS Caremark Specialty serves as the plans exclusive provider of specialty drugs. Specialty drugs are limited to one fill or one month's supply per month however your costs are based on the days' supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance	**40%** Coinsurance	----------none----------
	Physician/surgeon fees	**20%** Coinsurance	**40%** Coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	**$200** Copay/Visit	**$200** Copay/Visit	If admitted, the ER copay is waived. Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	----------none----------
	Urgent care	**$35** Copay/Visit	**40%** Coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Physician/surgeon fee	**20%** Coinsurance	**40%** Coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$25** Copay/Visit	**40%** Coinsurance	----------none----------
	Mental/Behavioral health inpatient services	**20%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.
	Substance use disorder outpatient services	**$25** Copay/Visit	**40%** Coinsurance	----------none----------
	Substance use disorder inpatient services	**20%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.
If you are pregnant	Prenatal and postnatal care	**20%** Coinsurance	**40%** Coinsurance	$25/$35 copay applies to Initial visit only. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Delivery and all inpatient services	**20%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%. Precert needed for childbirth if inpatient stay exceeds 48 hrs for normal delivery and 96 hrs after a cesarean delivery.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	**20%** Coinsurance	Coverage is limited to 100 visits maximum per calendar year combined In Network and Out of Network. Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.
	Rehabilitation services	**$25/$35** Copay/Visit	**30%** Coinsurance	Coverage is limited to 30 visits per calendar year for Occupational Therapy, 30 visits for Physical Therapy and 30 visits for Speech therapy combined In Network and Out of Network. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Habilitation services	**$25/$35** Copay/Visit	**30%** Coinsurance	Coverage is limited to 30 visits per calendar year for Occupational Therapy, 30 visits for Physical Therapy and 30 visits for Speech therapy combined In Network and Out of Network. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Skilled nursing care	**20%** Coinsurance	**20%** Coinsurance	Coverage is limited to 60 days per calendar year combined In Network and Out of Network. Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%.
	Durable medical equipment	**20%** Coinsurance	**20%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced coverage by 50%. Orthotics require pre-authorization and prosthetics that exceed $2,500 require precertification.
	Hospice service	**20%** Coinsurance	**20%** Coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	No Charges	No Charges	Glasses and Contact Lens are covered with Eye exam with a limit to $200 maximum per individual every 24 months combined In Network and Out of Network.
	Glasses	See limitations	See limitations	Glasses and Contact Lens are covered with Eye exam with a limit to $200 maximum per individual every 24 months combined In Network and Out of Network.
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact CONEXIS Participant Services at 1-877-722-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**.
For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
Anthem Blue Cross
P.O. Box 54159
Los Angeles, CA 90054-0159.

Or Contact:

Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

A consumer assistance program can help you file your appeal. Contact:

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-893-6366.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-893-6366.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-893-6366.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-893-6366.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $8,284
- Plan pays $6,010
- Patient pays $2,274

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory Tests	$500
Prescriptions	$944
Radiology	$200
Vaccines, other preventive	$40
Total	**$8,284**

Patient pays:	
Deductibles	$600
Copays	$294
Coinsurance	$1,210
Limits or exclusions	$170
Total	**$2,274**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $7,934
- Plan pays $6,166
- Patient pays $1,768

Sample care costs:	
Prescriptions	$5,434
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$7,934**

Patient pays:	
Deductibles	$600
Copays	$928
Coinsurance	$210
Limits or exclusions	$30
Total	**$1,768**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium,** the more you'll pay in out-ofpocket costs, such as **copayments, deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Glossary

annual enrollment – a period specified by Aflac during which you may change the plan options and benefits in which you are enrolled, as long as any change is consistent with plan eligibility rules and federal regulations.

catch-up contributions – additional 401(k) contributions that people age 50 or older can make after reaching the federal limit on annual 401(k) contributions. Federal law permits catch-up contributions to encourage people nearing retirement to expand their retirement savings.

certificate of creditable coverage – a document that verifies prior health care coverage.

