Davidson County Schools offers all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits program allows you to pay for certain insurance premiums, child-care, and non-reimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits by this method reduces your applicable FICA and income tax withholding resulting in increases to your take home pay. The Cafeteria Benefits program includes pre-tax and after-tax products.

- Plan Year: September 1, 2013 to August 31, 2014
- Enrollment Dates: May 17 - August 1, 2013
- Enroller Support: May 20 to May 31, 2013

**PRE-TAX BENEFITS**



***AFTER-TAX BENEFITS***



*(This booklet highlights the benefits offered through your employer for the current plan year. This is not an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only).*

# WeCare Internet Enrollment Instructions

Logon to the following website: www.mywecarebenefits.net/markiii

**To enter the enrollment site:**

- Enter Case ID: M124
- Enter the Online ID: Last 5 digits of your SSN, first initial of first name and first initial of last name
  - »*Example: John Smith #123-45-6789 would be 56789js*
- Enter password: enroll13
- Enter Security Code: (will see on screen)

**1. "On-line Service Agreement." – Please read the agreement**.

- Click Agree and then click Next.
- Clicking "Agree" will allow you to enter the site. Once you click "Agree" you will go to the "Welcome Page."
- Click "Enter" to continue.
- Clicking "Disagree" will prevent you from viewing the rest of the internet site.

**2. "Start Page"**

- Initially you will view the Start Page which contains important information relative to the site. Take a moment to read the information provided.
- Click "Next" to continue.
- Employee Data (you can update and correct info on this screen by clicking, Edit
- Click Next to proceed to the following screen(s)

**3. "Election Summary"**

- From the "Election Summary" screen you can review your benefit selection(s) and print a copy for your records.
- To print the Election Summary, click on the "Print Confirmation Statement Tab" at the bottom of the page.
- You will then need to click "Print" at the top of the "Benefit Election Form" page. Once you have printed the form, click "Close Window". Retain this print-out as proof of the benefits you have selected for the 2013-2014 plan year.

**4. "Logout"**

- Click "Logout" at the top of the Election Summary screen. Please close your browser when you are finished

You may enter and exit the website and update your elections as often as you like from May 17, 2013 through August 1, 2013. The site will recall the last change made each time you log on. For any changes you make, please print the benefit election summary confirmation statement for you records.

**Contacts regarding enrollment:**

- Shelly Hodges / 336.242.5531 or email at shodges@davidson.k12.nc.us
- Cindy Horton / 800.532.1044 ext. 210 or email at cindy@markiiieb.com
- Susan Murphy / Email at susan@markiiieb.com

# Key Points

- The Plan Year for Davidson County Schools is:
    - September 1, 2013 thru August 31, 2014.
- Payroll deductions for this year's enrollment:
    - End of month pay will be 8/31/2013.
    - Middle of month pay will be 9/15/2013.
- ***New Products This Year:***
  - **Aflac Accident**
    - Guaranteed issue coverage / No health questions during this enrollment
    - Pays a lump sum in accordance with a schedule due to an accident
    - 24 hour coverage benefits
    - Available for spouse and children
    - $60 wellness benefit payable to covered members
    - Coverage terminates at age 70
  - **Aflac Critical Illness -**
    - An annual Health Screening Benefit is included.
    - Spouse coverage is available.
    - Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
    - Each dependent child is covered at 25% of the primary insured's amount at no additional charge.
    - Coverage is guaranteed-issue
    - Your premiums are paid through the convenience of payroll deduction.
    - Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.
  - **AUL Long Term Disability -**
    - Guaranteed issue coverage/No health questions during this enrollment
    - No offsets with other disability income benefits
    - 24 hour coverage
    - Portable for 12 months after 3 months of coverage
    - Lump Sum Benefit pays a single payment of $10,000

- **AUL Short-Term Disability** - Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions. Current participants may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

- **Allstate Cancer -** Is offering guaranteed issue coverage for the cancer plan again this year. This may be your only opportunity to elect guaranteed issue coverage. If interested, please make an appointment to meet with a Mark III representative.

• **Ameritas Dental** - There is a late entrant provision on the Ameritas Dental Plan: *There is a 12-month waiting period on all services except for cleanings, exams, and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible. Annual enrollment is NOT considered the date of your eligibility.*

• Participants are required to have a prescription for Over-the-Counter ("OTC") medicines to be eligible under their FSA plan.

• Please remember that elections made during annual enrollment ***cannot*** be changed once the enrollment period ends unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.

• If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollment. All requests must be made in writing to your benefits office.

• You must re-elect your Gilsbar Medical Spending and Dependent Care Accounts each year. They do not automatically carry-over to the next year.

• For current Gilsbar participants, your existing Gilsbar account will be replenished as long as you re-elect the Medical Spending Account. Your existing card is good for 3 years from the issue date.

• For new Gilsbar participants, a card will be mailed to your home in a plain white envelope with no reference to Gilsbar. Again, this card will be good for three (3) years from issue date as long as you re-elect the Medical Spending Account each year.

• Medical Reimbursement and Dependent Care expenses must be incurred during the plan year to be eligible for reimbursement.

• Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to www.myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445- 7227 ext. 883.

• Access your Gilsbar account online.

1. Go to www.mygilsbar.com to register with a valid e-mail address and your Group Number. The group number is S2551

2. Once logged in, click the Reimbursement Account Center link on the left navigation bar.

• Any questions regarding all other benefits can be directed to Shelly Hodges at 336-242-5531.

# FSAs and Healthcare Reform
# What The New Legislation Means To You

**WILL HEALTHCARE REFORM LAWS AFFECT MY FLEXIBLE SPENDING ACCOUNT (FSA)?**
Yes. The new healthcare reform legislation will significantly change the landscape of cafeteria plans, including FSAs.

**CAN I STILL USE MY FSA FUNDS FOR OVER-THE-COUNTER (OTC) MEDICATIONS?**
Medications and drugs (other than insulin) are longer reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medication or drugs must meet one of the following criteria to be eligible for reimbursement.

1. The medicine or drug requires a prescription.

2. The medicine or drug is available without a prescription and the individual obtains a prescription.

3. The medicine or drug is insulin.

Not all OTC expenses are excluded from reimbursement. Items such as adult diapers, bandages, first aid kits, diabetes monitors, and test strips may still be purchased on a pre-tax basis, with reimbursable funds, without a doctor's prescription. A final list of approved OTC items has not been released by the U.S. Department of Health and Human Services.

**AM I STILL ABLE TO USE MY FSA DEBIT CARD FOR ELIGIBLE EXPENSES?**
Most retailers cannot distinguish which OTC medications and drugs are prescribed. Therefore, individuals may not use an FSA debit card to purchase OTC medications or drugs. Additionally, even though certain OTC expenses are still eligible for reimbursement with FSA funds, you may not use your FSA debit card for these eligible purchases. Individuals must submit an online claim for reimbursement of these items.

OTC medications must be substantiated by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) when the claim is filed with Gilsbar.

**HOW CAN I SUBMIT AN ONLINE CLAIM?**

1. Login to **www.myGilsbar.com**.
2. Select FSAs and HRAs.
3. Click *New Reimbursement Request* found in the center box labeled Recent Reimbursement Requests.
4. Click *Request Reimbursement* for the appropriate account.
5. Select the Claim Category from the drop down menu and click *Next*.
6. Fill in the Claim Type, Amount, Provider, and Service From Date(s) fields. Click *Next.*
7. Review the data entered. If you need to make an edit, click *Modify*. If everything is correct, click *Finish*.
8. Repeat Steps 4 – 6 if you need to enter multiple claims. When finished, click *Submit all Entered Claims for Processing*.
9. Select the box next to the statement "I hereby certify that all items..." and click *Confirm*.
10. Print a copy of the confirmation page with transaction number for your records.
11. Download the Fax Coversheet by selecting the link labeled *Click Here*.
12. Fax a copy of the Fax Coversheet and your receipt(s) to (866) 635-1329*.

* It is necessary to submit a faxed copy of your receipt(s) including a description of services in order to fully process the claim(s). Please attach a copy of your doctor's prescription or documentation that a prescription was issued when you submit your claim.

Because the majority of OTC medications and drugs are no longer eligible for reimbursement, this may affect how much you choose to contribute to your FSA. Remember, as a general rule, the IRS requires that all money in the account be used during the plan year.

Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your contribution amount.

## *Gilsbar Flexible Spending Accounts (General Overview)*

***Plan Year: September 1, 2013 - August 31, 2014***
***Medical Reimbursement Plan Maximum / Minimum: $2,500 / $240***
***Dependent Care Account Maximum: $5,000***
***Run-out Period: 90-days following end of plan year***

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in an FSA, including debit card transactions and over the counter drugs. As a reminder, participants should keep all of their receipts for the entire plan year in the event that Gilsbar ask for documentation or the IRS requests a copy of a receipt.

Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication (with a prescription or letter of medical necessity), certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA), you can save a significant amount of money on your health and day care expenses using a Health Care and/ or Dependent Care Flexible Spending Account (FSA). The frequently asked FSA questions below will help you understand how to make the most of this program and your paycheck.

***General questions regarding Health Care and Dependent Care Accounts:***

**What is an FSA?**
Provided by your employer, an FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help pay for your out-of-pocket medical expenses and/or dependent day care expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means your take home pay increases!

**Will I pay taxes on the money I set aside?**
No. FSA contributions and reimbursements are exempt from Federal Income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

**What kind of savings can I realize by participating in this program?**
Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

**Can I submit expenses I incurred before the beginning of the plan year?**
No. Only expenses incurred during the plan year and while you are a participant are eligible for reimbursement.

**How long do I have to file a claim with Gilsbar after the plan year ends?**
You have a grace period (90-days) after the end of the plan year to submit expenses incurred during the plan year.

**Can I change the amount of my election(s) in the FSA program during the plan year? (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)**
Generally, you may not change your FSA elections during the Plan Year.

However, you may change during the annual enrollment period for the coming Plan Year. There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Dependent Status. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a dependent or spouse
- Change in employment status of yourself or your spouse
- A significant change caused by a third party in the cost of your dependent care coverage

***(You have 30 days from the date of the qualifying event to request a change to your FSA election. This must be done in writing to your benefits office).***

**If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?**

You will be reimbursed only for expenses incurred prior to your termination date, and submitted within the termination grace period. Any money remaining in your account(s) after the grace period will be forfeited.

**Can I view my FSA balances online?**

Yes! Visit myGilsbar.com and login to access claims information and FSA balances online. Once you are logged in, select the FSA and HRA links on the left side of the screen to view your account balances. If you are new to myGilsbar, complete the brief site registration to login. You will need your group number, social security number, and a valid email address to complete this section.

**What if I have a question?**

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at myGilsbar.com or you can call our Customer Contact Center at 1-800-445-7227 ext. 883.

**How does participating in an FSA save me money?**

The following example illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

| | **With FSA** | **Without FSA** |
|---|---|---|
| **Salary** | $1000 | $1000 |
| **Less Pre-Taxed Dollars:** | | |
| Health Care Reimbursement | $100 | 0 |
| Dependent Day Care Reimbursement | $150 | 0 |
| Taxable Income | $750 | $1000 |
| **Less:** | | |
| Federal Income Tax | $82.00 | $121.00 |
| State Income Tax | $17.58 | $23.44 |
| Social Security | $57.37 | $76.50 |
| **Net Take Home Pay** | $593.05 | $779.06 |
| **Less Health Care & Dependent Care Expenses** | $0.00 | $250.00 |
| **Net After Expenses** | $593.05 | $529.06 |

Tax Savings This Pay Period: $63.99

Annual Tax Savings: $63.99 X 26 pay periods = $1,663.74

# MEDICAL REIMBURSEMENT ACCOUNT

The Health Care FSA is simple! Provided by your employer, a Health Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help you pay for your out-of-pocket medical expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses you save on income tax... which means your take home pay increases.

**How does the Health Care FSA Work?**

With a Health Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided between pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visit, and over-the-counter medications (with a prescription or letter of medical necessity) and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

The IRS requires you to forfeit any money that is left in the FSA at the end of the year. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money. To help avoid forfeitures, you will receive a notice of your balance prior to the end of each year.

