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If you wish to add or make changes to your insurance coverage(s), please consult with your Human Resources Department during your open enrollment period. You will not be able to make any changes once the enrollment period is over unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.

The Local Choice: Key Advantage 250

Coverage Period: 10/01/2015 – 09/30/2016

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

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.thelocalchoice.virginia.gov or by calling 1-888-642-4414.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For in-network providers \$250 person / \$500 family For out-of-network providers \$500 person / \$1,000 family Doesn't apply to preventive care, outpatient prescription drugs, or copayments	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of- <u>pocket limit</u> on my expenses?	Yes. For participating providers \$3,000 person / \$6,000 family For non-participating providers \$5,000 person / \$10,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of- <u>pocket limit</u> ?	Routine vision, dental, premiums, any health care services this plan doesn't cover and balanced-billed charges	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com/tlc or call 1-800-552-2682 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

Questions: Call 1-888-642-4414 or visit us at www.thelocalchoice.virginia.gov.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.thelocalchoice.virginia.gov or call 1-888-642-4414 to request a copy.

Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Specialist visit	\$35 copay	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Other practitioner office visit	\$35 copay for chiropractor	30% coinsurance after deductible for chiropractor	Coverage is limited to 30 visits annual max for chiropractic.
	Preventive care/screening/immunization	No Charge	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com.	Generic drugs	\$10 copay (retail); \$20 copay (home delivery)	\$10 copay (retail); \$20 copay (home delivery)	Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge.
	Preferred brand drugs	\$30 copay (retail); \$60 copay (home delivery)	\$30 copay (retail); \$60 copay (home delivery)	Please see limitations in Generic drugs.
	Non-preferred brand drugs	\$45 copay (retail); \$90 copay (home delivery)	\$45 copay (retail); \$90 copay (home delivery)	Please see limitations in Generic drugs.
	Specialty drugs	\$55 copay (retail); \$110 copay (home delivery)	\$55 copay (retail); \$110 copay (home delivery)	Please see limitations in Generic drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay/visit	30% coinsurance after deductible	_____none_____
	Physician/surgeon fees	\$20 copay for primary care physician and \$35 copay for specialist	30% coinsurance after deductible	_____none_____

If you need immediate medical attention	Emergency room services	\$150 copay/visit	30% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	_____none_____
	Urgent care	\$20 copay for primary care physician and \$35 copay for specialist	30% coinsurance after deductible	_____none_____
	Facility fee (e.g., hospital room)	\$300 copay/stay	30% coinsurance after deductible	_____none_____
If you have a hospital stay	Physician/surgeon fee	No Charge	30% coinsurance after deductible	_____none_____
	Mental/Behavioral health outpatient services	\$20 copay/visit	30% coinsurance after deductible	_____none_____
	Mental/Behavioral health inpatient services	\$300 copay/stay	30% coinsurance after deductible	_____none_____
	Substance use disorder outpatient services	\$150 copay	30% coinsurance after deductible	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder inpatient services	\$300 copay/stay	30% coinsurance after deductible	_____none_____
	Employee Assistance Program (EAP)	No Charge	Not Covered	Covers up to 4 visits per incident within a 12 month period.
	Prenatal and postnatal care	\$20 copay for primary care physician and \$35 copay for specialist	30% coinsurance after deductible	_____none_____
	Delivery and all inpatient services	\$300 copay/stay	30% coinsurance after deductible	_____none_____

If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Coverage is limited to 90 visits max. per coverage period.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Skilled nursing care	No Charge	30% coinsurance after deductible	Coverage is limited to 180 days max. per coverage period.
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Hospice service	No Charge	30% coinsurance after deductible	_____none_____
If your child needs dental or eye care	Eye exam	\$35 copay	Balance after \$50	Limit one exam per plan year In-Network – Pediatric eye exam now counts toward the out-of-pocket
	Glasses	\$20 copay for lenses, balance over \$100 for frames	Balance after \$50 for single lenses, balance over \$80 for frames	See your formal contract for complete details.
	Dental check-up	No Charge	Provider Charge in excess of plan's contractual rates	Dental coverage administered by Delta Dental of Virginia, www.deltadentalva.com or call 1-888-335-8296 .

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
• Acupuncture	• Hearing aids	• Routine foot care (except for some diabetic treatment – please see your member handbook for complete details)	• Weight loss programs
• Cosmetic surgery	• Infertility treatment		
	• Long-term care		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
• Bariatric surgery	• Most coverage provided outside the United States. See www.anthem.com/tlc	• Private-duty nursing	
• Chiropractic care		• Routine eye care	
• Dental care	• Non-emergency care when traveling outside the U.S.		

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是而非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adooohwol íinízinigo t'áa diné k'éjígoo, t'áa shoodí ba na' aln'íhí ya sidáhí bich'í naabídílkíid. Eí doo biigha daago ni ba'níja'go ho'aalagí bich'í hodiilní. Hai'daa'íini'taago eíya, t'áa shoodí diné ya atáh halné'ígí ní béesh bee hane'í wólta' bí'ki si'níligí bí'kégho bich'í hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

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

- Amount owed to providers: \$5,400
- Plan pays \$4,470
- Patient pays \$930

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Copays	\$460
Coinsurance	\$220
Limits or exclusions	\$0
Total	\$930

- Amount owed to providers: \$7,540
- Plan pays \$7,240
- Patient pays \$300

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$300
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$300

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Key Advantage 250 Employee Monthly Rates

Key Advantage 250 with Comprehensive Dental	
Employee Only	\$80.00
Employee + One	\$320.00
Family	\$579.00

Key Advantage 250 with Preventative Dental	
Employee Only	\$67.00
Employee + One	\$296.00
Family	\$544.00

The Local Choice: Key Advantage 500

Coverage Period: 10/01/2015 – 09/30/2016

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

Coverage for: Individual/Family | Plan Type: PPO



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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For in-network providers \$500 person / \$1,000 family For out-of-network providers \$1,000 person / \$2,000 family Doesn't apply to preventive care, outpatient prescription drugs, or copayments	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of- <u>pocket limit</u> on my expenses?	Yes. For participating providers \$4,000 person / \$8,000 family For non-participating providers \$7,000 person / \$14,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of- <u>pocket limit</u> ?	Routine vision, dental, premiums, any health care services this plan doesn't cover and balanced-billed charges	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com/tlc or call 1-800-552-2682 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$25) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Specialist visit	\$40 copay	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Other practitioner office visit	\$40 copay for chiropractor	30% coinsurance after deductible for chiropractor	Coverage is limited to 30 visits annual max for chiropractic.
	Preventive care/screening/immunization	No Charge	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	If you use a non-network provider, balance billing may occur.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance after deductible	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com.	Generic drugs	\$10 copay (retail); \$20 copay (home delivery)	\$10 copay (retail); \$20 copay (home delivery)	Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge.
	Preferred brand drugs	\$30 copay (retail); \$60 copay (home delivery)	\$30 copay (retail); \$60 copay (home delivery)	Please see limitations in Generic drugs.
	Non-preferred brand drugs	\$45 copay (retail); \$90 copay (home delivery)	\$45 copay (retail); \$90 copay (home delivery)	Please see limitations in Generic drugs.
	Specialty drugs	\$55 copay (retail); \$110 copay (home delivery)	\$55 copay (retail); \$110 copay (home delivery)	Please see limitations in Generic drugs.
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
If you have outpatient surgery	Physician/surgeon fees	\$25 copay for primary care physician and \$40 copay for specialist	30% coinsurance after deductible	_____none_____

If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	30% coinsurance after services will be considered at the In-Network benefit level; however, balance billing may still occur.	_____none_____
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	_____none_____
	Urgent care	\$25 copay for primary care physician and \$40 copay for specialist	30% coinsurance after deductible	_____none_____
	Facility fee (e.g., hospital room)	20% coinsurance after deductible/stay	30% coinsurance after deductible	_____none_____
If you have a hospital stay	Physician/surgeon fee	No Charge	30% coinsurance after deductible	_____none_____
	Mental/Behavioral health outpatient services	\$25 copay/visit 20% coinsurance after deductible/facility	30% coinsurance after deductible	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	20% coinsurance after deductible/stay	30% coinsurance after deductible	_____none_____
	Substance use disorder outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Substance use disorder inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Employee Assistance Program (EAP)	No Charge	Not Covered	Covers up to 4 visits per incident within a 12 month period.