co-pay or co-payment – a fixed-dollar amount that you pay each time you receive specified health-care services or prescription drugs.

covered service or covered expense – a service or supply, or a charge for a service or supply, that is eligible for payment under a plan.

co-insurance – the percentage of the cost that you or the plan pays for a covered medical expense after you have met your annual deductible.

deductible – the amount of covered expenses that you are responsible to pay each calendar year before the plan starts paying.

domestic partner – your same-gender or opposite-gender domestic partner with whom you have registered under a domestic partnership law or to whom you are married under a same-sex marriage law. Registration or same-sex marriage may be in any jurisdiction that legally allows domestic partnerships or same-sex marriage. You must provide documentation of the registration or same-sex marriage to the Benefits Department. Employees seeking coverage for a domestic partner cannot be legally married to an opposite-sex spouse.

eligible dependents – your lawful spouse, your registered domestic partner, and your child(ren) as defined under each plan. See the specific plan sections of this guide for details.

explanation of benefits or EOB – a statement from your health plan that explains the benefit calculation and payment of medical services. An explanation of benefits lists charges submitted, amount allowed, amount paid by the plan and any balance owed by the patient.

Employee Retirement Income Security Act – known more commonly as ERISA, enacted in 1974 to protect the interests of employee benefit plan participants and their beneficiaries. ERISA requires disclosure of financial and other plan information to participants, sets standards of conduct for plan fiduciaries, and provides for appropriate remedies and access to the federal courts.

flexible spending account – an employee benefit program that allows you to set aside untaxed money from your pay and reimburse yourself for eligible health-care and dependent "day care" expenses. This allows you to spend the dollars that you otherwise would have paid in income taxes. The accounts are separate bookkeeping accounts.

formulary – a drug list used as a guide to determine the amount of your co-pay for each prescription medication that you purchase. Drugs listed in the formulary are typically available to you at a lower co-pay than those that are not listed. A formulary may also be called a preferred drug list.

generic drugs – prescription drugs that are chemically equivalent to brand-name products and dispensed under their generic chemical names, usually at a lower cost.

HMO or Health Maintenance Organization – a healthcare delivery system that typically uses contracted primary care physicians to coordinate all health care for enrolled participants. An HMO coordinates your care and refers you to specialists and hospitals. Covered services are usually paid in full after you pay any required co-pay. No claim forms are required.

in-network – a group of medical-, dental- or vision-care providers who are members of a service administrator's network. The service administrator has a pricing arrangement with the group that helps to hold down the cost of the services received.

inpatient – treatment in a hospital or facility for which a room and board charge is made.

medically necessary or medical necessity — a healthcare service or treatment that's generally accepted in medical practice as needed for the diagnosis or treatment of a patient's condition and that can't be omitted without harming the patient (as judged against generally accepted standards of medical practice). Medical necessity is defined under the terms of the Aflac Employee Health Plan.

Medicare – health insurance benefits provided under Title XVIII of the Social Security Act of 1965 (Federal Health Insurance for the Aged Act), as presently constituted or as amended.

medical emergency – a sudden, serious, unexpected and acute onset of an illness or injury after which a delay in treatment could cause irreversible deterioration resulting in a

threat to the patient's life or a body part, or result in an organ not returning to full, normal function.

network – a group of providers of medical-, dental- or vision-care services and supplies approved by the service administrator.

out-of-network – a non-network provider who doesn't have a pricing or service arrangement with the medical-, dental- or vision-service administrator.

out-of-pocket maximum – the amount of eligible out-of-network expenses you would pay in a calendar year before the plan begins to pay 100 percent. Your deductibles and co-pays don't count toward this maximum.

outpatient – services or supplies a person receives while not an inpatient.

Patient Protection and Affordable Care Act – enacted in 2010, the Patient Protection Act (or the Affordable Care Act), commonly called health care reform.

participant – any enrolled person eligible for benefits under the plan, including employees, their dependents, COBRA beneficiaries and retirees.

physically or mentally handicapped – inability of a person to be self-sufficient as the result of a condition such as a mental disability, cerebral palsy, epilepsy or another neurological disorder that has been diagnosed by a physician as a permanent and continuing condition.