You can access balance information online 24/7 via myGILSBAR.com. Select the “FSAs and HRAs” link on the left side of the screen to view your balances. Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax your completed claim form and receipts to Gilsbar for reimbursement.

**What is eligible for reimbursement under the Health Care FSA?**

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the “Qualified Medical Expenses Eligible for Reimbursement” list below.

**How do I get reimbursed?**

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement
- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the “Explanation of Benefits” showing the unpaid expenses
- For reimbursement of expenses not covered under a health care plan, complete the Health Care Expenses claim form and attach itemized bills for the expense.

**FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329**

**How much will be reimbursed?**

When you submit a health care expense, you will be reimbursed for eligible expenses claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

**Can I use my Health Care FSA for my family's expenses?**

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

**If I don't have any medical insurance through my company, can I still participate in the Health Care FSA?**

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

**Is there anything I have to keep in mind when it comes time to file my taxes?**

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

**I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?**

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Gilsbar for reimbursement.

**If I have a question about my account, what should I do?**

If you have any questions, you can access your account information 24/7 at myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor.

## Qualified Medical Expenses Eligible For Reimbursement:

Acupuncture

Alcoholism Treatment

Ambulance

Anesthetists

Artificial limbs

Birth control pills (by prescription)

Blood tests

Braces

Braille books and magazines

Cardiographs

Chiropractor

Christian Science Practitioner

Contact lenses

Contraceptive devices

Convalescent home (for medical treatment only)

Crutches

Dental treatment

Dental x-rays

Dentures

Dermatologist

Diagnostic fees

Drug addiction therapy costs

Drugs (prescription)

Equipment (medical)

Eye exams and eyeglasses

FICA and FUTA tax for the handicapped

Guide dog

Gynecologist

Healing service

Hearing aid and batteries

Hospital bills

Hydrotherapy

Immunizations

Insulin treatments

Lab tests

Lead paint removal

Legal fees (to authorize treatment for a mental illness

Lodging away from home for outpatient care

Medical services

Medical Testing

Metabolism tests

Neurologist

Nursing (including board and meals)

Obstetrician

Operating room costs

Ophthalmologist

Optician

Oral surgery

Organ transplant (including donor's expenses)

Orthodontist

Orthopedic shoes

Orthopedist

Osteopath

Over-the-counter medications **

Oxygen

Paid-for medical care service

Pediatrician

Physician

Physiotherapist

Postnatal treatments

Practical nurse

Prenatal care

Prescription medicines

Psychiatrist

Psychoanalyst

Psychologist

Psychotherapy

Radium Therapy

Registered nurse

Special School

Spinal fluid tests

Splints

Sterilization

Stop smoking programs

Surgeon

Telephone equipment to assist the hearing impaired

Television equipment for the hearing impaired

Therapy equipment

Transplants (organ)

Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is nineteen (.23) cents per mile.)

Ultra-violet ray treatment

Vaccines

Vasectomy

Vitamins (if prescribed)

Weight loss programs* (not food)

Wheelchair

X-rays

* May require additional substantiation (documents of medical necessity)

## Expenses Not Eligible For Reimbursement

Any expense not considered "medically necessary" by the IRS

Any expense for your general health, even if your doctor prescribes the program

Babysitting and childcare

Bleaching teeth (cosmetic)

Cosmetic surgery

Dancing lessons

Diaper service

Dietary supplements

Electrolysis

Face lifts

Food

Funeral, cremation, or burial expenses

Hair transplants

Health club membership dues

Household help

Illegal operations and treatments

Insurance premiums

Laetrile

Liposuction

Marijuana used medically

Maternity clothes

Personal use items

Prescription drugs considered cosmetic

Rogaine

Swimming lessons

Vitamins

## *Over the Counter Drugs*

***Please be advised that participants are required to have a prescription for Over-the-Counter ("OTC") drugs/medicines to be eligible under their FSA plan.***

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1-800-829-3676).

### Drug/Medicine

| | |
|---|---|
| Allergy Prevention & Treatment | First Aid Supplies |
| Antacids and Acid Reducers | Hemorrhoid Treatments |
| Anticandial | Internal Analgesics / Antipyretic |
| Antihistamines | Incontinence Supplies |
| Anti-diarrheal and Laxatives | Liniments |
| Anti-fungal | Medical Monitoring |
| Anti-itch Lotions and Creams | Medical Products and Devices |
| Asthma | Menstrual Cycle Medications |
| Cold Sore / Fever Blister | Migraine |
| Condoms and other contraceptive Devices | Motion Sickness Medication |
| Contact Lenses Solutions | Nicotine Gum or Patches and smoking Cessation Aids |
| Cough Suppressants | Pediculicide ( head lice) |
| Decongestant / Nasal Decongestant and Cold Remedies | Smoking Cessation |
| Diaper Rash Ointments | Toothache/Teething Pain Relievers |
| Eye Drops for Allergy / Cold Relief | Wart Removal and Medications |

# Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year, keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

**HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:**

| | |
|---|---|
| Deductibles | |
| (medical and dental) | $___________ |
| Benefit percentage/co-insurance | |
| (The amount NOT paid by your insurance) | $ ___________ |
| Amounts paid over plan limits | |
| Over reasonable and customary allowance | $ ___________ |
| Over psychiatric limits | $ ___________ |
| Over private room allowance | $ ___________ |
| Expenses NOT covered by your insurance plan | |
| Physicals | |
| Prescription drugs | $ ___________ |
| Over-the-counter medications | $ ___________ |
| Vision care | $ ___________ |
| Hearing expenses | $ ___________ |
| Psychiatric care | $ ___________ |
| Dental and orthodontic care | $ ___________ |
| Assistance for the handicapped | $ ___________ |
| Therapy/treatments | $ ___________ |
| Physician's fees/services | $ ___________ |
| Medical equipment | $ ___________ |
| Miscellaneous charges | $ ___________ |
| | |
| My out-of-pocket health care (expenses last year) | $___________ |

## Flex Debit Card

### How does the FSA Debit Card work?

Shortly after the start of the plan year you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

### Where can I use my FSA Debit Card?

Your FSA Debit Card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

### If I use my FSA Debit Card, is verification of claims still required?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transaction can be verified using one of the IRS' approved electronic methods: however, not all transactions can be verified electronically. For any expense that cannot be verified electronically, you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost and patient liability. If Gilsbar does not receive verification within 30 days of the date requested you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

### Are there special rules that are related to prescriptions, over-the-counter (OTC) products, and vision expenses incurred at retail merchants?

Over the Counter (OTC) are only eligible with a prescription. You must submit the prescription with the receipt for reimbursement.

### Can I use my FSA Debit Card for eligible Dependent Care expenses?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

### What happens if the FSA Debit Card is used for an ineligible expense?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

### What should I do to pay for an expense that is more than my account balance?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

# FSA Substantiation

## Documenting & Submitting Proof of FSA Eligible Purchases

**FREQUENTLY ASKED QUESTIONS:**

**Previously, I never received notices asking for debit card receipts. Why am I now getting these notices?**
According to the new rules, there are five basic requirements that must be met for you to use a debit card for your FSA. These requirements are:

• Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.

• The participant must retain all receipts for all transactions.

• 100% of debit card transaction must be reviewed by a third party to ensure that the items purchased are FSA eligible.

• Sampling or employee “self-certification” is not allowed for an FSA.

• Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, in the new rules, the IRS defines several electronic substantiation methods that we can follow to help with the adjudication process. These methods are:
• Co-pay Match – If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.

• Recurring Expense – For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.

• Real-Time or Merchant Substantiation – If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

All in all, with the new rules, about 72% of all debit card transactions fit one of the electronic substantiation categories listed above. Meaning, Gilsbar is asking for detail on about 28% of all debit cards transactions.

**Why does the IRS have these rules? Isn’t it my money?**
Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

**What should I do if I receive substantiation letters?**
You should sign and return these notices to Gilsbar when you submit your receipts, and keep a copy of these letters for your records. Remember, you can mail or fax your receipts and forms to Gilsbar:

*Mail: Employee Reimbursement Center/P.O. Box 25123 /Lehigh Valley, PA 18002-5123 / Fax: 1-866-635-1329*

**What are acceptable forms of substantiation?**

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register and/or provider receipts showing the date, item bought and dollar amount charged. Credit card receipts are not acceptable forms because they do not provide the specific item purchased; therefore, Gilsbar cannot determine if the expense was an FSA eligible item.

**Is it a requirement that providers, pharmacies, hospitals, etc. provide a receipt with service?**

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

**In addition to sending my receipts to Gilsbar, should I also keep copies of my receipts?**

Because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending to Gilsbar.

Here are a few organization and record-keeping suggestions:

- Designate a folder to keep copies of only your FSA eligible receipts.
- In this same folder, keep copies of any information you receive from your employer or Gilsbar regarding FSAs. This includes marketing pieces, letters, or notices you may receive.
- Register on myGilsbar.com and start utilizing the Reimbursement Account Center to stay informed and up-to-date on your account. The reimbursement account center allows you to access the following:
    - Available balance
    - Submitted claims
    - Pending claims
    - Payments received
    - Lists of eligible expenses
    - Downloadable forms
    - And much more!

**I thought purchases at certain vendors were automatically substantiated and considered approved purchases?**

No additional substantiation will be required for debit card transactions that are approved at the point of sale by merchants (specifically pharmacies) who have adopted the Inventory Information Approval System (IIAS). The IIAS system compares the SKU on the item being purchased to a list of FSA eligible items sold at the store. When a FSA debit card is used, the pharmacy will only allow the card to pay for the FSA eligible items and any non-FSA eligible items will need to be paid for using an alternative method of payment. If merchants have not adopted this system, FSA debit cards might not work at their places of business. Until then, providing copies of receipts, even pharmacy purchases, is still required.

## DEPENDENT CARE REIMBURSEMENT ACCOUNT

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

The Dependent Care FSA creates tax savings on up to $5,000 of daycare expenses.  That can mean $1,500 in tax savings enough to pay for weeks of eligible child or adult daycare!

### How Does a Dependent Care FSA work?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year, is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax…which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the plan year. You can access balance information 24/7 online via myGilsbar.com. Select the “Reimbursement Account Center” link on the left side of the screen to view your balances.

### Am I eligible to use the Dependent Care FSA?

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;
- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

### Who is an eligible dependent?

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age;
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself;
- Is your spouse who is physically or mentally incapable of caring for himself or herself,
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

**What expenses are covered?**

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attended school full- time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

**Is there anything I have to keep in mind when it comes time to file my taxes?**

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return. If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit ($2,400 for one dependent or $4,800 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA.

**How do I get reimbursed?**

As you incur eligible expenses you must submit a completed Dependent Care FSA claim form to Gilsbar with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in “pending” status until funds are received through payroll deduction at which time you will receive reimbursement.

**FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329 FOR PROCESSING.**

**Can I pay my in-home daycare provider through the Dependent Care FSA?**

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider's home or a "daycare center". Receipts for the expenses and the caregiver's Tax ID number or Social Security number must be provided.

**I'm divorced; my ex-spouse claims our child as a dependent for tax purposes. I pay for child care. Can I use the Dependent Care FSA?**

If your child resides with you most of the year, you can use the dependent care account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

**If I have a question about my account, what should I do?**

If you have any questions, you can access your account information 24/7 at myGilsbar.com or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

# Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities*

Day Care Center / Nursery School $ _____________

Family Day Care / Adult Day Care Centers** $ _____________

Wages paid to a nanny or in home care provider*** $ _____________

* The facility must follow all local and state laws.

** These costs are eligible only if the adult dependent spends at least eight hours per day at home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS $ ____________

TOTAL ESTIMATED DEPENDENT CARE EXPENSES $ ____________

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

PLEASE FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329
FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

**Questions? Call Gilsbar's Customer Contact Center;**
**1-800-445-7227, ext. 883**

If you prefer to submit your form by mail, please send claim form and receipts to:
Claims Processing Center / *P.O. Box 25123 / Lehigh Valley, PA 18002-5123*
(PLEASE KEEP YOUR ORIGINALS)

# Gilsbar Welcome Letter

Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your FSA plans are administered by Gilsbar, Inc. **Your Gilsbar group number is S2551.**

**Access the MyGilsbar.com Website to Manage your Account 24/7!**

- View plan year balance
- Set up or edit ACH/Bank Draft information*
- Check claim status
- View claim/ receipt images within 24 hours
- Obtain claim forms
- Set up email messaging
- View payments and payment dates
- File appeals to denied claims

**To participate in the FSA Direct Deposit (ACH / Bank Draft) a valid email address is required.*

**It's easy to get started:**

**Step 1: After your effective date, go to www.mygilsbar.com and register as a new participant.**
You will complete a brief registration form to register with a valid email address and your group number.