If you are pregnant	Prenatal and postnatal care	\$25 copay for primary care physician and \$40 copay for specialist	30% coinsurance after deductible	_____none_____
	Delivery and all inpatient services	20% coinsurance after deductible / stay	30% coinsurance after deductible	_____none_____
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Coverage is limited to 90 visits max. per coverage period.
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Habilitation services	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Skilled nursing care	No Charge	30% coinsurance after deductible	Coverage is limited to 180 days max. per coverage period.
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Hospice service	No Charge	30% coinsurance after deductible	_____none_____
	Eye exam	\$40 copay	Balance after \$50	Limit one exam per plan year. In-Network – Pediatric eye exam now counts toward the out-of-pocket.
If your child needs dental or eye care	Glasses	\$20 copay for lenses, balance over \$100 for frames	Balance after \$50 for single lenses, balance over \$80 for frames	See your formal contract for complete details.
	Dental check-up	No Charge	Provider Charge in excess of plan's contractual rates	Dental coverage administered by Delta Dental of Virginia, www.deltadentalva.com or call 1-888-335-8296.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
• Acupuncture	• Hearing aids	• Routine foot care (except for some diabetic treatment – please see your member handbook for complete details)	
• Cosmetic surgery	• Infertility treatment		
	• Long-term care	• Weight loss programs	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
• Bariatric surgery	• Most coverage provided outside the United States. See www.anthem.com/tlc	• Private-duty nursing	
• Chiropractic care		• Routine eye care	
• Dental care	• Non-emergency care when traveling outside the U.S.		

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'ligoo eí dooda'í, shikáa adooohwoí íinízinigo t'áá diné k'éíígo, t'áá shoodí ba na' alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biígha daago ni ba'níja'go ho'aalagíí bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halné'ígíí ní béesh bee hane'í wólta' bí'ki si'níligíí bí'kégho bich'í hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

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

- Amount owed to providers: \$5,400
- Plan pays \$4,190
- Patient pays \$1,210

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$490
Coinsurance	\$220
Limits or exclusions	\$0
Total	\$1,210

- Amount owed to providers: \$7,540
- Plan pays \$5,640
- Patient pays \$1,900

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$0
Coinsurance	\$1,400
Limits or exclusions	\$0
Total	\$1,900

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Key Advantage 500 Employee Monthly Rates

Key Advantage 500 with Comprehensive Dental	
Employee Only	\$30.00
Employee + One	\$227.00
Family	\$444.00

Key Advantage 500 with Preventative Dental	
Employee Only	\$17.00
Employee + One	\$203.00
Family	\$409.00

The Local Choice: High Deductible Health Plan (HDHP)

Coverage Period: 10/01/2015 – 09/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual/Family | Plan Type: High Deductible



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.thelocalchoice.virginia.gov or by calling 1-888-642-4414.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Combined deductible for in-network providers \$2,800 person / \$5,600 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$5,000 person / \$10,000 family For non-participating providers \$10,000 person / \$20,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. There are no out-of-network benefits except in an emergency.
What is not included in the <u>out-of-pocket limit</u> ?	Deductible and coinsurance for routine dental service and adult routine vision services	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com or call 1-800-552-2682 for a list of in-network providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .

Questions: Call 1-888-642-4414 or visit us at www.thelocalchoice.virginia.gov.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.thelocalchoice.virginia.gov or call 1-888-642-4414 to request a copy.

Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

 • Copayments are fixed dollar amounts (for example, \$25) you pay for covered health care, usually when you receive the service. • Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible. • The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.) • This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.		
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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Other practitioner office visit	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 30 visits annual max for chiropractic.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com .	Generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge.
	Preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
	Non-preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
	Specialty drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	40% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	_____none_____
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	_____none_____
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Substance use disorder outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Employee Assistance Program (EAP)	No Charge	40% coinsurance after deductible	Covers up to 4 visits per incident within a 12 month period.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 90 visits max. per coverage period.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 180 days max. per coverage period.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

If your child needs dental or eye care	Eye exam	\$15 copay	Not Covered	Limit one exam per plan year
	Glasses	\$20 copay for lenses, balance over \$100 for frames	Not Covered	See your formal contract for complete details
	Dental check-up	No Charge	Provider Charge in excess of plan's contractual rate	Dental coverage administered by Delta Dental of Virginia, www.deltadentalva.com or call 1-888-335-8296.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
• Acupuncture • Cosmetic surgery • Hearing aids	• Infertility treatment • Long-term care • Routine eye care • Routine foot care (except for some diabetic treatment – please see your member handbook for complete details) • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Bariatric surgery • Chiropractic care • Dental care	• Most coverage provided outside the United States. See www.anthem.com/tlc • Non-emergency care when traveling outside the U.S. • Private-duty nursing

Your Rights to Continue Coverage:

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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



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See the next page for important information about these examples.

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,100
- Patient pays \$3,300

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,800
Copays	\$0
Coinsurance	\$500
Limits or exclusions	\$0
Total	\$3,300

- Amount owed to providers: \$7,540
- Plan pays \$3,790
- Patient pays \$3,750

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,800
Copays	\$0
Coinsurance	\$950
Limits or exclusions	\$0
Total	\$3,750

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

High Deductible Health Plan Employee Monthly Rates

High Deductible Health Plan with Comprehensive Dental	
Employee Only	\$0.00
Employee + One	\$134.00
Family	\$268.00

High Deductible Health Plan with Preventative Dental	
Employee Only	\$0.00
Employee + One	\$110.00
Family	\$233.00

HSA Administrators Health Savings Account (HSA)

Effective Date: October 1, 2015

Health Savings Account Annual Employer Contribution:

\$720- Individual

\$1,200- Family

2015 Maximum Allowable Contribution Amounts:

\$3,350- Individual

\$6,650- Family

The Health Savings Account (HSA) is an account that can be used to reimburse a portion of you and your eligible family members' out-of-pocket medical expenses, such as deductibles, coinsurance and pharmacy expenses.

Basically all types of medical, dental, vision, deductibles, copayments, coinsurance, and other healthcare related expenses may be reimbursed through the HSA as defined by Code Section 213(d). In order to be an eligible **premium expense** under an HSA, the premium must qualify as a medical expense under Code Section 213(d).

Other qualified medical expenses from your HSA include the following:

- Amounts paid for health insurance premiums during continuation of coverage provisions during unemployment.
- Amounts paid for qualified long-term care coverage.

Good news is that you do not pay federal income taxes or employment taxes on amounts the County contributes to the HSA. You also earn interest on the account over time - tax-free.

Balances that remain at the end of the year can be carried over to the next year and you own the account.

HSA Administrators' Customer Contact Center - 1.888.354.0697



Blue View Vision Plan



Key Advantage 250

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, discounts, and much more!

Blue View VisionSM

Your Blue View Vision network

Your routine vision benefit uses the Blue View Vision network – one of the largest vision care networks in the industry with a wide selection of ophthalmologists, optometrists and opticians. The network also includes convenient retail locations, many with evening and weekend hours, including 1-800 CONTACTS, LensCrafters®, Sears OpticalSM, Target Optical®, and JCPenney® Optical.

Go to www.anthem.com/tlc to find a Blue View Vision provider near you.

Out-of-network services

You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. Just pay in full at the time of service and then file a claim for reimbursement. In-network benefits and discounts will not apply.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

ROUTINE VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam (<i>once per plan year</i>)		\$35 copayment	\$50 allowance
Eyeglass frames Once every 12 months you may select any eyeglass frame ¹ and receive the following allowance toward the purchase price:		\$100 allowance then 20% off remaining balance	\$80 allowance
Standard Eyeglass Lenses <i>Polycarbonate lenses included for children under 19 years old.</i> Once every 12 months you may receive any one of the following lens options: - Standard plastic single vision lenses (<i>1 pair</i>) - Standard plastic bifocal lenses (<i>1 pair</i>) - Standard plastic trifocal lenses (<i>1 pair</i>)		\$20 copay; then covered in full \$20 copay; then covered in full \$20 copay; then covered in full	\$50 allowance \$75 allowance \$100 allowance
Upgrade Eyeglass Lenses (available for additional cost) When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lenses copayment applies, plus the cost of the upgrade.		Lens Options - UV Coating - Tint (<i>Solid and Gradient</i>) - Standard Scratch-Resistance - Standard Polycarbonate - Standard Progressive (<i>add-on to bifocal</i>) - Standard Anti-Reflective Coating - Other Add-ons and Services Member cost for upgrades \$15 \$15 \$15 \$40 \$65 \$45 20% off retail price	Discounts on lens upgrades are not available out-of-network
Contact lenses Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses once every 12 months.		- Elective Conventional Lenses² - Elective Disposable Lenses² - Non-Elective Contact Lenses²	\$100 allowance then 15% off the remaining balance \$100 allowance (<i>no additional discount</i>) \$250 allowance \$80 allowance \$80 allowance \$210 allowance

¹ Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

² Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are medically necessary when glasses are not an option for vision correction, such as after cataract surgery.