PPO or Preferred Provider Organization – a health or dental plan that offers in-network and out-of-network benefit levels. To receive the highest level of benefits, you must choose an in-network provider or an in-network facility.

pre-authorization/prior notification requirements – a review by the service administrator of planned treatment to advise you of the services or expenses covered. Before you receive certain medical treatments or are admitted to a hospital, you must request that your doctor or other provider submit details about your condition and the proposed treatment or the plan reduces the amount it will pay for the covered services or expenses. For further information, refer to the Aflac Employee Health Plan SPD.

reasonable and customary charge or usual and customary charge – commonly referred to as R&C or U&C, a charge within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other physicians or practitioners. R&C and U&C charges don't apply to providers participating in the network.

Roth contributions – 401(k) contributions that you may make from your after-tax pay. Roth contributions and any related earnings generally may be distributed to you tax-free at retirement or any other distributable event, if the Roth contributions have been held by the plan for at least five years. Roth contributions are included in any plan limits, such as the overall regulatory contribution limit and the catch-up contribution limit. Roth contributions to a 401(k) plan should not be confused with Roth IRAs.

self-funded – an arrangement in which an employer provides health or disability benefits to employees by assuming the direct risk for payment of their benefits claims. The medical and dental benefit options under the Aflac Employee Health Plan are self-funded.

spouse – the employee's legal spouse or registered domestic partner for which proof of marriage or the registration of a domestic partnership has been provided.

summary plan description – a detailed summary that describes a plan's provisions.

tier 3, non-formulary or non-preferred prescription drugs – brand-name drugs manufactured by more than one company and for which no special pricing has been negotiated. Your purchase of these prescription drugs usually requires a higher co-pay from you.

urgent care facility – a public or private facility licensed and operated according to applicable state law, at which ambulatory patients can receive immediate, nonemergency care for mild to moderate injuries and/or illnesses without scheduling appointments.

vesting – the years of Aflac service it takes to gain 100 percent ownership of Aflac's contributions to your 401(k) savings plan account or your accrued benefit in the pension plan.

The definitions listed here are basic terms and are for informational purposes only. Please refer to the SPDs at **myAflac.com > Employee Services > Benefits** for each of the plans in which you are enrolled for a detailed listing of the plan's official definitions.

Quick Reference

Aflac Benefits Department
Human Resources
706-317-0770

401(k) Plan
T. Rowe Price
800-922-9945
rps.troweprice.com

Accidental-Death & -Dismemberment
Insurance Plan
Benefits Department
706-317-0770

Aflac/Aflac Group Plans
Aflac Policies and Services
800-992-3522
aflac.com

Aflac Group Customer Service
800-433-3036
caicworksite.com

Credit Union
Aflac Credit Union
706-596-3239
aflacfcu.net

Dental Plan
Ameritas Group
800-487-5553
ameritas.com
Also use the number for replacement cards.

Disability – Short- and Long-Term
Reliance Standard
877-202-0055
matrixeservices.com

Employee Assistance Plan
Bensinger, DuPont & Associates
800-807-1535
bensingerdupont.com *(Password: AFLAC)*

Family and Medical Leave
Reliance Standard
877-202-0055
matrixeservices.com

Flexible Spending Accounts
WageWorks
877-924-3967
wageworks.com

Health Plan
Anthem PPO
888-893-6366
anthem.com

Life Insurance Plan
Lincoln Financial Group
800-423-2765
lfg.com

Pension Plan
Milliman, Inc.
866-767-1212
millimanbenefits.com

Prescription Drug Plan
Aflac Health Plan
CVS/Caremark
866-818-6911
caremark.com

Specialty Rx
800-387-2573

Mail Order
800-875-0867

Prior Authorization *(Physician)*
800-294-5979

Stock Options
Aflac Stock Option Administration
706-596-3562

Stock Purchase Plan
Aflac Shareholder Services
706-596-3279

Vision Plan
VSP
800-877-7195
vsp.com

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