**Step 2: Once logged in, click on a selection under the *FSA and HRA sections* in the left navigation bar.**
If you are a first time user, you will be prompted to enter your email address to sign up for our Reimbursement Account Center email service. This is an important step to ensure you will receive email updates when:

a. A claim is received
b. The claim/receipt images are ready to view online
c. The claim is processed and posted for payment

**Step 3: Click the *Accounts* tab at the top to confirm that your annual election(s) and address are accurate.** Contact us with any discrepancies.

**Step 4: Confirm that your ACH/Auto Bank Draft information is entered and accurate,** (or to set up direct deposits into your bank account) click the **Profile** tab at the top and click **Edit** under the **Your ACH** section. To update your email address, click **Edit** under the **View / Edit Your Profile** section.

| | |
|---|---|
| **For Fastest Processing, FAX Claims and Receipts to: 1-866-635-1329**<br><br>Mail Claims and Receipts to:<br>Claims Processing Center<br>PO Box 25123<br>Lehigh Valley, PA 18002-5123<br><br>***(Please keep your originals)*** | **Customer Contact Center**<br><br>**7:00 AM – 7:00 PM Central Time**<br><br>**Phone: 1-800-445-7227 ext. 883**<br>**Email: flex@gilsbar.com**<br><br>(Please do not email claims/receipts) |

# Ameritas Dental Plan - High

***Policy Effective Date: September 1, 2013***

**CALENDAR YEAR DEDUCTIBLE**

$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

**TYPE I - PREVENTIVE AND DIAGNOSTIC**

Type I benefits are payable at 100% U&C*. No deductible applies.

- Evaluations *(Two per calendar year)*
- Space Maintainers
- Cleanings *(Two per calendar year)*
- Bitewings *(Two per calendar year)*
- Fluoride for Children *(Under age 19 / One per calendar year)*

**TYPE II - BASIC PROCEDURES**

Type II benefits are payable at 80-90-100% U&C*. $50.00 deductible applies.

- Sealants (Under age 17)
- Anesthesia
- Limited Exams (Problem Focused)
- Denture Repair
- Oral Surgery-Simple Extractions
- Oral Surgery-Complex Extractions
- Restorative Amalgam & Resin (excluding inlays & crowns)

**TYPE III - MAJOR PROCEDURES**

Type III Benefits are payable at 50% U&C*. $50.00 deductible applies.

- Endodontics (Root Canal)
- Restorative - Crown
- Periodontics (Gum Disease)
- Crown Repair
- Crowns
- Prosthodontics (Removable Dentures, Partials)
- Prosthodontics (Fixed Pontics or Abutments)

**ORTHODONTIA**

Paid at 50% U&C* with a $1,000 lifetime maximum per person. No deductible applies. (Includes Children and Adults)

**Usual & Customary*

**ANNUAL MAXIMUM BENEFIT**

Type I, II and III Procedures -$1,000 per calendar year per person.
Orthodontia Procedures - $1,000 Lifetime per person.

**80-90-100% INCENTIVE**

Everyone insured on the effective date of the Company's policy begins with 80% coinsurance for Basic procedures and will remain at that level until the next January 1. If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Basic procedures will advance to the next coinsurance level at the beginning of each year as long as you had one covered procedure in the previous year.

Once you have reached the 100% coinsurance level, basic will remain at that level as long as you continue to visit the dentist for one covered procedure each year.

If you do not have at least one covered dental procedure during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

**ANNUAL MAXIMUM CARRYOVER**

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to **March 1** of the following year.
3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1,000. This benefit allows you to accumulate up to a $2,000 **annual dental maximum.**

**ELIGIBLE EMPLOYEES**

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

**ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.). A child must be added within thirty-one (31) days of turning age 2 not to be considered a late entrant.

**All new enrollees in this plan** will begin at the 80% coinsurance for Basic procedures. These employees will advance through the Incentive plan at the 80, 90, and 100% levels.

**DENTAL EXCLUSIONS (DEFERMENT PERIOD)**

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

**PRE-DETERMINATION OF BENEFITS**
A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

**LATE ENTRANT**
If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.** For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

**COORDINATION OF BENEFITS**
If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

**CERTIFICATE OF INSURANCE**
The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

**SECTION 125**
This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

**LIMITATIONS/EXCLUSIONS** (This is not a complete List)
• For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
• Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
• Services which are not recommended by a dentist or which are not required necessary care and treatment.
• Expenses incurred to replace lost or stolen appliances.
• Expenses incurred by an insured because of a sickness for which he/she is eligible for benefits under Worker's Compensation Act or similar laws.

## Ameritas Managed Care Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

## Passive PPO

In passive PPO, the coinsurance, deductible and maximum are the same for the member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in network dentist; however, there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

### Ameritas Managed Care Products

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- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

## Commonly Asked PPO Questions

The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

**Do I have to use an Ameritas PPO provider?**

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

**Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.**

**Why would I use an Ameritas PPO provider?**

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing

the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

**What happens if I don't use an Ameritas PPO provider?**
For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

• Your Employer wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C (Usual & Customary) which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

• Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on the Ameritas website (this will be available via our Intranet in the near future), or the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

**ORTHODONTIA LIMITATIONS** (This is not a complete list)
No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

**MONTHLY DENTAL RATES**

| | |
|---|---|
| **Employee Only** | **$31.74** |
| **Employee & Spouse** | **$92.24** |
| **Employee & Child(ren)** | **$96.08** |
| **Employee & Family** | **$156.58** |

**For Claims/Customer Service Questions call Ameritas: 1-800-487-5553.**
**Or, visit the Ameritas website at: www.AmeritasGroup.com**

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS
LIFE INSURANCE CORP.

# Ameritas Dental Plan - Low

**Effective Date: September 1, 2013**

**TYPE I - PREVENTIVE AND DIAGNOSTIC**
70-80-90-100% coinsurance requirements. $100.00 combined lifetime (per person) deductible applies.

- Evaluations ( Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

**TYPE II - BASIC PROCEDURES**
70-80-90-100% coinsurance requirements. $100.00 combined lifetime (per person) deductible applies.

- Sealants (Under age 17)
- Restorative Amalgam & Resin (Excluding Inlays & Crowns)
- Oral Surgery - Simple Extractions
- Oral Surgery - Complex Extractions
- Limited exams
- Anesthesia
- Denture Repair
- Endodontics (Root Canal)
- Periodontics (Gum Disease)

**ANNUAL MAXIMUM BENEFIT**
Type I and II Procedures -$1,000 per calendar year per person.

**INCENTIVE MECHANISM 70-80-90-100%**
Everyone insured on the effective date of the Company's policy begins with 70% coinsurance for (Preventive) and (Basic) procedures and will remain at that level until the next January 1. If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Preventive and Basic procedures will advance to the next coinsurance level at the beginning of each year as long as you had one covered procedure in the previous year.

Once you have reached the 100% coinsurance level, preventive and basic will remain at that level as long as you continue to visit the dentist for one covered procedure each year.

If you do not have at least one covered dental procedure during any calendar year while insured under the Company's policy, you will revert back to 70% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

**All new enrollees in this plan** will begin at the 70% coinsurance for Preventive and Basic procedures. These employees will advance through the Incentive plan at the 80, 90, and 100% levels.

**ANNUAL MAXIMUM CARRYOVER**

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to **March 1** of the following year.
3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1,000. This benefit allows you to accumulate up to a $2,000 **annual dental maximum.**

**ELIGIBLE EMPLOYEES**

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

**ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.). A child must be added within thirty-one (31) days of turning age 2 not to be considered a late entrant.

**PASSIVE PPO**

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**AMERITAS MANAGED CARE PRODUCTS**

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

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**Why would I use an Ameritas PPO provider?**
By using a PPO provider:

• A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider

• As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.

• PPO providers are required to file the claim for the patient.

• PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

**What happens if I don't use an Ameritas PPO provider?**
For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

• Your Employer wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C (Usual & Customary) which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

• Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on the Ameritas website (this will be available via our Intranet in the near future), or the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

**LATE ENTRANT PROVISION**

There is a 12 month waiting period on all services except **cleanings, exams, and fluoride applications** for employees who do not enroll when first eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

**LIMITATIONS/EXCLUSIONS *(not a complete list)***

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he /she is eligible for benefits under Worker's Compensation Act or similar laws.
- Services for Major and Orthodontic procedures. Endodontics (root canals) and Periodontics (gum disease) which are normally in the Major category are included in the Basic procedural category for this plan.

**SECTION 125**

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

***A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.***

**PRE-DETERMINATION OF BENEFITS**

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

**COORDINATION OF BENEFITS**

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

**CERTIFICATE OF INSURANCE**

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

**MONTHLY DENTAL RATES**

| | |
|---|---|
| **Employee Only** | **$22.28** |
| **Employee & Spouse** | **$63.98** |
| **Employee & Child(ren)** | **$56.38** |
| **Employee & Family** | **$96.26** |

**For Claims/Customer Service Questions call Ameritas: 1-800-487-5553.**
**Or, visit the Ameritas website at: www.AmeritasGroup.com**

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS
LIFE INSURANCE CORP.

**Effective Date: September 1, 2013**

***To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced.***

**CALENDAR YEAR DEDUCTIBLE**

$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

**TYPE I - PREVENTIVE AND DIAGNOSTIC**

- Type I benefits are payable at 100% MAC*. **No deductible applies.**

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year) (Under age 19)
- Space Maintainers
- Bitewing x-rays (Two per calendar year)

**TYPE II - BASIC PROCEDURES**

Type II benefits are payable at 80-90-100% MAC*. $50.00 deductible applies.

- Fillings
- Simple Extractions
- Sealants
- Oral Surgery
- Denture Repair

**TYPE III - MAJOR PROCEDURES**

Type III benefits are payable at 50% MAC*. $50.00 deductible applies.

- Crown-Precious Metal
- Prosthodontics- (Removable Dentures, Partials)
- Crown Repair
- Periodontics (Gum Disease)
- Complex Extractions
- Endodontics (Root Canal)
- Anesthesia

**ORTHODONTIA**

Paid at 50% MAC* with a $1,000 lifetime maximum per person. No deductible applies. (Includes Children and Adults)

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

*Percentage Paid based on Maximum Allowable Charge

**ANNUAL MAXIMUM BENEFIT**

- Type I, II, and III Procedures - $1,000 per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carryover does not apply)

*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $500.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $500, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,000 in any one year.

**ELIGIBLE EMPLOYEES**

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

**ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.). A child must be added within thirty-one (31) days of turning age 2 not to be considered a late entrant.

**DENTAL EXCLUSIONS (DEFERMENT PERIOD*)***

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, dentures, partial dentures, inlays or crowns is excluded.

Exceptions to this exclusion will be made if the replacement is made necessary by:

a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or

b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

**PRE-DETERMINATION OF BENEFITS**

A treatment plan MAY be filed if a proposed course of treatment will exceed $300.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

**COORDINATION OF BENEFITS**

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

**LATE ENTRANT**

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.** For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

**CERTIFICATE OF INSURANCE**

This is a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

**SECTION 125**

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

**ORTHODONTIA LIMITATIONS (NOT A COMPLETE LIST)**

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

**LIMITATIONS/EXCLUSIONS (NOT A COMPLETE LIST)**

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.

• Services which are not recommended by a dentist or which are not required for necessary care and treatment.

• Expenses incurred to replace lost or stolen appliances.

• Expenses incurred by an insured because of a sickness for which he/she is eligible for benefits under Worker's Compensation Act or similar.

***A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.***

***This information is not a guarantee of eligibility or benefits. The benefits shown are subject to policy provisions and the patient's eligibility at the time services are rendered.***

**AMERITAS MANAGED CARE PRODUCTS**

• Employers achieve a balance between cost efficiency and employee choice.

• Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.

• Over 70,000 PPO provider access points are available nationwide.

• PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

## Commonly Asked PPO Questions

Your employer is proud to provide their employees with a new dental program administered by Ameritas Group. The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

### Do I have to use an Ameritas PPO provider?

Davidson County Schools has provided members an option of choosing between three dental plans. If you elect to enroll in the PPO plan, you and your covered dependents should utilize a participating network provider in order to see the full benefits of the PPO plan option

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

### Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

### What happens if I don't use an Ameritas PPO provider?

A member covered under the PPO option should use a panel provider whenever possible. If a member in the PPO option visits a non-panel provider, covered services will be reimbursed based on MAC (Maximum Allowable Charge) of an Ameritas network provider. Dentists not participating in the Ameritas network can charge any price for services but Ameritas will only reimburse based on the MAC if the member is enrolled in the PPO option. If this occurs, the member is responsible for any charges above our MAC reimbursement

### Filing A Claim

Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com

**MONTHLY DENTAL RATES**

| | |
|---|---|
| **Employee Only** | **$25.61** |
| **Employee & Spouse** | **$74.17** |
| **Employee & Child(ren)** | **$76.36** |
| **Employee & Family** | **$124.92** |

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS
LIFE INSURANCE CORP.

# *Superior Vision Plan 1 - Full Services*

**Effective Date: September 1, 2013**

**Outline of Benefits** Gold Preferred Plan with Materials Discount

**Co-pays**:

| | |
|---|---|
| Comprehensive Eye Exam | $10 |
| Materials | $10 |
| Contact Lens Fitting | $25 |

**How to Use the Plan**

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

**Benefits**

| | FREQUENCY | IN-NETWORK | NON-NETWORK |
|---|---|---|---|
| **Comprehensive Exam** | | | |
| Ophhalmologist | 12 Months | Covered in Full | Up to $44.00 |
| Optometrist | 12 Months | Covered in Full | Up to $39.00 |
| **Standard Lenses (per Pair):** | | | |
| Single Vision | 12 Months | Covered in Full | Up to $34.00 |
| Bifocal | 12 Months | Covered in Full | Up to $48.00 |
| Trifocal | 12 Months | Covered in Full | Up to $64.00 |
| Lenticular | 12 Months | Covered in Full | Up to $88.00 |
| **Contact Lenses (Per Pair)**[2] | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to $210.00 |
| Cosmetic (Elective)[3] | 12 Months | Up to $150.00 | Up to $100.00 |
| **Contact Lens Fitting**[4] | | | |
| Standard | 12 Months | Covered in Full | Not Covered |
| Specialty | 12 Months | Up to $50.00 | Not Covered |
| **Frames -Standard**[3] | 24 Months | Up to $150.00 | Up to $77.00 |

1 All in-network and out-of-network allowances are at the retail value.
2 Contact lenses are in lieu of eyeglass lenses and frames benefits.
3 The insured is responsible for paying any charges in excess of this allowance.
4 Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

**Discount Features**

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

| | |
|---|---|
| Frames: | 20% off amount over allowance |
| Lens options: | 20% off retail |
| Progressives: | 20% off amount over retail lined trifocal lens, including lens options |

The following options have out-of-pocket maximums[5] on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

| | **Maximum Member Out-of-Pocket** | |
|---|---|---|
| | Single Vision | Bifocal & Trifocal |
| Scratch coat | $13 | $13 |
| Ultraviolet coat | $15 | $15 |
| Tints, solid or gradients | $25 | $25 |
| Anti-reflective coat | $50 | $50 |
| Polycarbonate | $40 | 20% off retail |
| High-index 1.6 | $55 | 20% off retail |
| Photochromic | $80 | 20% off retail |

**Discounts on Non-Covered Exam and Materials**

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

| | |
|---|---|
| Exams, frames, and prescription lenses: | 30% off retail |
| Lens options, contacts, other prescription materials: | 20% off retail |
| Disposable contact lenses: | 10% off retail |

**Refractive Surgery**

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

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

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

**Items or Services Not Covered**
While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. Please confirm the details of your employer's plan prior to seeking services.

**MONTHLY RATES**

| | |
|---|---|
| Employee Only | $9.70 |
| Employee + 1 Dependent | $18.80 |
| Employee + Family | $27.60 |

## Superior Vision Contacts

**Customer Service**
**800-507-3800**
**916-852-2277 Fax**

Explanation of benefits
Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
Grievance issues

**Customer Service/Corporate Office**
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

**Claims Administration**
P.O. Box 967
Rancho Cordova, CA 95741

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

The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life

Superior Vision
Our Members. Our Mission.

# Superior Vision - Materials Only Plan

**Effective Date: September 1, 2013**

| | | |
|---|---|---|
| Outline of Benefits | Gold Preferred Materials Only Plan with Materials Discount | |
| Co-pays: | Materials | $15 |
| | Contact Lens Fitting | $25 |

**How to Use the Plan**

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

**BENEFITS**

| | FREQUENCY | IN-NETWORK[1] | NON-NETWORK[1] |
|---|---|---|---|
| **Eye Exam** | No Benefit | No Benefit | No Benefit |
| **Standard Lenses (per Pair):** | | | |
| Single Vision | 12 Months | Covered in Full | Up to $34.00 |
| Bifocal | 12 Months | Covered in Full | Up to $48.00 |
| Trifocal | 12 Months | Covered in Full | Up to $64.00 |
| Lenticular | 12 Months | Covered in Full | Up to $88.00 |
| **Contact Lenses (Per Pair)[2]** | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to $210.00 |
| Cosmetic (Elective)[3] | 12 Months | Up to $120.00 | Up to $100.00 |
| **Contact Lens Fitting Fee[4]** | | | |
| Standard | 12 Months | Covered in Full | Not Covered |
| Specialty | 12 Months | Up to $50.00 | Not Covered |
| **Frames -Standard[3]** | 24 Months | Up to $100.00 | Up to $50.00 |

1 All in-network and out-of-network allowances are at the retail value.
2 Contact lenses are in lieu of eyeglass lenses and frames benefits.
3 The insured is responsible for paying any charges in excess of this allowance.
4 Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

**Discount Features**

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

**Discounts on Covered Materials**

| | |
|---|---|
| Frames: | 20% off amount over allowance |
| Lens options: | 20% off retail |
| Progressives: | 20% off amount over retail lined trifocal lens, including lens options |

The following options have out-of-pocket maximums[5] on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

| | **Maximum Member Out-of-Pocket** | |
|---|---|---|
| | Single Vision | Bifocal & Trifocal |
| Scratch coat | $13 | $13 |
| Ultraviolet coat | $15 | $15 |
| Tints, solid or gradients | $25 | $25 |
| Anti-reflective coat | $50 | $50 |
| Polycarbonate | $40 | 20% off retail |
| High-index 1.6 | $55 | 20% off retail |
| Photochromic | $80 | 20% off retail |

**Discounts on Non-Covered Exam and Materials**

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

| | |
|---|---|
| Exams, frames, and prescription lenses: | 30% off retail |
| Lens options, contacts, other prescription materials: | 20% off retail |
| Disposable contact lenses: | 10% off retail |

**Refractive Surgery**

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

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

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

**Items or Services Not Covered**

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. Please confirm the details of your employer's plan prior to seeking services.

**MONTHLY RATES**

| | |
|---|---|
| Employee Only | $5.12 |
| Employee + 1 Dependent | $9.92 |
| Employee + Family | $14.56 |

## Superior Vision Contacts

**Customer Service**
**800-507-3800**
**916-852-2277 Fax**

Explanation of benefits
Provider locator; provider nomination
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Authorization numbers (out-of-network)
Grievance issues

**Customer Service/Corporate Office**
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

**Claims Administration**
P.O. Box 967
Rancho Cordova, CA 95741

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

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Superior Vision
*Our Members. Our Mission.*

# *Allstate Benefits (AB) Group Cancer Plan*

***In the United States, about 1,596,670 new cancer cases were expected to be diagnosed in 2011.*** [1]

### *Group Voluntary Cancer*

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

### *Meeting Your Needs:*

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

### *Benefit Coverage Highlights*

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It can help protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability for qualified employees

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance can help offset some of the expenses your health insurance may not cover, so you can focus on getting well.

***Primary insured only*

****List of covered diseases on the next page.***

*[1] Cancer Facts & Figures, American Cancer Society, 2011*

**In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[2]**

### *Your Benefit Coverage*

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

### *Specified Diseases*

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

### *Continuous Hospital Confinement*

**A $100 benefit will be paid** for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

### *Government or Charity Hospital*

**A $100 benefit will be paid** for each day a covered person is confined to:

(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);

(2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

### *Surgery*

**Up to a $3,000** benefit will be paid** when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; AB pays the amount for the procedure with the greatest benefit. AB pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

*2 Cancer Facts & Figures, American Cancer Society, 2011.*

### *Second Opinion*

**A $400 benefit will be paid** for a second opinion, if physician recommends surgery or treatment for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

### *Physical or Speech Therapy*

**A $50 benefit will be paid** per day for physical or speech therapy for restoration of normal body function.

### *Anesthesia*

**25% of the surgery benefit will be paid** for anesthesia.

### *Ambulatory Surgical Center*

**A $500 benefit will be paid** for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.

### *Radiation/Chemotherapy for Cancer*

**Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid** per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

### *Anti-Nausea Benefit*

**Up to a $200 benefit will be paid** per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

### *Inpatient Drugs and Medicine*

**A $25 benefit will be paid** per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

### *Hematological Drugs*

**Up to a $200 (Low and Mid) or $400 (High) benefit will be paid** per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

### *Medical Imaging*

**Actual cost up to a $500 (Low and Mid) or $1,000 (High) benefit will be paid** per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

### *Private Duty Nursing Services*

**A $100 benefit will be paid** per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

### *New or Experimental Treatment*

**Actual charges up to a $5,000 benefit will be paid** per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

### *Blood, Plasma, and Platelets*

**Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid** per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

### *Physician's Attendance*

**A $50 benefit will be paid** for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

### *At Home Nursing*

**A $100 benefit will be paid** per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

### *Prosthesis*

**Up to a $2,000 benefit will be paid** per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

### *Hair Prosthesis*

**A $25 benefit will be paid** every 2 years for a wig or hairpiece if the covered person experiences hair loss.

### *Nonsurgical External Breast Prosthesis*

**Up to a $50 benefit will be paid** for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

### *Ambulance*

**A $100 benefit will be paid** per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

### *Hospice Care*

**A $100 benefit will be paid** for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

### *Extended Care Facility*

**A $100 benefit will be paid** for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

### *Outpatient Lodging*

**A $50 benefit will be paid** for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to AB during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

### *Non-Local Transportation*

**$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid** for treatment at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

### *Family Member Lodging and Transportation*

**Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid** for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement.

(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

### *Waiver of Premium (primary insured only)*

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, AB pays premiums due after such 90 days for as long as the insured employee remains disabled.

### *Bone Marrow or Stem Cell Transplant**

**A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid** for the following types of bone marrow or stem cell transplants performed on a covered person.

(1) A transplant which is other than non-autologous.

(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.

(3) A transplant which is non-autologous for the treatment of Leukemia.

***This benefit is payable only once per covered person per calendar year.**

## *ADDITIONAL BENEFITS*

### *Wellness*

**A $100 benefit will be paid** per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

## *OPTIONAL BENEFITS*

### *Cancer Initial Diagnosis (First Occurrence)*

**A one time benefit of $3,000 (Low and High) or $10,000 (Mid) benefit will be paid** when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

### *Intensive Care (Low and High Plans Only)**

**A benefit will be paid** for each day for the following types of intensive care confinement:

(1) **Hospital Intensive Care Unit Confinement $600*** - This benefit is for hospital intensive care unit confinement for any illness or accident.

(2) **Step-Down Hospital Intensive Care Unit Confinement $300*** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.

(3) **Ambulance - AB pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

*****This benefit is not disease specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage***

**Issue Ages: 18 and older while actively at work.**

**Certificates** - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

**Eligibility** - Family members eligible for coverage include: you, your legal spouse or domestic partner; and your children.