ROUTINE VISION CARE SERVICES (continued)

Contact lens fitting and follow-up

A contact lens fitting, and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.

- Standard contact fitting*
- Premium contact lens fitting**

IN-NETWORK

You pay up to \$55

10% off retail price

OUT-OF-NETWORK

Discounts not available out-of-network

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

ADDITIONAL SAVINGS ON EYEWEAR & ACCESSORIES

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

Additional Pairs of Complete Eyeglasses

As many pairs as you like

Conventional Contact Lenses Materials Only

Additional Eyewear & Accessories

Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eye glass cases, lens cleaning supplies, contact lens solutions, etc.

MEMBER DISCOUNTS

40% discount off retail*

15% off retail price

20% off retail price

LASIK VISION CORRECTION

Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to www.anthem.com/tlc and select Discounts under the Health and Wellness tab.

NON-ROUTINE VISION SERVICES

The Blue View Vision network is for routine eye care only. Non-routine vision care is covered under your medical benefits. Refer to your COVA Care member handbook for more information.

OUT-OF-NETWORK

If you choose an out-of-network provider, you must complete the Blue View out-of-network claim form and submit it with your receipt. You will be reimbursed according to the out-of-network reimbursement schedule. Go to www.anthem.com/tlc and select Forms under the Resources & Tools tab. Your out-of-pocket expenses related to the vision benefits do not count toward your annual out of pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

The Additional Savings Program is subject to change without notice.

QUESTIONS? Contact Anthem member services at 1-800-552-2682.



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Key Advantage 500

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, discounts, and much more!

Blue View VisionSM

Your Blue View Vision network

Your routine vision benefit uses the Blue View Vision network – one of the largest vision care networks in the industry with a wide selection of ophthalmologists, optometrists and opticians. The network also includes convenient retail locations, many with evening and weekend hours, including 1-800 CONTACTS, LensCrafters®, Sears OpticalSM, Target Optical®, and JCPenney® Optical.

Out-of-network services

You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. Just pay in full at the time of service and then file a claim for reimbursement. In-network benefits and discounts will not apply.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

ROUTINE VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam (<i>once per plan year</i>)		\$40 copayment	\$50 allowance
Eyeglass frames Once every 12 months you may select any eyeglass frame ¹ and receive the following allowance toward the purchase price:		\$100 allowance then 20% off remaining balance	\$80 allowance
Standard Eyeglass Lenses <i>Polycarbonate lenses included for children under 19 years old.</i> Once every 12 months you may receive any one of the following lens options:			
Standard plastic single vision lenses (<i>1 pair</i>)		\$20 copay; then covered in full	\$50 allowance
Standard plastic bifocal lenses (<i>1 pair</i>)		\$20 copay; then covered in full	\$75 allowance
Standard plastic trifocal lenses (<i>1 pair</i>)		\$20 copay; then covered in full	\$100 allowance
Upgrade Eyeglass Lenses (available for additional cost) When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lenses copayment applies, plus the cost of the upgrade.		Lens Options	
		Member cost for upgrades	
		UV Coating	Discounts on lens upgrades are not available out-of-network
		Tint (<i>Solid and Gradient</i>)	
		Standard Scratch-Resistance	
		Standard Polycarbonate	
		Standard Progressive (<i>add-on to bifocal</i>)	
		Standard Anti-Reflective Coating	
		Other Add-ons and Services	
Contact lenses Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses once every 12 months.		Elective Conventional Lenses²	\$80 allowance
		Elective Disposable Lenses²	\$80 allowance
		Non-Elective Contact Lenses²	\$210 allowance

¹ Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

² Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are medically necessary when glasses are not an option for vision correction, such as after cataract surgery.

ROUTINE VISION CARE SERVICES (continued)

Contact lens fitting and follow-up

A contact lens fitting, and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.

- Standard contact fitting*
- Premium contact lens fitting**

IN-NETWORK
You pay
up to \$55

10% off retail price

OUT-OF-NETWORK
Discounts not available
out-of-network

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

ADDITIONAL SAVINGS ON EYEWEAR & ACCESSORIES

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

**Additional Pairs of
Complete Eyeglasses**
As many pairs as you like

Conventional Contact Lenses
Materials Only

**Additional Eyewear &
Accessories**
Includes eyeglass frames and
eyeglass lenses purchased
separately, some non-
prescription sunglasses, eye
glass cases, lens cleaning
supplies, contact lens
solutions, etc.

MEMBER DISCOUNTS

40% discount off retail*

15% off retail price

20% off retail price

LASIK VISION CORRECTION

Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to www.anthem.com/tlc and select Discounts under the Health and Wellness tab.

NON-ROUTINE VISION SERVICES

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OUT-OF-NETWORK

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Go to www.anthem.com/tlc to find a Blue View Vision provider near you.

Out-of-network services

You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. Just pay in full at the time of service and then file a claim for reimbursement. In-network benefits and discounts will not apply.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

ROUTINE VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam (<i>once per plan year</i>)		\$15 copayment	\$50 allowance
Eyeglass frames Once every 12 months you may select any eyeglass frame ¹ and receive the following allowance toward the purchase price:		\$100 allowance then 20% off remaining balance	\$80 allowance
Standard Eyeglass Lenses <i>Polycarbonate lenses included for children under 19 years old.</i> Once every 12 months you may receive any one of the following lens options:			
• Standard plastic single vision lenses (<i>1 pair</i>)		\$20 copay; then covered in full	\$50 allowance
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• Standard plastic trifocal lenses (<i>1 pair</i>)		\$20 copay; then covered in full	\$100 allowance
Upgrade Eyeglass Lenses (available for additional cost) When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lenses copayment applies, plus the cost of the upgrade.		Lens Options Member cost for upgrades	Discounts on lens upgrades are not available out-of-network
	• UV Coating	\$15	
	• Tint (<i>Solid and Gradient</i>)	\$15	
	• Standard Scratch-Resistance	\$15	
	• Standard Polycarbonate	\$40	
	• Standard Progressive (<i>add-on to bifocal</i>)	\$65	
	• Standard Anti-Reflective Coating	\$45	
	• Other Add-ons and Services	20% off retail price	
Contact lenses Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses once every 12 months.	• Elective Conventional Lenses ²	\$100 allowance then 15% off the remaining balance	\$80 allowance
	• Elective Disposable Lenses ²	\$100 allowance (no additional discount)	\$80 allowance
	• Non-Elective Contact Lenses ²	\$250 allowance	\$210 allowance

¹ Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

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ADDITIONAL SAVINGS ON EYEWEAR & ACCESSORIES

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

Additional Pairs of Complete Eyeglasses

As many pairs as you like

Conventional Contact Lenses Materials Only

Additional Eyewear & Accessories

Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eye glass cases, lens cleaning supplies, contact lens solutions, etc.

MEMBER DISCOUNTS

40% discount off retail*

15% off retail price

20% off retail price

LASIK VISION CORRECTION

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Delta Dental

Welcome to Delta Dental of Virginia

In addition to the largest network of dentists in Virginia* and valuable benefits that help keep your out-of-pocket costs down, The Local Choice members also get 24/7 access to dental benefits information, claims and resources to help you manage your dental benefits. Visit Delta Dental of Virginia's interactive website today to find all the real-time information you need to make the most of your dental coverage benefits.



Getting started

- Go to DeltaDentalVA.com
- Click the Subscribers arrow to go to the Subscribers page
- Click the "New Users Register Here" link under the Subscribers Login box
- Follow the instructions to complete the registration process

Once you have your user name and password, you can log into our secure site to:

- Verify your benefits
- Check claims
- Access forms

You can also visit deltadentalva.com for information to help you understand your benefits, learn more about the value of good oral health and find a dentist near you. Just click on The Local Choice Plan link from the home page or Subscribers page of DeltaDentalVA.com or log into the secure website and you'll see why Delta Dental gives you something to smile about.

*Delta Dental Plans Association, September 2014



Your Dental Benefits

As a subscriber with The Local Choice, your dental benefits are administered by Delta Dental of Virginia. With Delta Dental you have your choice of more than 6,900 dental locations throughout Virginia* and more than 327,000 dental offices across the country*. All dentists who have agreed to participate in a Delta Dental network will file your claims for you, will accept Delta Dental's allowances for services (in addition to any required coinsurance and deductible) and will abide by Delta Dental's guidelines for dental treatment.

Delta Dental Network

Delta Dental offers The Local Choice members its largest network, with more than 85% of all dentists in Virginia**. When you receive your dental care from a Delta Dental participating dentist, you will not be responsible for any charges that exceed Delta Dental's allowance for the covered services you receive. This means your out-of-pocket expenses will be limited to the amount of your coinsurance, deductible and any amounts that exceed your annual or lifetime maximums.

Receiving care from dentists outside the Delta Dental Network

Should you decide to receive dental care from a dentist who is not a member of the Delta Dental Network, you will still receive benefits from your dental plan, but your share of the cost will likely be higher than if you received care from a network dentist. In addition, you may have to file any claims yourself.

*Delta Dental Plans Associations, September 2014

**Delta Dental of Virginia, November 2014

Highlights of the Local Choice Dental Plan (Included in all Local Choice state wide options.)

Preventive Option (Covers Diagnostic and Preventive services only, for a lower Premium.)

Coverage	DELTA DENTAL PAYS	Benefit Limitations
Diagnostic and Preventive	100%	No Deductible or maximum
Oral exams and cleanings		Twice in a plan year.
Fluoride treatment		Twice in a plan year for dependents under age 19.
Bitewing X-rays		Twice in a plan year.
Full mouth or panorex X-rays		Once each three years.
Emergency treatment		
Space maintainers		
Sealants		Only for non-carious, non-restored 1st and 2nd permanent molars for dependant children under age 19. Limited to one application per tooth.

Comprehensive Option (Covers Diagnostic and Preventive services above. Also includes coverage for basic, major and orthodontic services for a higher Premium.)

Annual Benefit Maximum	\$1,500/member	Maximum paid by Delta Dental
Annual Deductible	\$25/member \$75/family	Paid by member
Lifetime Orthodontic Maximum	\$1,500/member	Maximum paid by Delta Dental
Coverage	DELTA DENTAL PAYS	Benefit Limitations
Primary Dental Care	80%	Deductible Applies
Restorative (silver or toothcolored fillings; stainless steel crowns and other restorative services)		Retreatment limited to once per surface in a two year period.
Oral surgery (simple extractions and other minor surgical procedures)		Services covered under medical benefits are excluded.
Endodontics (root canal therapy and other Endodontic services)		Repeat treatment is a covered benefit only after two years from initial treatment.
Periodontics (scaling and root planing, soft tissue and bony surgery, including grafts and other Periodontic services)		
Denture repair and recementation of existing crowns, bridges and dentures		
Major Dental Care	50%	Deductible Applies
Crowns (single crowns, inlays and onlays)		Once per tooth every five years. Crowns for dependents under the age of 12 are not covered.
Prosthodontics (partials or complete dentures and fixed bridges)		Once every five years, fixed bridges or removable partials are not covered for dependents under age 16.
Dental implants		
Orthodontic Benefits	50%	No Deductible
Removable fixed appliance therapy and comprehensive therapy		For adults and children.

Delta Dental Participating Dentist

- Participating dentists will have claim forms in the office and will complete and submit to Delta Dental at no charge.
- Payment will be made directly to the dentist for covered benefits.
- The dentist will accept Delta Dental's allowance for covered benefits. This means that you pay only the applicable coinsurance and deductible for these covered services.

Non-Participating Dentist

- You may be required to pay the non-participating dentist in advance for the entire bill, complete claim forms and submit to Delta Dental.
- Payment will be made directly to you unless your dentist agrees to accept payment from Delta Dental.
- Non-participating dentists have not agreed to accept Delta Dental's allowance for their services. This means that, in addition to what Delta Dental pays, you must pay the applicable coinsurance and deductible and difference between the non-participating dentist's charges and Delta Dental's payment for covered benefits.

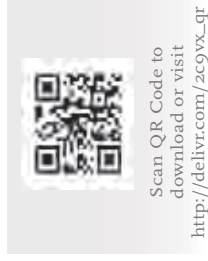
The Delta Dental Mobile App



Your oral health is important to Delta Dental – and to your overall health. We want to make it easy for you to make the most of your dental benefits so you can maximize your health, wherever you are. Delta Dental's mobile app gives you access to dentist search, claims and coverage right on your mobile device. We even have a toothbrush timer built in to make sure you keep up with your daily oral health routine.

Getting Started

Delta Dental's mobile app is available for mobile devices using iOS (Apple) or Android. To download and install the app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, if you have a QR Code Reader installed on your phone, scan the code at the right to download. You will need an internet connection in order to download and use our free app.



Using the App Without Logging In

Delta Dental's mobile app is available to all users. Without logging in, you can access our Find a Dentist and Toothbrush Timer tools.

Logging in to View Benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. Launch the app on your device, then click the Login button. Enter your username and password, and click Login. If you've forgotten your username or password, there are links to retrieve them. Currently, we do not support registration on the mobile app. There is a link to register which will direct you to our website using your device's browser. For a better experience, we recommend registering on your personal computer and returning to the app to login.

Securely Access Your Benefits

You must enter your user name and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

Questions and Answers Concerning Your Dental Program

1. How can I find out if my dentist participates with Delta Dental?

There are several ways:

- Call The Local Choice Service Team at 888.335.8296 from 8:15 a.m. – 6:00 p.m. EST, Monday through Thursday and 8:15 a.m. – 4:45 p.m. EST on Friday.
- Check Delta Dental's website at DeltaDentalVA.com.
- Ask your dentist if he/she is a Delta Dental participating dentist.

2. How can I avoid unexpected charges for dental care?

- See a Delta Dental participating dentist.
- Have your dentist file a pre-determination (not required, but recommended for services over \$250).
- Call your Service Team with any benefit clarification questions.

3. What will happen if I go out of network?

- You will be responsible for paying the difference between the non-participating dentist's charges and Delta Dental's payment.
- The dentist is not required to file the claim for you, and you may be required to pay the dentist at the time services are rendered and then file the claim for reimbursement from Delta Dental.

4. Where do I file my claims?

- All claims should be filed with Delta Dental of Virginia, 4818 Starkey Road, Roanoke, Virginia 24018.

5. Can I access Delta Dental information online or using my Smartphone?

- Yes. Delta Dental offers TLC members the ability to view claims and eligibility, as well as estimate procedure costs, find a dentist and much more! Register at DeltaDentalVA.com for secure access to your dental benefits information.

You can also access these same great online features from your mobile device at the same web address.



Chard-Snyder Flexible Spending Accounts

Open a Flexible Spending Account To Save 25-40% on Healthcare And Dependent Daycare Expenses!



With a Flexible Spending Account (FSA), you pay for eligible expenses with tax-free dollars. You won't have to pay federal, social security or most states' taxes on the money you put into the plan. Your exact savings will depend on your personal tax rate.

It's So Easy to Use Your Flexible Spending Account

If you use the Benny[®] prepaid benefits card, you can pay for many expenses without cash! Or you can just pay for your expenses and submit a claim by email, fax, U.S. mail or through the website or app. Most reimbursements are received within two weeks depending on your plan's payment option.

Use the Chard Snyder website or mobile app any time to check your current balance, see the status of a claim or review the history of your account.

Get the Most From Your Flexible Spending Account... Plan Ahead to Save

You will want to plan ahead to save the most you can. Follow these steps:

1. Check your plan rules for possible claims deadlines
2. Use the Annual Expense Estimate Worksheets on the back of this brochure or on our website to help you plan
3. Review the lists of eligible expenses for your plans
4. Total what you paid last year for eligible expenses for each plan
5. Write down any new expenses you are sure of for the new plan year. Include new glasses, prescriptions, orthodontia or another family member needing daycare, etc.
6. The total for each plan helps you decide how much to put into your accounts

Use the
Tax-Savings
Calculator at
Chard-Snyder.com

Eligible healthcare and dependent daycare expenses are exempt from federal income and social security taxes as well as most state income taxes. Your tax savings will vary based on your tax bracket.

Set money aside for healthcare and/or dependent daycare expenses

A Whole New Way to Manage Your Account

Chard Snyder offers you the tools you need to manage your Flexible Spending Account whether you are on the road or at your home computer. The secure online access lets you see your account activity, manage your personal profile, access forms and read messages...the information you need when you need it.

Pay for Eligible Expenses With Benny... No Cash Required!

Benny® is smarter than the average card and recognizes many eligible expenses such as doctor's office visits, prescriptions and emergency room visits. Benny helps you stay within IRS rules by allowing purchases only at locations that provide eligible services or merchandise. Benny even knows which items are eligible at most places that sell over-the-counter healthcare merchandise. Using Benny means you can keep your cash in your pocket for other things. You'll receive two cards, one for you and one for another family member.