**Portability Privilege** -AB will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage," we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

**Termination of Coverage** - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision, the date you are no longer in an eligible class, or the date your class is no longer eligible.

AB will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. • Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If AB accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

| Low Option without Optional Benefits | |
|---|---|
| **Insureds** | **Monthly Rates** |
| ***Employee*** | ***$20.07*** |
| ***Employee + Child(ren)*** | ***$27.71*** |
| ***Employee + Spouse*** | ***$30.96*** |
| ***Family*** | ***$38.57*** |

| Low Option with Optional Benefits | |
|---|---|
| **Insureds** | **Monthly Rates** |
| ***Employee*** | ***$26.06*** |
| ***Employee + Child(ren)*** | ***$36.81*** |
| ***Employee + Spouse*** | ***$41.50*** |
| ***Family*** | ***$52.23*** |

| Mid Option with $10,000 Initial Diagnosis Benefit | |
|---|---|
| **Insureds** | **Monthly Rates** |
| ***Employee*** | ***$29.75*** |
| ***Employee + Child(ren)*** | ***$42.16*** |
| ***Employee + Spouse*** | ***$47.02*** |
| ***Family*** | ***$59.39*** |

| High Option without Optional Benefits | |
|---|---|
| **Insureds** | **Monthly Rates** |
| ***Employee*** | ***$31.09*** |
| ***Employee + Child(ren)*** | ***$43.65*** |
| ***Employee + Spouse*** | ***$47.51*** |
| ***Family*** | ***$60.04*** |

| High Option with Optional Benefits | |
|---|---|
| **Insureds** | **Monthly Rates** |
| ***Employee*** | ***$37.08*** |
| ***Employee + Child(ren)*** | ***$52.75*** |
| ***Employee + Spouse*** | ***$58.05*** |
| ***Family*** | ***$73.70*** |

**Pre-Existing Condition, Exclusions and Limitations** - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if AB is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. AB does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, AB will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

**Intensive Care Exclusions and Limitations** - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. AB does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

**Coverage Subject to the Policy** - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between AB and the policyholder. Your consent is not required for this. AB is not required to give you prior notice.

**The policy is Limited Benefit Cancer and Specified Disease Insurance.** This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

**The coverage is provided by a limited benefit supplemental insurance policy.**

This material is valid as long as information remains current, but in no event later than August 1, 2015. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, call 1-800-521-3535. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

***Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.***

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***1776 American Heritage Life Drive, Jacksonville, Florida 32224***

**Customer Care Center: 1.800.521.3535**
**www.allstate.com or AllstateBenefits.com**

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# *Aflac Accident (High Plan)*

***Effective Date: September 1, 2013***

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series 7700.

**What is Aflac accident insurance? Why should I consider it?**

Aflac accident insurance provides benefits for the treatment of injuries suffered as the result of a covered accident. These benefits are payable regardless of any other insurance you may have.

Many families don't budget for the out-of-pocket costs associated with accidents. While we all hope to steer clear of accidents, at some point most of us will probably take a trip to the local emergency room. When you (or a covered family member) are injured in an accident, the last things on your mind are the charges that may be accumulating for services like the following:

- ***Ambulance ride***
- ***Emergency room use***
- ***Surgery and anesthesia***
- ***Casts***
- ***Crutches***
- ***Wheelchairs***
- ***Stitches***

These costs add up—fast. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered accident? Aflac accident insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

What are some of the highlights of the Aflac accident plan?

- There's no limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Spouse and dependent child coverage is available.

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• The plan provides 24-hour protection.

• There are benefits for inpatient and outpatient treatment of covered accidents.

• Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).

• Your premiums are paid through the convenience of payroll deduction.

• Coverage will be effective the date you sign the enrollment form.

• Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

**What is guaranteed-issue coverage? Am I eligible?**

Guaranteed-issue refers to certain types of coverage that may be issued without your having to answer health questions. Guaranteed-issue coverage is offered during your employer's initial enrollment period (and for new hires after the enrollment period).

**Am I eligible for Aflac accident coverage? What about my family?**

You are eligible to apply for Aflac accident coverage if you:

• Are between the ages of 18 and 69;

• Are a full-time, benefit-eligible employee;

• Are working at least 30 hours per week;

• Have been employed for at least 90 continuous days by the enrollment date; and

• Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

**What core benefits does the Aflac accident plan feature?**

• Accident Benefits
You may receive benefits if you incur one of the following covered events:

o Fractures
o Dislocations
o Paralysis
o Lacerations
o Burns (second- and third-degree)
o Concussion
o Coma
o Emergency dental work
o Injuries requiring surgery
˜ Eye injuries
˜ Removal of foreign body
˜ Ruptured disc
˜ Torn knee cartilage
o Internal injuries
o Exploratory surgery

- **Medical Fees Benefit**
You may receive this benefit for up to six treatments per covered accident for physician charges, emergency room services and supplies, and X-rays.

- **Accident Follow-Up Treatment Benefit**
You may receive this benefit for up to six treatments per covered accident for follow-up treatment.

- **Physical Therapy Benefit**
You may receive this benefit for up to six treatments per covered accident for physical therapy.

- **Ambulance Benefit**
You may receive this benefit if you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident.

- **Transportation Benefit**
You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn't available in your hometown).

- **Blood/Plasma Benefit**
You may receive this benefit if you receive blood and plasma within 90 days after a covered accident.

- **Prosthesis Benefit**
You may receive this benefit if a covered accident requires the use of a prosthetic device (hearing aids, wigs, or dental aids—including (but not limited to) false teeth—are not covered).

- **Appliance Benefit**
You may receive this benefit for use of a medical appliance due to injuries received in a covered accident (payable for crutches, wheelchairs, leg braces, back braces, and walkers).

- **Family Lodging Benefit**
If you are required to travel more than 100 miles for inpatient treatment of injuries suffered in a covered accident, you may receive this benefit for an immediate family member's lodging (payable up to 30 days per accident while the insured is confined to the hospital).

- **Wellness Benefit - $60.00**
You may receive this benefit for one routine examination or other preventive testing once each 12-month period (payable for one covered person annually). Benefits are payable for the following:

o Annual physical exams
o Mammograms
o Pap smears
o Eye examinations
o Immunizations
o Flexible sigmoidoscopies
o PSAs
o Ultrasounds
o Blood screenings

- **Hospital Admission Benefit**

You may receive this benefit if you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the accident.

- **Hospital Confinement Benefit (per day)**

You may receive this benefit on the first day of hospital confinement for up to 365 days. The confinement must begin within 90 days after the date of the accident (payable once per confinement).

- **Hospital Intensive Care (per day)**

You may receive this benefit up to 30 days per covered accident (payable in addition to the Hospital Confinement Benefit).

- **Accidental-Death and-Dismemberment Benefit**

  o Accidental Death

  o Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)

  o Dismemberment

  o Loss of One or More Fingers and Toes

  o Partial Amputation of Fingers or Toes

**What else do I need to know about the Aflac accident plan?**

You should know that the plan includes:

- **A pre-existing condition limitation.** A pre-existing condition is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.

- **Certain exclusions.** No benefits are payable for loss resulting from:

  o Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. Aflac will return the prorated premium for any period not covered when you are in such service.

  o Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

  o Participating or attempting to participate in an illegal activity or working at an illegal job.

  o Committing or attempting to commit suicide, while sane or insane.

  o Injuring or attempting to injure yourself intentionally.

  o Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica (except under the Accidental Common Carrier Death Benefit).

o Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

o Participating in any organized sport, professional or semi-professional.

o Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.

o Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

o Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.

o Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.

o Having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

***What would my monthly payroll deduction cost be for the Aflac accident plan?***

| 24 Hour Coverage | Monthly Premium |
|---|---|
| Employee | $16.21 |
| Employee and Spouse | $23.18 |
| Employee and Dependent Child(ren) | $30.90 |
| Employee & Family | $37.89 |

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Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

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Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan. As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

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# *Aflac Critical Illness Insurance (with cancer)*

*The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a **general summary** of the coverage. This overview is subject to the terms, conditions, and limitations of policy series 2800.*

**What is Aflac critical illness insurance? Why should I consider it?**

Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Cancer (internal or invasive)
  (Carcinoma in Situ)
- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack
  (Coronary Artery Bypass Surgery)
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, **what about the out-of-pocket expenses that pile up** while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance **benefits are paid directly to you (unless otherwise assigned) to use as you see fit.** You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

**What are some of the highlights of the Aflac critical illness plan?**

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
- Each dependent child is covered at 25% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

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**Am I eligible for Aflac critical illness coverage? What about my family?**

You are eligible to apply for Aflac critical illness coverage if you:

- o Are between the ages of 18 and 69;
- o Are a full-time, benefit-eligible employee;
- o Are working at least 30 hours per week;
- o Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

**What core benefits does the Aflac critical illness plan feature?**

- **First Occurrence Benefit**

After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

- **Additional Occurrence Benefit**

After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

- **Reoccurrence Benefit**

You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months. Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid.

- **Heart Benefit**

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

- o Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- o Mitral valve replacement or repair
- o Aortic valve replacement or repair
- o Surgical treatment of abdominal aortic aneurysm
- o AnjioJet clot busting*
- o Balloon angioplasty (or balloon valvuloplasty)*
- o Laser angioplasty*
- o Atherectomy*
- o Stent implantation*
- o Cardiac catherization*
- o Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- o Pacemaker insertion*

**Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.*

• **Health Screening Benefit**

After the waiting period, you may receive a maximum of $100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

**What else do I need to know about the Aflac critical illness plan?**

You should know that the plan includes:

• **A 30-day waiting period**. This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.

• **A pre-existing condition limitation**. A pre-existing condition is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.

• **Certain exclusions**. No benefits are payable for loss resulting from:

o Intentionally self-inflicted injury or action;

o Suicide or attempted suicide while sane or insane;

o Illegal activities or participation in an illegal occupation;

o War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;

o Substance abuse; or

o Diagnosis and/or treatment received outside the United States.

## Aflac Critical Illness Plan (with cancer)
## Employee and Spouse Monthly Rates

| NONTOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $ 5,000 | $ 10,000 | $ 15,000 | $20,000 | $25,000 | $ 30,000 | $ 35,000 | $ 40,000 | $ 45,000 | $ 50,000 |
| 18-29 | $ 6.52 | $ 9.54 | $ 12.56 | $ 15.57 | $ 18.59 | $ 21.61 | $ 24.63 | $ 27.65 | $ 30.67 | $ 33.69 |
| 30-39 | $ 8.44 | $ 13.37 | $ 18.31 | $ 23.24 | $ 28.18 | $ 33.12 | $ 38.05 | $ 42.99 | $ 47.92 | $ 52.86 |
| 40-49 | $ 13.94 | $ 24.38 | $ 34.82 | $ 45.26 | $ 55.70 | $ 66.14 | $ 76.58 | $ 87.02 | $ 97.46 | $ 107.90 |
| 50-59 | $ 21.95 | $ 40.39 | $ 58.84 | $ 77.28 | $ 95.73 | $ 114.17 | $ 132.62 | $ 151.06 | $ 169.51 | $ 187.95 |
| 60-69 | $ 37.64 | $ 71.78 | $ 105.92 | $ 140.06 | $ 174.21 | $ 208.35 | $ 242.49 | $ 276.63 | $ 310.77 | $ 344.91 |

| NONTOBACCO - Spouse | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $ 5,000 | $ 7,500 | $ 10,000 | $ 12,500 | $ 15,000 | $17,500 | $20,000 | $22,500 | $25,000 | $30,000 |
| 18-29 | $ 6.52 | $ 8.03 | $ 9.54 | $ 11.05 | $ 12.56 | $ 14.07 | $ 15.57 | $ 17.08 | $ 18.59 | $ 21.61 |
| 30-39 | $ 8.44 | $ 10.90 | $ 13.37 | $ 15.84 | $ 18.31 | $ 20.78 | $ 23.24 | $ 25.71 | $ 28.18 | $ 33.12 |
| 40-49 | $ 13.94 | $ 19.16 | $ 24.38 | $ 29.60 | $ 34.82 | $ 40.04 | $ 45.26 | $ 50.48 | $ 55.70 | $ 66.14 |
| 50-59 | $ 21.95 | $ 31.17 | $ 40.39 | $ 49.61 | $ 58.84 | $ 68.06 | $ 77.28 | $ 86.50 | $ 95.73 | $ 114.17 |
| 60-69 | $ 37.64 | $ 54.71 | $ 71.78 | $ 88.85 | $ 105.92 | $ 122.99 | $ 140.06 | $ 157.14 | $ 174.21 | $ 208.35 |

| TOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 8.31 | $ 13.12 | $ 17.93 | $ 22.74 | $ 27.54 | $ 32.35 | $ 37.16 | $ 41.97 | $ 46.78 | $ 51.59 |
| 30-39 | $ 11.75 | $ 20.00 | $ 28.25 | $ 36.50 | $ 44.74 | $ 52.99 | $ 61.24 | $ 69.49 | $ 77.74 | $ 85.99 |
| 40-49 | $ 25.01 | $ 46.52 | $ 68.03 | $ 89.54 | $ 111.05 | $ 132.56 | $ 154.07 | $ 175.58 | $ 197.08 | $ 218.59 |
| 50-59 | $ 39.93 | $ 76.36 | $ 112.79 | $ 149.22 | $ 185.66 | $ 222.09 | $ 258.52 | $ 294.95 | $ 331.38 | $ 367.81 |
| 60-69 | $ 70.93 | $ 138.36 | $ 205.80 | $ 273.23 | $ 340.66 | $ 408.09 | $ 475.53 | $ 542.96 | $ 610.39 | $ 677.82 |

| TOBACCO - Spouse | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $5,000 | $7,500 | $10,000 | $12,500 | $15,000 | $17,500 | $20,000 | $22,500 | $25,000 | $30,000 |
| 18-29 | $ 8.31 | $ 10.71 | $ 13.12 | $ 15.52 | $ 17.93 | $ 20.33 | $ 22.74 | $ 25.14 | $ 27.54 | $ 32.35 |
| 30-39 | $ 11.75 | $ 15.87 | $ 20.00 | $ 24.12 | $ 28.25 | $ 32.37 | $ 36.50 | $ 40.62 | $ 44.74 | $ 52.99 |
| 40-49 | $ 25.01 | $ 35.76 | $ 46.52 | $ 57.27 | $ 68.03 | $ 78.78 | $ 89.54 | $ 100.29 | $ 111.05 | $ 132.56 |
| 50-59 | $ 39.93 | $ 58.15 | $ 76.36 | $ 94.58 | $ 112.79 | $ 131.01 | $ 149.22 | $ 167.44 | $ 185.66 | $ 222.09 |
| 60-69 | $ 70.93 | $ 104.65 | $ 138.36 | $ 172.08 | $ 205.80 | $ 239.51 | $ 273.23 | $ 306.95 | $ 340.66 | $ 408.09 |

*Rates include cancer benefit.*

*Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.*

*No benefit reduction at age 70.*

We've got you under our wing.®

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

**800.433.3036 | aflacgroupinsurance.com**

# Aflac Critical Illness Insurance (without cancer)

*The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series 2800.*

**What is Aflac critical illness insurance? Why should I consider it?**
Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack
  (Coronary Artery Bypass Surgery)
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like..

**What are some of the highlights of the Aflac critical illness plan?**

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
- Each dependent child is covered at 25% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

**Underwritten by Continental American Insurance Company**

*A proud member of the Aflac family of insurers*

**Am I eligible for Aflac critical illness coverage? What about my family?**

You are eligible to apply for Aflac critical illness coverage if you:

- o Are between the ages of 18 and 69;
- o Are a full-time, benefit-eligible employee;
- o Are working at least 30 hours per week;
- o Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

**What core benefits does the Aflac critical illness plan feature?**

- **First Occurrence Benefit**

After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

- **Additional Occurrence Benefit**

After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

- **Reoccurrence Benefit**

You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months.

- **Heart Benefit**

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

- o Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- o Mitral valve replacement or repair
- o Aortic valve replacement or repair
- o Surgical treatment of abdominal aortic aneurysm
- o AnjioJet clot busting*
- o Balloon angioplasty (or balloon valvuloplasty)*
- o Laser angioplasty*
- o Atherectomy*
- o Stent implantation*
- o Cardiac catherization*
- o Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- o Pacemaker insertion*

**Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.*

- **Health Screening Benefit**

After the waiting period, you may receive a maximum of $100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

**What else do I need to know about the Aflac critical illness plan?**

You should know that the plan includes:

- **A 30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.

- **A pre-existing condition limitation.** A pre-existing condition is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.

- **Certain exclusions.** No benefits are payable for loss resulting from:
    - o Intentionally self-inflicted injury or action;
    - o Suicide or attempted suicide while sane or insane;
    - o Illegal activities or participation in an illegal occupation;
    - o War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
    - o Substance abuse; or
    - o Diagnosis and/or treatment received outside the United States.

## Aflac Critical Illness Plan (without cancer)
## Employee and Spouse Monthly Rates

| NONTOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $ 5,000 | $ 10,000 | $ 15,000 | $20,000 | $25,000 | $ 30,000 | $ 35,000 | $ 40,000 | $ 45,000 | $ 50,000 |
| 18-29 | $ 5.52 | $ 7.54 | $ 9.56 | $ 11.57 | $ 13.59 | $ 15.61 | $ 17.63 | $ 19.65 | $ 21.67 | $ 23.69 |
| 30-39 | $ 6.89 | $ 10.27 | $ 13.66 | $ 17.04 | $ 20.43 | $ 23.82 | $ 27.20 | $ 30.59 | $ 33.97 | $ 37.36 |
| 40-49 | $ 10.44 | $ 17.38 | $ 24.32 | $ 31.26 | $ 38.20 | $ 45.14 | $ 52.08 | $ 59.02 | $ 65.96 | $ 72.90 |
| 50-59 | $ 15.20 | $ 26.89 | $ 38.59 | $ 50.28 | $ 61.98 | $ 73.67 | $ 85.37 | $ 97.06 | $ 108.76 | $ 120.45 |
| 60-69 | $ 25.34 | $ 47.18 | $ 69.02 | $ 90.86 | $ 112.71 | $ 134.55 | $ 156.39 | $ 178.23 | $ 200.07 | $ 221.91 |

| NONTOBACCO - Spouse | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $ 5,000 | $ 7,500 | $ 10,000 | $ 12,500 | $ 15,000 | $17,500 | $20,000 | $22,500 | $25,000 | $30,000 |
| 18-29 | $ 5.52 | $ 6.53 | $ 7.54 | $ 8.55 | $ 9.56 | $ 10.57 | $ 11.57 | $ 12.58 | $ 13.59 | $ 15.61 |
| 30-39 | $ 6.89 | $ 8.58 | $ 10.27 | $ 11.96 | $ 13.66 | $ 15.35 | $ 17.04 | $ 18.74 | $ 20.43 | $ 23.82 |
| 40-49 | $ 10.44 | $ 13.91 | $ 17.38 | $ 20.85 | $ 24.32 | $ 27.79 | $ 31.26 | $ 34.73 | $ 38.20 | $ 45.14 |
| 50-59 | $ 15.20 | $ 21.04 | $ 26.89 | $ 32.74 | $ 38.59 | $ 44.43 | $ 50.28 | $ 56.13 | $ 61.98 | $ 73.67 |
| 60-69 | $ 25.34 | $ 36.26 | $ 47.18 | $ 58.10 | $ 69.02 | $ 79.94 | $ 90.86 | $ 101.79 | $ 112.71 | $ 134.55 |

| TOBACCO - Employee | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 18-29 | $ 6.61 | $ 9.72 | $ 12.83 | $ 15.94 | $ 19.04 | $ 22.15 | $ 25.26 | $ 28.37 | $ 31.48 | $ 34.59 |
| 30-39 | $ 8.85 | $ 14.20 | $ 19.55 | $ 24.90 | $ 30.24 | $ 35.59 | $ 40.94 | $ 46.29 | $ 51.64 | $ 56.99 |
| 40-49 | $ 17.21 | $ 30.92 | $ 44.63 | $ 58.34 | $ 72.05 | $ 85.76 | $ 99.47 | $ 113.18 | $ 126.88 | $ 140.59 |
| 50-59 | $ 26.68 | $ 49.86 | $ 73.04 | $ 96.22 | $ 119.41 | $ 142.59 | $ 165.77 | $ 188.95 | $ 212.13 | $ 235.31 |
| 60-69 | $ 45.28 | $ 87.06 | $ 128.85 | $ 170.63 | $ 212.41 | $ 254.19 | $ 295.98 | $ 337.76 | $ 379.54 | $ 421.32 |

| TOBACCO - Spouse | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGES | $5,000 | $7,500 | $10,000 | $12,500 | $15,000 | $17,500 | $20,000 | $22,500 | $25,000 | $30,000 |
| 18-29 | $ 6.61 | $ 8.16 | $ 9.72 | $ 11.27 | $ 12.83 | $ 14.38 | $ 15.94 | $ 17.49 | $ 19.04 | $ 22.15 |
| 30-39 | $ 8.85 | $ 11.52 | $ 14.20 | $ 16.87 | $ 19.55 | $ 22.22 | $ 24.90 | $ 27.57 | $ 30.24 | $ 35.59 |
| 40-49 | $ 17.21 | $ 24.06 | $ 30.92 | $ 37.77 | $ 44.63 | $ 51.48 | $ 58.34 | $ 65.19 | $ 72.05 | $ 85.76 |
| 50-59 | $ 26.68 | $ 38.27 | $ 49.86 | $ 61.45 | $ 73.04 | $ 84.63 | $ 96.22 | $ 107.82 | $ 119.41 | $ 142.59 |
| 60-69 | $ 45.28 | $ 66.17 | $ 87.06 | $ 107.96 | $ 128.85 | $ 149.74 | $ 170.63 | $ 191.52 | $ 212.41 | $ 254.19 |

*Rates do not include cancer benefit.*

*Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.*

*No benefit reduction at age 70.*

Aflac.
We've got you under our wing.

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

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Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

**800.433.3036 | aflacgroupinsurance.com**

# AUL Short Term Disability

***Effective September 1, 2013***

***Why do you need Disability Insurance?  Consider this . . .***

**Statistics show you are much more likely to be injured in an accident than to die from one.**

• A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.[1]

• There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.[1]

• In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.[1]

**While many people survive accidental injuries, many others live with serious illnesses.**

• In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.[2]

• One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]

• More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

**Advances in medicine are allowing us to live longer.  However, recovery from a serious illness or injury often requires time away from work.**

• In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three are up dramatically!  Things that use to kill now disable.[5]

***You have life insurance, home insurance, and automobile insurance. But is your income insured?***

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

### *Class Description*

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

### *Disability*

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness

### *Monthly Benefit*

You can choose to ***insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,500.***

### *Elimination Period*

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury

### *Benefit Duration*

This is the period of time that benefits will be payable for disability. The benefit duration is thirteen (13) weeks.

### *Basis of Coverage*

24 hour coverage, on or off the job.

### *Maternity Coverage*

Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

### *STD Pre-Existing Condition Exclusion*

3/12, A limited benefit will be paid if the Person's disability begins in the first 12 months following the effective date of the Person's coverage; and the Person disability is caused by, contributed to by, or the result of a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 3 months just prior to the Person's Individual Effective Date of Insurance.

### *Recurrent Disability*

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

### *Annual Enrollment*

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions. Current participants may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

### *Portability*

Once an employee is on the AUL disability plan for 3 months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to contact AUL and make application to port your coverage by calling 1.800.553.3522.