Use Our Mobile App and Stay Up-To-Date Wherever You Are

Use your iPhone®, Android® or tablet device to access your account balance anywhere. See specific transaction details and submit healthcare claims and receipt images, plus, choose the text alerts you want to receive. You'll know when claims are confirmed or denied and when receipts are needed to support your claim.



Benny Prepaid Benefits Card Helps You Save Money

See the list of stores that accept Benny at www.chard-snyder.com.



Don't throw away your Benny...you can use it for up to five years. There is an expiration date on the front of your card.



Your healthcare election will be available on the first day of your plan year.



New participants will be mailed a set of two cards in their name.



Look for this Envelope

Be on the lookout for this envelope in the mail. It will say Your New Employee Benefits Materials Are Enclosed – Please Open Immediately! Your cards are enclosed.



Save Your Receipts!

No matter how you submit a claim, the IRS requires that you prove it was for an eligible expense. Even if you use Benny® you may be asked to send us a receipt, Explanation of Benefits (EOB), or bill as proof. Your proof must provide the date of the expense, a description of the item or service, the name of the store or provider and the amount you paid. Your expense must have occurred during the time period covered by your plan.

Find the
Using Your
Flexible Spending
Account
brochure on the
Chard Snyder
website for
complete details

Your Healthcare Flexible Spending Account

Save on out-of-pocket healthcare expenses for you and your family. Use your healthcare account to pay for expenses not covered by your medical, dental and vision insurance plans such as deductibles, co-payment amounts and eligible services and merchandise for which you have no coverage.

Use your plan like an interest-free loan for expenses such as glasses, contact lenses, dentures, oral surgery, tooth implants or LASIK surgery. The tax-free money withheld from your check helps you pay for big expenses painlessly.

The IRS does not allow us to pay claims for doctor's retainer fees (VIP fees), medical services before they are provided (such as your expected costs as shown on dental estimates) or cosmetic merchandise or procedures such as tummy-tucks or teeth-whitening.

Over-the-counter drugs and medicines such as ibuprofen, acetaminophen or cough syrup are eligible with a prescription from your doctor. A copy of the prescription for your over-the-counter medications must be sent to Chard Snyder once a year for claim approval.

Examples of Eligible Healthcare Account Expenses

Acupuncture	Fluoridation treatments	Physical therapy
Alcoholism / drug addiction treatment	Guide dog	Prescriptions
Artificial limbs	Hearing aid / batteries	Private hospital room
Artificial teeth	Hospital services	Psychiatric care (prescribed)
Braille books / magazines	Insulin	Reading glasses
Childbirth classes	Laboratory fees	Sales tax (on eligible expenses)
Chiropractors	LASIK surgery	Smoking cessation (prescribed)
Co-insurance / co-pays	Learning disability	Speech training
Contact lenses / solution	Medical monitoring devices	Transplants
Crutches	Medical services	Vaccines
Deductibles	Operations / surgery	Weight loss (prescribed)
Dental treatment	Optometrist	Wheelchair
Denture adhesives	Orthodontia*	X-ray fees
Eye exams / eyeglasses	Osteopath	
Fitness classes (Prescribed)	Physical exams (non-employment)	

*Find our brochure titled *Save on Orthodontia With a Flexible Spending Account* on our website for a complete explanation of how orthodontia claims are paid.

Your Dependent Daycare Flexible Spending Account Can Save You Hundreds of Dollars

Are you paying for the care of dependent children under the age of 13 or dependents of any age who are unable to care for themselves? Now you can pay for your dependents' daycare while you are at work or school and save 25-40% in taxes on every dollar.

Just enroll in the plan during your benefits open enrollment period and choose the amount you want to put aside for daycare. The annual maximum a household may set aside is \$5,000. Married couples filing singly may each set aside up to \$2,500. Divorced couples should check the FAQs on our website for special rules.

Tax-free money from your paycheck will be added to your dependent daycare account balance. You pay your daycare provider and then submit a claim for reimbursement. The plan works like a checking account in that you may only be reimbursed for the amount you have in your account at the time of your claim. If your claim is for more than the balance in your account, the rest of your claim will be paid when more money is added.



Examples of Eligible Dependent Daycare Expenses

Choose the care that best suits your situation:

In-home babysitter	Nursery school
Daycare center	Summer day camp
Outside babysitter	Elder custodial care
Latchkey program	Elder daycare



Important Points

You save 25-40% because you don't pay federal, social security or most states' taxes on the money you spend for daycare.



Choose your amount carefully. Once you are enrolled you cannot change it unless you change daycare providers, you have or adopt a child, or your child turns 13.



Services must be provided while you and your spouse are at work, seeking employment or attending classes as a full-time student.



Services must be provided during the current plan year. Your plan year is explained in your enrollment materials.



You should contact your tax advisor to discuss how you might use this benefit with the child care tax credit.



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Mason, OH 45040
Tel: 513.459.9997 | 800.982.7715
Fax: 513.459.9947 | 888.245.8452
askpenny@chard-snyder.com
www.chard-snyder.com



Healthcare Account

Annual Expense Estimate Worksheet

	Actual Expenses Last Year	Estimated Expenses New Year
<u>Medical</u>		
Co-pays / expenses		
Prescriptions	\$ _____	\$ _____
Physician visits	\$ _____	\$ _____
Hospital visit co-pays /expenses (including Emergency)	\$ _____	\$ _____
Laboratory/testing expenses	\$ _____	\$ _____
Deductible expenses	\$ _____	\$ _____
Over-the-counter items (medicines require a prescription to be eligible)	\$ _____	\$ _____
<u>Vision</u>		
Eye examination	\$ _____	\$ _____
Eyeglasses	\$ _____	\$ _____
Contact lenses and solution	\$ _____	\$ _____
LASIK surgery	\$ _____	\$ _____
Other expenses	\$ _____	\$ _____
<u>Hearing</u>		
Hearing examination	\$ _____	\$ _____
Hearing aid	\$ _____	\$ _____
<u>Dental</u>		
Co-pays / expenses		
Dental visits	\$ _____	\$ _____
Fillings	\$ _____	\$ _____
Major work (root canals, crowns, dentures, etc.)	\$ _____	\$ _____
Orthodontia (braces)	\$ _____	\$ _____
Deductible expenses	\$ _____	\$ _____
Other expenses	\$ _____	\$ _____
Total annual amounts	\$ _____	\$ _____

Dependent Daycare Account Annual Expense Estimate

Child Daycare*

Full-time daycare (per week)

Child one \$ _____

Child two \$ _____

Part-time daycare (per week)

Child one \$ _____

Child two \$ _____

1. Estimate the cost per week for each category of care
2. Calculate annual cost
(Weekly full-time daycare + weekly part-time daycare X number of weeks per year)
3. Total amount \$ _____

* Child must be less than 13 years of age.

Disabled Daycare*

Caregiver
monthly cost \$ _____

Multiply monthly
cost times
number of months
estimated \$ _____

*Daycare provided for a dependent of any age who requires assistance with the basic tasks of daily life due to physical or mental challenges.



3510 Irwin Simpson Road
Mason, OH 45040
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Fax: 513.459.9947 | 888.245.8452
askpenny@chard-snyder.com
www.chard-snyder.com



Unum Accident Plan

Group Accident Insurance

Some features listed below may be applicable only to certain quotes and/or classes. Please see the "Plan Description" section of your Benefits and Cost Summary for specific plan details.

Enrollment Frequency

Any Time/Scheduled

Newly eligible employees may apply for coverage at any time within 31 days of becoming eligible. Those applying after the first 31 days may do so only at a scheduled enrollment period. If the plan includes employee choices, employees may increase only during a scheduled enrollment period and within plan design limits.

Portability

Allows an employee who has been insured under the policy to continue Group Accident coverage at group rates when; employment ends or when the policy is terminated by the policyholder and is not being replaced. An employee must apply for coverage and pay the first premium within 31 days of the continuation event.

Wellness Benefit

Coverage Amount \$100

Unum will pay the Wellness Benefit once per insured per calendar year while coverage is inforce.

Wellness tests are:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Hemoglobin A1C(HbA1c);
- Flexible sigmoidoscopy;
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Virtual colonoscopy

New Employee Waiting Period

This represents the period that a new employee, hired after the effective date of the plan, will have to wait to be eligible for coverage. Please see the plan description section of the Benefits and Cost Summary for the waiting period duration.

Present Employee Waiting Period

This represents the period that a current employee will have to wait to be eligible for coverage. This applies only at the initial enrollment event. Please see the plan description section of the Benefits and Cost Summary for the waiting period duration.

Credit Prior Service

Credit prior service allows Unum to apply a prior period of work with the Employer toward the eligibility waiting period.

Exclusions

Unum will not pay any benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- participating or attempting to participate in a felony, being engaged in an illegal occupation or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having a work related injury
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the Exclusions listed above, Unum will also not pay the Catastrophic Accidental Dismemberment or Catastrophic Accidental Loss benefit for the following injuries that are caused by or are the result of:

- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Insured Coverage Termination

An insured's (employee or dependent) coverage under the policy will end on the earliest of:

- date the policy is cancelled;
- date the insured is no longer in an eligible group;
- date the eligible group is no longer covered;
- date of insured's death;
- last day of the period for which contributions were made;
- last day the insured is in active employment;
- date spouse no longer meets the definition of spouse;
- date of divorce or annulment;
- date dependent child(ren) no longer meets the definition of dependent child(ren); or
- however, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of the policy.

If dependent coverage is present and the employee chooses to cancel spouse and/or child coverage under the policy, coverage for the spouse and/or child ends on the first of the month following the date notification is provided to the Plan Administrator.

Unum will provide coverage for a payable claim which occurs while the insured is covered under the policy.

Underwritten by the following subsidiary of Unum Group:

Unum Life Insurance Company of America
2211 Congress St, Portland ME 04122

Unum Accident Employee Monthly Rates	
Employee Only	\$15.26
Employee + Spouse	\$25.62
Employee + Child	\$27.70
Employee + Spouse + Child	\$38.04

Unum Critical Illness Plan

Group Critical Illness Insurance

Some features listed below may be applicable only to certain quotes and/or classes. Please see the "Plan Description" section of your Benefits and Cost Summary for specific plan details.

Enrollment Frequency

Scheduled

Eligible Employees may apply for coverage at a scheduled enrollment period. If the plan includes employee choices, employees may increase only during a scheduled enrollment period and within plan design limits. Employees applying for or increasing coverage may be required to submit Evidence of Insurability (EOI). Decreases can be made at anytime and do not require EOI.

Portability

Portability allows an employee who has been insured under the policy to continue Group Critical Illness coverage at group rates when employment ends or when the policy is terminated by the policyholder and is not being replaced. An employee must apply for coverage and pay the first premium within 31 days of the continuation event.

New Employee Waiting Period

This represent the period that a new employee, hired after the effective date of the plan, will have to wait to be eligible for coverage. Please see the plan description section of the Benefits and Cost Summary for the waiting period duration.

Present Employee Waiting Period

This represents the period that a current employee will have to wait to be eligible for coverage. This applies only at the initial enrollment event. Please see the plan description section of the Benefits and Cost Summary for the waiting period duration.

Credit Prior Service

Credit prior service allows Unum to apply a prior period of work with the Employer toward the eligibility waiting period.

Benefit Waiting Period

None

Evidence of Insurability

Evidence of Insurability is a statement of the employee and/or spouse medical history, which Unum will use to determine if the applicant will be approved for the Critical Illness Insurance.

Limitations and Exclusions

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating or attempting to participate in a felony or being engaged in an illegal occupation;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- participating in war or any act of war, whether declared or undeclared;
- being under the influence of or addicted to intoxicants or narcotics. This would not include Physician prescribed medication, taken in the prescribed dosage; or
- having a Date of Diagnosis during the Benefit Waiting Period.

Termination of Employee Coverage

If You choose to cancel Your coverage under the policy, Your coverage ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You are no longer in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions; or
- last day You are in Active Employment. However, as long as premium is paid as required, coverage will continue if You elect to continue coverage under the Portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy.

Coverage on Your Dependent Children ends on the earliest of the date Your coverage under the policy ends or the date a dependent child no longer meets the definition of Dependent Children.

Unum will provide coverage for a Payable Claim which occurs while You are covered under this policy.

Termination of Spouse Coverage

If You choose to cancel Your Spouse's coverage under the policy, coverage for Your Spouse ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Spouse coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You are no longer in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions;
- last day You are in Active Employment, as long as premium is paid as required, coverage will continue if You elect to continue coverage under the Portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy;
- date Your coverage under the policy ends;
- date Your Spouse no longer meets the definition of Spouse; or
- date of divorce or annulment.

Unum will provide coverage for a Payable Claim which occurs while Your Spouse is covered under this policy.

Underwritten by the following subsidiary of Unum Group:

Unum Life Insurance Company of America
2211 Congress St, Portland ME 04122

**Rate Information for Critical Illness
Class 1**

Critical Illness with Cancer Employee Monthly Rates per \$1000		
Issue Ages	Non-Tobacco	Tobacco
<25	\$0.56	\$0.86
25-29	\$0.64	\$1.06
30-34	\$0.84	\$1.51
35-39	\$1.15	\$2.50
40-44	\$1.63	\$3.21
45-49	\$2.28	\$4.54
50-54	\$3.10	\$6.18
55-59	\$4.22	\$8.20
60-64	\$5.78	\$10.53
65-69	\$7.53	\$12.76
70+	\$9.45	\$14.45

Spouse issue ages are 17 through 64. Dependent Children issue ages are newborn up to their 26th birthday or to the maximum coverage age defined in the policy.

Unum Short-Term Disability Plan

Individual Short Term Disability Insurance

Enrollment Frequency

Any Time/Scheduled

Newly eligible employees may apply for coverage at any time within 31 days of becoming eligible. Those applying after the first 31 days may do so only at a scheduled enrollment period. If the plan includes employee choices, employees may increase only during a scheduled enrollment period and within plan design limits. Employees applying for or increasing coverage may be required to submit Evidence of Insurability (EOI). Decreases can be made at any time and do not require EOI.

Non-Occupational Plan Design

Coverage for sickness and off-the-job accidents.

Definition of Benefit Period

The benefit period is the length of time benefits are payable for a covered disabling condition.

Rates and Cost Information

One rate class is assigned per account, based on industry.

Definition of Elimination Period

The elimination period is the length of time of continuous disability that must be satisfied before the employee is eligible to receive benefits.

Definition of Total Disability

An employee is considered disabled when Unum determines that:

- during the first two years of disability the employee is unable to perform the duties of his or her occupation, is not engaged in any occupation and is under the care of a physician; and
- after the second year of disability, if applicable, the employee is unable to perform the duties of any occupation for which he or she is fitted by education, training or experience, is not engaged in any occupation and is under the care of a physician.

Pre-Existing Conditions

Benefits for a pre-existing condition will not be paid during the first 12 months the policy is in force. A pre-existing condition means a sickness or physical condition for which the insured individual received medical treatment, consultation, or has taken medicine, or exhibited symptoms that would cause a person to seek medical treatment, within the 12 months just prior to his or her coverage effective date.

Offsets

- Individual offsets
 - All inforce disability coverage with Unum will be offset against the short term disability insurance coverage applied for by the employee.
 - No offsets will apply to benefit amounts up to the Guaranteed/Modified Issue limits.

Waiver of Premium

Included in policy, waives premium after 90 days of total disability or after the elimination period (whichever is greater) up to the maximum benefit period.

State Exceptions

California residents must apply using a CA application.

Michigan and New Hampshire - Special rates

South Carolina - Special forms required at solicitation for applicants age 65 or older.

California, Georgia, Idaho, Maine, Montana, Nevada, New Hampshire, Oregon, Texas, West Virginia and Wisconsin - Outline of coverage required at time of application.

Kansas, Montana and Oklahoma - Pregnancy exclusion does not apply.

Idaho - 6-month pre-existing condition period

Vermont - All policies include the Mental Illness Rider. Coverage will be provided for 100% of the base benefit amount with a maximum benefit duration of 24 months. Special rates will reflect the inclusion of the required benefit.

Mental Illness Rider is mandatory in California when the Benefit Period is <60 months.

Exclusions

We will not pay benefits for losses that are caused by or occur as the result of:

- war or act of war, whether declared or undeclared;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing or parakiting or any similar activities;
- participating or attempting to participate in an illegal activity and/or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring him or herself intentionally, whether he or she is sane or not;
- addiction to alcohol or drugs, except for drugs taken as prescribed by the employee's physician;
- having a pre-existing condition as described and limited in this policy;
- practice for or participation in any semi-professional or professional competitive athletic contest for which the employee receives any type of compensation or remuneration;
- having a psychiatric or psychological condition, including but not limited to, affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's disease and other organic senile dementias are covered under this policy;
- having a work-related injury, unless an on-job total disability benefit is shown on the policy schedule; or
- giving childbirth within the first nine months after the coverage effective date as the result of a normal pregnancy, including Cesarean. Complications of a pregnancy will be covered to the same extent as any other covered sickness.