### *Exclusions and Limitations*

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

**This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.**

**Customer Service**
1.800-553-5318

**Disability Claims**
1.866-258-8744
Fax: 207-591-3048

**Disability Claims Email**: claims@disabilityrms.com

**Website:** www.employeebenefits.aul.com

ONEAMERICA® | AMERICAN UNITED LIFE INSURANCE COMPANY® *a* ONEAMERICA® *company*

# AUL Life Short-Term Disability

**13-Week Benefit Duration**

| Monthly Benefit | Monthly Premium |
|---|---|
| $500 | $10.36 |
| $600 | $12.43 |
| $700 | $14.50 |
| $800 | $16.57 |
| $900 | $18.64 |
| $1,000 | $20.71 |
| $1,100 | $22.78 |
| $1,200 | $24.85 |
| $1,300 | $26.92 |
| $1,400 | $28.99 |
| $1,500 | $31.07 |
| $1,600 | $33.14 |
| $1,700 | $35.21 |
| $1,800 | $37.28 |
| $1,900 | $39.35 |
| $2,000 | $41.42 |
| $2,100 | $43.49 |
| $2,200 | $45.56 |
| $2,300 | $47.63 |
| $2,400 | $49.70 |
| $2,500 | $51.78 |

# AUL Long Term Disability with Lump Sum

**Effective Date: September 1, 2013**

**LTD and Lump Sum Class Description**

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Long Term Disability Lump Sum Insurance LTD Monthly Benefit

You can choose to insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000 in $500 increments. The minimum benefit is $500.

**LTD Elimination Period**

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

**LTD Benefit Duration**

This is the period of time that benefits will be payable for long term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

| *Age When Total Disability Begins* | *Maximum Period Benefits are Payable* |
|---|---|
| *Prior to Age 61* | *5 Years* |
| *61* | *Lesser of SSFRA or 5 Years* |
| *62* | *3.5 Years* |
| *63* | *3 Years* |
| *64* | *2.5 Years* |
| *65* | *2 Years* |
| *66* | *21 Months* |
| *67* | *18 Months* |
| *68* | *15 Months* |
| *Age 69 and over* | *12 Months* |

**LTD Total Disability Definition**

An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefit have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

**LTD Mental & Nervous / Drug & Alcohol**

Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

### Special Conditions

Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

### Lump Sum Benefit Amount Single payment of $10,000

### Lump Sum Elimination Period 90 days

This is the period of consecutive days the employee is disabled from their regular occupation beginning on the date of the disability. Because of an injury of sickness, you are unable to work at all or you are performing some of the substantial duties of your regular occupation for less than 80% of your regular hours.

### Lump Sum Benefit Eligibility Period

The period of consecutive days the employee is disabled beginning on the first day following the elimination period and continuing for 24 months. After satisfying the Elimination Period, the employee must be permanently and totally disabled during this time period in order to be entitled to the benefit.

### Lump Sum Permanent and Totally Disabled

Because of injury or sickness, you are expected to be unable: to work, engage in any activity for profit, receive income from a hobby or perform the substantial duties of any occupation for which you are reasonably fitted by training, education or experience on a full-time basis for a continuous period of not less than 24 months. You must also be under the regular attendance of a physician.

### Other income Offsets

AUL will not reduce your LTD or Lump Sum disability benefit with other disability income benefits that you might be receiving from AUL or external sources such as Social Security or other disability or income benefits you may receive, or be eligible to receive.

### Waiver of Premium

AUL will waive the premium payments for your coverage while you are disabled and will continue to be waived during the elimination period and the benefit eligibility period.

### Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date

Or

Continuity of Coverage will apply if the employee was insured under the employers prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

**Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period**

This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit IF:

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and

2. The Person changes from one AUL short term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period. The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short term disability plan's Pre-Existing Condition Limitation.

**Portability**

Once an employee is on the AUL disability plan for 3 months, you may be Eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to contact AUL and make application to port your coverage by calling 1.800.553.3522.

**Annual Enrollment**

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly LTD benefit with Lump Sum without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

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**Exclusions and Limitations**

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

***<u>Customer Service</u>***

*800-553-5318*

***<u>Disability Claims</u>***

*866-258-8744*

*Fax: 207-591-3048*

*Disability Claims Email: claims@disabilityrms.com*

***www.employeebenefits.aul.com***

This information is provided as a Benefit Outline. It is not a part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

# Monthly Rates

| Voluntary Long-Term Disability | |
|---|---|
| **Monthly Benefit Amount** | **Monthly Deduction** |
| $500 | $6.40 |
| $1,000 | $12.80 |
| $1,500 | $19.20 |
| $2,000 | $25.60 |

| Lump Disability | | |
|---|---|---|
| **Employees** | **Benefit Amount** | **Monthly Deduction** |
| Under 65 | $10,000 | $9.00 |
| Age 65 - 69 | $7,000 | $6.30 |
| Age 70 - 74 | $4,500 | $4.05 |
| Age 75 - 79 | $3,000 | $2.70 |
| Age 80 - 84 | $2,500 | $2.25 |
| Age 85 - 89 | $2,000 | $1.80 |
| Age 90 and Over | $1,500 | $1.35 |

ONEAMERICA®

American United Life Insurance Company®
a OneAmerica® company
One American Square
P.O. Box 6123Indianapolis, IN 46206-6123
(800) 553-5318

# MetLife Term Life Plan

**Effective Date: When approved by carrier**

**Existing Employees** - Electing coverage for the first time or any increases to existing coverage is not effective until approved by Metropolitan Life.

**Newly Hired Employees** - Coverage is effective the first day of either the first or the second month following employment, provided eligibility requirements are met in "When Your Insurance Starts".

**BASIC EMPLOYEE LIFE INSURANCE**
This insurance is payable for death from any cause to any person you name as beneficiary.

**OPTIONAL EMPLOYEE LIFE INSURANCE**
Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can... at low group rates and through payroll deductions.

To help meet this need, you now have the opportunity to elect additional group life insurance under the optional portion of your program to go along with any personal insurance coverage you may have.

**OPTIONAL DEPENDENT LIFE INSURANCE**
Provides coverage on:

- Your Spouse
- Child(ren) from 15 days of age up to 19 (to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college.

**FEATURES**
The plan features easy eligibility and simple enrollment procedures.
Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

**LOW COST**
Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the system absorbs the cost of administering the program which is underwritten by MetLife - a leader in the field of group coverage.

**ELIGIBILITY**
You will be eligible for this program if you are a full-time active employee.

**ENROLLMENT**
Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

**BENEFICIARY**
You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

**WHEN YOUR INSURANCE STARTS**
Your Basic Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work. In order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have not been "hospitalized "in the last three months prior to your enrollment date. The term "hospitalized" includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term "hospitalized".

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

**If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to MetLife**.

**REDUCTIONS AT AGE 70 AND OVER**
If you remain in active service beyond age 70 your combined amount of Basic and Optional Employee Life Insurance will be as follows:

| Attained Age | Percent of Original Amount |
|---|---|
| 70 | 65% |
| 75 | 45% |
| 80 | 30% |

**TERMINATION OF COVERAGE**

All insurance under this plan will terminate with the earliest of the following events. The events include: termination upon retirement, termination of employment, plan cessation or withdrawal from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

**DISABILITY**

Your insurance may be continued during your disability provided the Board of Education continues premium payments on your behalf. However, your insurance will be subject to reduction as shown under " Reductions at ages 70 & Over."

**CONVERSION**

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Metropolitan Life in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Dependent Life Insurance as well as the Basic Employee Life Insurance.

**PORTABILITY**

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance not dependent(s).

**Qualifying Events Include:**

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is $20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

**THE ACCELERATED BENEFIT OPTION (ABO)**

Metropolitan Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you, or your spouse, are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

**SUICIDE EXCLUSION**

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage.

## CLAIMS PROCEDURE

**Procedures for Presenting Claims for Benefits**

Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

**Routine Questions**

If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

# SCHEDULE OF BENEFITS

## BASIC EMPLOYEE LIFE INSURANCE

All eligible employees . . . . . . . . . . . . . . .$5,000*
(No cost to you)

**See "Reductions at age 70 & Over."*

## OPTIONAL EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:
$350,000, $300,000, $250,000, $200,000, $150,000, $100,000, $50,000, $40,000, $30,000, $20,000 or $10,000

*To be eligible for amounts above $50,000, you must furnish medical evidence of insurability satisfactory to MetLife. (If you elect amounts of $300,000 or $350,000 they may not exceed 5 times your base annual salary).*

## OPTIONAL DEPENDENT LIFE INSURANCE

Spouse - $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000

*To be eligible for amounts above $10,000, you must furnish medical evidence of insurability satisfactory to MetLife.*

Child(ren) - $5,000, $15,000, $25,000

*To be eligible for amounts above $5,000, you must furnish medical evidence of insurability satisfactory to MetLife.*

You choose either:
Family coverage (Spouse and Child), Spouse only coverage or Child(ren) only coverage.

*Optional Dependent Life Insurance is available only to those eligible employees who are insured for Employee Optional Life Insurance. Spouse or Child coverage cannot exceed the amount of employee's optional life coverage. If both husband and wife are employees of Davidson County Schools, only one can cover the dependent children.*

***Will Preparation Service*[2]**

To help ensure your decisions are carried out

Like life insurance, a carefully prepared Will (Simple, Complex or Living) along with a Power of Attorney are important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property.

**Living Will:**

- Ensures your wishes are carried out, and protects your loved ones from making these very difficult and personal medical decisions by themselves.

- Also called an “advanced directive,” it is a document authorized by statutes in all states. A person appoints someone as his/her proxy or representative to make decisions on maintaining extraordinary life-support if the person should become incapacitated so that he or she is unable to communicate his or her wishes

**Power of Attorney:**

- Allows you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated. It is a written document that grants an individual the power to act on the grantor’s behalf.

By enrolling for Supplemental Term Life coverage, you will have access to Hyatt Legal Plans’ network of 12,000 participating attorneys. When you enroll in this plan, you may take advantage of face-to-face access to a participating plan attorney to prepare or update a will, living will or powers of attorney * When you use a participating plan attorney there will be no charge for the services. To obtain the legal plan’s toll-free number and your company’s group access number, please contact your employer or your plan administrator for this information.

* You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans’ network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney’s fees that exceed the reimbursed amount.

**MetLife Estate Resolution Services—ERS3**

Personal service and compassion to help your beneficiaries and others manage your estate during their time of need

MetLife Estate Resolution Services—is a valuable service offered under the plan. When your estate representative uses a participating Hyatt Legal plan attorney there will be no charge for the services. A Hyatt Legal Plan attorney will consult face-to-face with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

For more information on the Will Preparation or
Estate Resolutions Services, please call Hyatt Legal Plans:
Toll-Free Number 1-800-821-6400
Monday – Friday, 8:00 a.m. – 7:00 p.m. Eastern Time
Please reference Group #27827 when you call

## YOUR MONTHLY COST

| Optional Employee Life Insurance | Monthly Payroll Deduction |
|---|---|
| $350,000 | $38.50 |
| 300,000 | 33.00 |
| 250,000 | 27.50 |
| 200,000 | 22.00 |
| 150,000 | 16.50 |
| 100,000 | 11.00 |
| *50,000 | 5.50 |
| 40,000 | 4.40 |
| 30,000 | 3.30 |
| 20,000 | 2.20 |
| 10,000 | 1.10 |

| Optional Spouse Life Insurance | Monthly Payroll Deduction |
|---|---|
| $100,000 | $40.30 |
| 90,000 | 36.27 |
| 80,000 | 32.24 |
| 70,000 | 28.21 |
| 60,000 | 24.18 |
| 50,000 | 20.15 |
| 40,000 | 16.12 |
| 30,000 | 12.09 |
| 20,000 | 8.06 |
| *10,000 | 4.03 |

| Optional Child Life Insurance | Monthly Payroll Deduction |
|---|---|
| $25,000 | 3.60 |
| 15,000 | 2.16 |
| *5,000 | 0.72 |

**Amounts above these require evidence of insurability if applied for when first eligible. Any amounts elected after 31 days of becoming eligible (a late request), or any increases to an existing amount of coverage, require evidence of insurability.*

*This information has been prepared to give you the highlights of additional coverage now being offered by your School Board to meet your insurance needs. For details please ask your personnel office or refer to the certificate of insurance that you will receive after you have signed up for protection.*

***If you have any questions regarding your statement of health or life insurance claim, please call (800)638-6420.***

# *Hyatt Legal Plan*

**Effective Dates:**
**Existing Employees -** September 1, 2013
**Newly Hired Employees -** Coverage is effective the first day of either the first or second month following employment.

**HOW TO GET LEGAL SERVICES**
To use your Legal Plan, visit our web site at www.legalplans.com or call Hyatt Legal Plans' Client Service Center at 1-800-821-6400. Be prepared to give the last 4-digits of your Social Security Number. If you are the spouse or an eligible dependent of a Plan Member, you will need the last 4-digits of the Social Security Number of the Plan Member through whom you are eligible.

If you use Hyatt's web site at www.legalplans.com, click "Members Log In," and provide the Plan Member's last 4-digits of Social Security Number when prompted.

If you call the Client Service Center, the Client Service Representative who answers your call will:
- verify your eligibility for services;
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- give you a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

Then call the Plan Attorney and identify yourself as a legal plan member referred to them by Hyatt Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday appointments are available. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees based on a set fee schedule.

**WHAT SERVICES ARE COVERED**
You and your eligible dependents are entitled to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that must be met. Please take time to read the description of benefits carefully. All benefits are available to you and your spouse and dependents, who are referred to below as Participant(s), unless otherwise noted.

## ADVICE AND CONSULTATION

**Office Consultation and Telephone Advice**
This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

## DEBT MATTERS

**Debt Collection Defense**
This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include vacating a judgment; counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

**Identity Theft Defense**
This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

## DEFENSE OF CIVIL LAWSUITS

**Administrative Hearing Representation**
This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being

provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

**Civil Litigation Defense**
This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

**Incompetency Defense**
This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

## DOCUMENT PREPARATION

**Affidavits**
This service covers preparation of any affidavit in which the Participant is the person making the statement.

**Deeds**
This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

**Demand Letters**
This service covers the preparation of letters that demand money, property or some other property interest of the
Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

**Document Review**
This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

**Elder Law Matters**
This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds for the parents when the Participant is either the grantor or grantee; and preparing promissory notes for the parents when the Participant is the payor or payee.

**Mortgages**
This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

**Notes**
This service covers the preparation of any promissory note for which the Participant is the payor or payee.

## FAMILY LAW

**Name Change**
This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

**Uncontested Adoption**
This service covers all legal services and court work in a state or federal court for an uncontested adoption for the Plan Member and spouse. If an adoption becomes contested, the Plan Member or spouse must pay all additional legal fees.

**Uncontested Guardianship or Conservatorship**
This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, the Plan Member or spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

## IMMIGRATION

**Immigration Assistance**
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

## REAL ESTATE MATTERS

**Eviction and Tenant Problems (Primary Residence - Tenant Only)**
This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

**Home Equity Loans (Primary Residence)**
This service covers the review or preparation of a home equity loan on the Participant's primary residence.

**Refinancing of Home (Primary Residence)**
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.

**Sale or Purchase of Home (Primary Residence)**
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

## TRAFFIC AND CRIMINAL MATTERS

**Traffic Ticket Defense (No DUI)**
This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

## WILL AND ESTATE MATTERS

**Living Wills**
This service covers the preparation of a living will for the Participant.

**Powers of Attorney**
This service covers the preparation of any power of attorney when the Participant is granting the power.

**Trusts**
This service covers the preparation of revocable and irrevocable trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

**Wills and Codicils**
This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

## EXCLUSIONS

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the company, MetLife® and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business or investment matters, involving property held for investment or rental,
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits.

## PORTABILITY PROCEDURES

If you wish to continue your legal plan benefit after retiring or terminating employment with Davidson County Schools, you must enroll for portable enrollment within 30 days of your last day of work for the legal plan.

To apply for portable enrollment:

• An employee needs to call Hyatt's Client Service Center at 1-800-821-6400, Monday–Friday (8am – 7pm ET). A highly trained Client Service Representative will assist you in the application process.
• Enrollment is prepaid via remittance of a lump sum payment equal to the sponsor's monthly rate times 30 months.
($21.50 X 30 months = $645.00).
• Upon receipt and approval of payment, Hyatt will send the enrollee verification of the portable enrollment.
• Portable enrollments will remain effective for a 30 month period and refunds will not be issued.
• Under portable enrollment, dependent definitions are the same as for active Employees.

If you should have any questions, please do not hesitate to call Hyatt's Client Service Center.

**Monthly Rates through payroll deduction are $21.50**
**(Includes coverage for employee, spouse and dependents)**
If you would like more information about The Hyatt Premier Legal Plan, please call us at 1-800-821-6400 between 8:00am and 7:00pm EST Monday through Friday. A knowledgeable Client Service Representative will be available to assist you. You may also access additional information on Hyatt's website: **www.legalplans.com.** The password is 572513.

Hyatt Legal Plans
A MetLife® Company

# Premier

## Davidson County Schools

## Smart. Simple. Affordable.®

**21.50 per month** — covers you, your spouse and dependents

**Telephone and office consultations** for an unlimited number of personal legal matters with an attorney of your choice. During the consultations, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action.

### Full representation for these services:

| | | |
|---|---|---|
| **Estate Planning Documents**<br>▪ Simple and Complex Wills<br>▪ Trusts (Revocable and Irrevocable)<br>▪ Powers of Attorney (Healthcare, Financial, Childcare)<br>▪ Living Wills<br>▪ Codicils | **Real Estate Matters**<br>▪ Sale, Purchase or Refinancing of Your Primary Residence<br>▪ Eviction and Tenant Problems (for Tenant's Primary Residence)<br>▪ Home Equity Loans for Your Primary Residence | **Family Law**<br>▪ Uncontested Adoption<br>▪ Uncontested Guardianship<br>▪ Name Change |
| **Document Preparation**<br>▪ Affidavits<br>▪ Deeds<br>▪ Demand Letters<br>▪ Mortgages<br>▪ Notes | **Financial Matters**<br>▪ Negotiations with Creditors<br>▪ Debt Collection Defense<br>▪ Identity Theft | **Defense of Civil Lawsuits**<br>▪ Administrative Hearings<br>▪ Civil Litigation Defense<br>▪ Incompetency Defense<br>▪ School hearings<br>▪ Pet Liabilities |
| **Traffic Offenses**<br>▪ Defense of Traffic Tickets (Excludes DUI) | **Immigration Assistance**<br>▪ Advice and Consultation<br>▪ Review of Immigration Documents<br>▪ Preparation of Affidavits and Powers of Attorney | **Document Review**<br>▪ Any Personal Legal Document |
| **Elder Law Matters**<br>▪ Consultation and document review for issues related to your parents including Medicare, Medicaid, prescription plans, nursing home agreements, leases, notes, deeds, wills and powers of attorney as they affect the participant | **Additional Services:**<br>**Family Matters™***<br>▪ Separate plan for parents of participants for estate planning documents<br>▪ Available for an additional fee | **E-Services**<br>▪ Attorney Locator<br>▪ Law Firm E-Panel®<br>▪ Life Guide<br>▪ Free, downloadable legal documents<br>▪ Links to resources for financial planning, insurance and work/life matters |

### For More Information:

Visit our web site: **www.legalplans.com** and enter **572513**
Or call our **Client Service Center** at **1-800-821-6400**

Smart. Simple. Affordable.
Hyatt Legal Plans
A MetLife Company

Please see your plan description for complete details. No service (including consultations) will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife® and affiliates, and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters listed specifically in this brochure.

Group Legal Plans and Family Matters offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, the group legal plans and Family Matters are provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island.
L0111154477[exp0113][All States][DC]

# Texas Life Whole Life Policy - VPL Plus

**Common Issue Date: October 1, pending Underwriting Approval**

This **Voluntary Permanent Life** Program will allow you to purchase permanent life insurance for you and your eligible dependents.

VPL-plus plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.[1]

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.[2]

**WHY VOLUNTARY COVERAGE**

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amounts of coverage[3].
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection[3].
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force? --Answer: When you die
- Term if for IF you die, permanent is for WHEN you die

**TEXAS LIFE'S VPL-plus**

- Portable, permanent life insurance through the convenience of payroll deduction
- Whole life chassis
- Strong guarantees[1]
- Popular features
- Coverage available for spouse, minor children and grandchildren[2]

**VPL-plus: PORTABLE AND PERMANENT**

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite.
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid.

**VPL-plus: THE GUARANTEED EMPLYEES WANT**

- Guaranteed level premium
- Guaranteed level death benefit[1]
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

12M203-C Edu 2004 (exp0914) Rev0513 See the VPL-plus brochure for complete details. Policy PWLESV-NI-05

## VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

Employee, spouse coverage require 3 Express Issue health and employment related questions:

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Child coverage (ages 15 days – 26 years old)[2]

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

### Express Issue Maximums

- Employee

  ---ages 17-49, $150,000

  ---ages 50-65, $75,000

  ---ages 66-70, $10,000
- Spouse

  ---ages 17-49, $50,000

  ---ages 50-60, $25,000
- Children – ages 15 days – 26 years $25,000[2]
- Grandchildren – ages 15 days – 18 years $25,000[2]

### Simplified Issue[4]

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of $150,000
- Rates are unisex
- Rates are unismoke

**Accelerated Death Rider**

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren)[2]
- Pays 92% of death benefit, (84% in Illinois) less $150 ($100 in Florida) processing fee, upon physician certified diagnosis of condition expected to result in death within 12 months (24 months in Illinois) (conditions and limitations apply).
- No extra charge for rider
- Policy terminates when rider is exercised

**Waiver of Premium**

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

**VPL-plus Review**

- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit[1]
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over $150,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

[1]Guarantees are backed by the claims paying ability and financial strength of the issuing company

[2]Policies not available on children and grandchildren in WA

[3]Generations at Risk LIMRA International (2008)

[4]We retain the right to require a medical exam

Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships.

*This brochure has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.*

***If you have any questions regarding your Texas Life policy, please call 800-283-9233, prompt #3***

TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

# Continuation of Benefits

**Aflac Group Accident and Critical Illness**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **Aflac Group at 800.433.3036.**

**Ameritas Dental:**

Under the Ameritas dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following “qualifying events”. If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. You will receive notification from IMS with premium and continuation options shortly following your termination of employment. Should you have any questions, please call **IMS (Interactive Medical Systems) at 800.426.8739.**

**Assurity / Allstate Cancer:**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **Assurity: 866-289-7337 or Allstate: 800.521.3535**

**AUL Short-Term and Long-Term Disability:**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **AUL at 800.553.5318.**

**Gilsbar Medical and Dependent Care Accounts:**

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. Terminated employees have 30 days from their date of termination to submit claims incurred prior to the termination date. To continue your medical spending account, you may contact **IMS (Interactive Medical Systems) at 800.426.8739**.

**Hyatt Legal Plan:**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **Hyatt Legal at 800.821.6400**.

**MetLife Term Life:**

***Conversion:*** If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life as well as the basic coverage.

To get information and rates for converting coverage, please contact MetLife direct at **877.275.6387.**

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be ACTIVELY at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information and rates for porting coverage, please contact MetLife direct at: **866.492.6983**.

**MetLife Whole Life:**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **MetLife 800.634.5007.**

**Superior Vision:**

Under the Superior Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following "qualifying events". If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave your for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. You will receive notification from IMS with premium and continuation options shortly following your termination of employment. If you have any questions, please call **IMS (Interactive Medical Systems) at 800-426-8739.**

**Texas Life Whole Life:**

When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questions you may contact **Texas Life 800.283.9233 prompt #3.**

# Contact Information

Aflac Accident and Critical Illness - 800.433.3036

Allstate Cancer - 800.521.3535

Ameritas Dental Plan - 800.487.5553

Assurity Cancer Claims/Customer Service - 866.289.7337

Assurity Wellness Claims / Customer Service - 888.358.8808, ext 23

AUL STD & LTD Claims - 866.258.8744

AUL - STD and LTD Customer Service - 800.553.5318

Gilsbar Medical and Dependent Care - 800.445.7227 ext. 883

Hyatt Legal Plan - 800.821.6400

Mark III Brokerage, Inc. - 800.532.1044, ext. 210

MetLife Term Life Plan - 800.638.6420 (ext. 2 for claims)

MetLife Conversions - 877.275.6387

MetLife Portability - 866.492.6983

MetLife Whole Life Plan - 800.634.5007

Philadelphia American Cancer Plan (Formerly CSO) - 800.554.0092

Superior Vision Plan -(800.507.3800

Texas Life - 800.283.9233, prompt 3