Terminations

The policy will terminate on the earliest of the following:

- written request by the insured individual to terminate the policy;
- failure to pay the premiums for the policy, subject to the grace period allowed;
- the policy anniversary on or following the insured individual's 72nd birthday; or
- death of the insured.

Underwritten by the following subsidiary of Unum Group:

Provident Life and Accident Insurance Company

1 Fountain Square, Chattanooga, TN 37402

60% of Monthly Income for 14 Days Accident / 14 Days Sickness / 6 Months Benefit			
		Issue Ages 17-49	Issue Age 50-69
Monthly Income Range	Maximum Monthly Benefit	Sickness and Off Job Accident	Sickness and Off Job Accident
\$501 - \$666	\$400	\$10.40	\$13.91
\$667 - \$833	\$500	\$13.00	\$17.38
\$834 - \$1,000	\$600	\$15.60	\$20.85
\$1,001 - \$1,166	\$700	\$18.20	\$24.31
\$1,167 - \$1,333	\$800	\$20.80	\$27.78
\$1,334 - \$1,500	\$900	\$23.40	\$31.25
\$1,501 - \$1,666	\$1,000	\$26.00	\$34.71
\$1,667 - \$1,833	\$1,100	\$28.60	\$38.18
\$1,834 - \$2,000	\$1,200	\$31.20	\$41.65
\$2,001 - \$2,166	\$1,300	\$33.80	\$45.11
\$2,167 - \$2,333	\$1,400	\$36.40	\$48.58
\$2,334 - \$2,500	\$1,500	\$39.00	\$52.09
\$2,501 - \$2,666	\$1,600	\$41.60	\$55.56
\$2,667 - \$2,833	\$1,700	\$44.20	\$59.02
\$2,834 - \$3,000	\$1,800	\$46.80	\$62.49
\$3,001 - \$3,166	\$1,900	\$49.40	\$65.96
\$3,167 - \$3,333	\$2,000	\$52.00	\$69.42
\$3,334 - \$3,500	\$2,100	\$54.60	\$72.89
\$3,501 - \$3,666	\$2,200	\$57.20	\$76.36
\$3,667 - \$3,833	\$2,300	\$59.80	\$79.82
\$3,834 - \$4,000	\$2,400	\$62.40	\$83.29
\$4,001 - \$4,166	\$2,500	\$65.00	\$86.76
\$4,167 - \$4,333	\$2,600	\$67.60	\$90.22
\$4,334 - \$4,500	\$2,700	\$70.20	\$93.69
\$4,501 - \$4,666	\$2,800	\$72.80	\$97.20
\$4,667 - \$4,833	\$2,900	\$75.40	\$100.67
\$4,834 - \$5,000	\$3,000	\$78.00	\$104.13
\$5,001 - \$5,166	\$3,100	\$80.60	\$107.60
\$5,167 - \$5,333	\$3,200	\$83.20	\$111.07
\$5,334 - \$5,500	\$3,300	\$85.80	\$114.53
\$5,501 - \$5,666	\$3,400	\$88.40	\$118.00
\$5,667 - \$5,833	\$3,500	\$91.00	\$121.47

\$5,834 - \$6,000	\$3,600	\$93.60	\$124.93
\$6,001 - \$6,166	\$3,700	\$96.20	\$128.40
\$6,167 - \$6,333	\$3,800	\$98.80	\$131.87
\$6,334 - \$6,500	\$3,900	\$101.40	\$135.33
\$6,501 - \$6,666	\$4,000	\$104.00	\$138.80
\$6,667 - \$6,833	\$4,100	\$106.60	\$142.31
\$6,834 - \$7,000	\$4,200	\$109.20	\$145.78
\$7,001 - \$7,166	\$4,300	\$111.80	\$149.24
\$7,167 - \$7,333	\$4,400	\$114.40	\$152.71
\$7,334 - \$7,500	\$4,500	\$117.00	\$156.18
\$7,501 - \$7,666	\$4,600	\$119.60	\$159.64
\$7,667 - \$7,833	\$4,700	\$122.20	\$163.11
\$7,834 - \$8,000	\$4,800	\$124.80	\$166.58
\$8,001 - \$8,166	\$4,900	\$127.40	\$170.04
\$8,167 - \$8,333	\$5,000	\$130.00	\$173.51

60% of Monthly Income for 30 Days Accident / 30 Days Sickness / 6 Months Benefit

		Issue Ages 17-49	Issue Age 50-69
Monthly Income Range	Maximum Monthly Benefit	Sickness and Off Job Accident	Sickness and Off Job Accident
\$501 - \$666	\$400	\$7.15	\$10.58
\$667 - \$833	\$500	\$8.93	\$13.22
\$834 - \$1,000	\$600	\$10.71	\$15.86
\$1,001 - \$1,166	\$700	\$12.48	\$18.51
\$1,167 - \$1,333	\$800	\$14.26	\$21.15
\$1,334 - \$1,500	\$900	\$16.04	\$23.79
\$1,501 - \$1,666	\$1,000	\$17.81	\$26.44
\$1,667 - \$1,833	\$1,100	\$19.59	\$29.08
\$1,834 - \$2,000	\$1,200	\$21.37	\$31.68
\$2,001 - \$2,166	\$1,300	\$23.14	\$34.32
\$2,167 - \$2,333	\$1,400	\$24.92	\$36.97
\$2,334 - \$2,500	\$1,500	\$26.74	\$39.61
\$2,501 - \$2,666	\$1,600	\$28.52	\$42.25
\$2,667 - \$2,833	\$1,700	\$30.29	\$44.90
\$2,834 - \$3,000	\$1,800	\$32.07	\$47.54
\$3,001 - \$3,166	\$1,900	\$33.85	\$50.18
\$3,167 - \$3,333	\$2,000	\$35.62	\$52.83

\$3,334 - \$3,500	\$2,100	\$37.40	\$55.47
\$3,501 - \$3,666	\$2,200	\$39.18	\$58.11
\$3,667 - \$3,833	\$2,300	\$40.95	\$60.76
\$3,834 - \$4,000	\$2,400	\$42.73	\$63.40
\$4,001 - \$4,166	\$2,500	\$44.51	\$66.00
\$4,167 - \$4,333	\$2,600	\$46.28	\$68.64
\$4,334 - \$4,500	\$2,700	\$48.06	\$71.29
\$4,501 - \$4,666	\$2,800	\$49.88	\$73.93
\$4,667 - \$4,833	\$2,900	\$51.66	\$76.57
\$4,834 - \$5,000	\$3,000	\$53.43	\$79.22
\$5,001 - \$5,166	\$3,100	\$55.21	\$81.86
\$5,167 - \$5,333	\$3,200	\$56.99	\$84.50
\$5,334 - \$5,500	\$3,300	\$58.76	\$87.15
\$5,501 - \$5,666	\$3,400	\$60.54	\$89.79
\$5,667 - \$5,833	\$3,500	\$62.32	\$92.43
\$5,834 - \$6,000	\$3,600	\$64.09	\$95.08
\$6,001 - \$6,166	\$3,700	\$65.87	\$97.72
\$6,167 - \$6,333	\$3,800	\$67.65	\$100.32
\$6,334 - \$6,500	\$3,900	\$69.42	\$102.96
\$6,501 - \$6,666	\$4,000	\$71.20	\$105.61
\$6,667 - \$6,833	\$4,100	\$73.02	\$108.25
\$6,834 - \$7,000	\$4,200	\$74.80	\$110.89
\$7,001 - \$7,166	\$4,300	\$76.57	\$113.54
\$7,167 - \$7,333	\$4,400	\$78.35	\$116.18
\$7,334 - \$7,500	\$4,500	\$80.13	\$118.82
\$7,501 - \$7,666	\$4,600	\$81.90	\$121.47
\$7,667 - \$7,833	\$4,700	\$83.68	\$124.11
\$7,834 - \$8,000	\$4,800	\$85.46	\$126.75
\$8,001 - \$8,166	\$4,900	\$87.23	\$129.40
\$8,167 - \$8,333	\$5,000	\$89.01	\$132.04

Underwritten by the following subsidiary of Unum Group:

Provident Life and Accident Insurance Company

1 Fountain Square, Chattanooga, TN 37402

In New York, coverage is underwritten by:

First Unum Life Insurance Company

666 3rd Avenue, Suite 301, New York, NY 10017

Unum Whole Life Plan

Whole Life Insurance

Some features listed below may be applicable only to certain quotes and/or classes. Please see the "Plan Description" section of your Benefits Summary for specific plan details.

Enrollment Frequency

Any Time/Scheduled

Newly eligible employees may apply for coverage at any time within 31 days of becoming eligible. Those applying after the first 31 days may do so only at a scheduled enrollment period. If the plan includes employee choices, employees may increase only during a scheduled enrollment period and within plan design limits. Employees applying for or increasing coverage may be required to submit Evidence of Insurability (EOI).

Family Coverage Options

Spouse Coverage

- The employee does not have to apply for coverage to purchase standalone spouse coverage.
- The spouse cannot be covered under both the spouse standalone policy and spouse term rider.
- The premiums are based on the issue age of the spouse.
- This is an individually owned policy, so coverage can be continued if the employee retires or leaves the company.

Children's Coverage

Either Employee or Spouse has the option of choosing a standalone policy for each child.

Children's Whole Life Insurance Policy

- Premiums are based on the issue age of the child and are payable to age 70 .
- Coverage can be continued if the employee retires or leaves the company.
- This is available to children and grandchildren, regardless of dependency.

Additional Coverage Options

Accidental Death Benefit Rider

Provides an additional death benefit equal to the base policy face amount if the insured individual dies before age 70 as a result of an accident as defined in the policy.

- This rider is available to employees and spouses age 15 to 65, and only at initial enrollment.
- The maximum available benefit is \$150,000.

Waiver of Premium

Waives the policy's premium during disability if the insured employee becomes disabled prior to age 65 and remains disabled for at least six months.

- Available to employees between the ages of 15-55, and only at initial enrollment.
- Premiums paid during the six-month waiting period are refunded and will be waived as long as the disability continues.

Living Benefit Option Rider

A Living Benefit Option Rider is automatically included at no extra premium on all policies. This feature allows the policyowner to request up to 100% of the death benefit (to a maximum of \$150,000) if the insured is diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout reduces the death benefit. May vary by state.

State Approvals

Whole life is currently available for sale in all states.

Exclusions

If the insured individual commits suicide within two years from the policy date, Unum's liability will be the refund of premiums paid, without interest, less the sum of any debt, and the cost of any supplementary benefit riders. May vary by state.

Policy Termination

All coverage terminates when any one of the following occurs:

- You request coverage to terminate;
- The Insured dies;
- The policy matures; or
- The loan value exceeds the Guaranteed Cash Value of the policy.

Policy Definitions

- Premiums are guaranteed level based on the insured individual's age at policy issue, and do not increase due to age.
- The guaranteed non-forfeiture interest rate is 4.5%.
- The policy contains a reduced paid-up provision, which allows employees to use their accumulated cash value to purchase a smaller, paid-up policy with no further premiums due, subject to minimum policy limits.
- Coverage may be continued as long as sufficient premiums are paid.

Rates and Cost Information

Whole Life

Some rates and costs listed below may be applicable only to certain quotes and/or classes. Please see the "Plan Description" section of your Benefits Summary for specific plan details.

Premium illustrates base product premium only; optional rider premium is in addition to base premium.

The guaranteed interest rate is 4.5%. Surrender value will be reduced by any outstanding loans.

Employee and Spouse Volume Purchase				
Paid Up Age 120 Cash Value at 65				
Monthly premiums based on a volume purchase of \$5,000				
	Non-Tobacco		Tobacco	
Issue Age	Premium	Cash Value	Premium	Cash Value
15	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A
30	N/A	N/A	N/A	N/A
35	N/A	N/A	N/A	N/A
40	N/A	N/A	N/A	N/A
45	N/A	N/A	\$15.86	\$1,599
50	N/A	N/A	\$20.93	\$1,293
55	\$17.90	\$823	\$29.82	\$888
60	\$24.92	\$981	\$40.56	\$1,012
Monthly premiums based on a volume purchase of \$10,000				
	Non-Tobacco		Tobacco	
Issue Age	Premium	Cash Value	Premium	Cash Value
15	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A
30	N/A	N/A	\$14.74	\$4,274
35	N/A	N/A	\$18.42	\$4,009
40	\$14.35	\$3,245	\$23.92	\$3,660
45	\$18.72	\$2,856	\$31.72	\$3,197
50	\$25.27	\$2,340	\$41.82	\$2,587
55	\$35.75	\$1,645	\$59.59	\$1,776
60	\$49.84	\$1,963	\$81.12	\$2,024
Monthly premiums based on a volume purchase of \$20,000				
	Non-Tobacco		Tobacco	
Issue Age	Premium	Cash Value	Premium	Cash Value
15	N/A	N/A	\$18.38	\$9,516
20	N/A	N/A	\$21.58	\$9,262
25	\$14.52	\$7,872	\$25.31	\$8,949
30	\$17.86	\$7,530	\$29.47	\$8,548
35	\$22.32	\$7,080	\$36.79	\$8,018
40	\$28.69	\$6,491	\$47.84	\$7,319
45	\$37.44	\$5,712	\$63.40	\$6,394
50	\$50.49	\$4,680	\$83.59	\$5,174
55	\$71.46	\$3,291	\$119.17	\$3,552
60	\$99.67	\$3,925	\$162.20	\$4,048

Child Volume Purchase Child Maximum Amount is \$7,000 in Washington Paid Up Age 70 Cash Value at 65		
Child monthly premiums based on a volume purchase of \$5,000		
Uni-Tobacco		
Issue Age	Premium	Cash Value
0	N/A	N/A
1	N/A	N/A
2	N/A	N/A
3	N/A	N/A
4	N/A	N/A
5	N/A	N/A
10	N/A	N/A
15	N/A	N/A
26	\$5.59	\$2,220
Child monthly premiums based on a volume purchase of \$10,000		
Uni-Tobacco		
Issue Age	Premium	Cash Value
0	\$5.81	\$4,637
1	\$5.85	\$4,634
2	\$5.85	\$4,630
3	\$5.94	\$4,626
4	\$6.03	\$4,621
5	\$6.16	\$4,616
10	\$7.02	\$4,588
15	\$8.24	\$4,552
26	\$11.14	\$4,439

Accidental Death Benefit (ADB) Rider Paid Up Age 120		
Monthly premiums based on a volume purchase of \$5,000		
	Non-Tobacco	Tobacco
Issue Age	ADB	ADB
15	N/A	N/A
20	N/A	N/A
25	N/A	N/A
30	N/A	N/A
35	N/A	N/A
40	N/A	N/A
45	N/A	\$0.40
50	N/A	\$0.40
55	\$0.40	\$0.40
60	\$0.40	\$0.40
Monthly premiums based on a volume purchase of \$10,000		
	Non-Tobacco	Tobacco
Issue Age	ADB	ADB
15	N/A	N/A
20	N/A	N/A
25	N/A	N/A
30	N/A	\$0.80
35	N/A	\$0.80
40	\$0.80	\$0.80

Monthly premiums based on a volume purchase of \$10,000		
	Non-Tobacco	Tobacco
Issue Age	ADB	ADB
45	\$0.80	\$0.80
50	\$0.80	\$0.80
55	\$0.80	\$0.80
60	\$0.80	\$0.80
Monthly premiums based on a volume purchase of \$20,000		
	Non-Tobacco	Tobacco
Issue Age	ADB	ADB
15	N/A	\$1.60
20	N/A	\$1.60
25	\$1.60	\$1.60
30	\$1.60	\$1.60
35	\$1.60	\$1.60
40	\$1.60	\$1.60
45	\$1.60	\$1.60
50	\$1.60	\$1.60
55	\$1.60	\$1.60
60	\$1.60	\$1.60

Virginia Retirement System

Virginia Retirement System

Full-time employees have retirement benefits through the state's Virginia Retirement System (VRS). Your benefit is funded through member and employer contributions to VRS, which are invested over your career. You contribute 5 percent of your salary each month to your member contribution account on a pre-tax salary reduction basis. Your contributions are tax-deferred until you withdraw them as part of your retirement benefit or as a refund. Goochland County funds your retirement benefit by making a separate contribution to VRS. VRS invests these contributions to provide benefits for future retirees.

Retirement benefits are based on age, years of service, and average final compensation. There are three plan types depending on your membership date status. To learn more about your retirement benefits, please refer to your member handbook or visit the VRS website at www.varetire.org.

Goochland County pays toward other coverage that protects you and your loved ones while you are employed and after you retire. These additional VRS benefits include life insurance, disability coverage, long-term care benefits, and benefits for your beneficiary or survivor if you die while you are an active member.

Basic Group Life Insurance

If you are a full-time employee, you have life insurance benefit coverage from your first day of employment. Goochland County pays for your coverage, which includes a natural death benefit, equal to your compensation, rounded to the next highest thousand and then doubled; an accidental death benefit, double the natural death benefit; an accidental dismemberment benefit; a safety belt benefit; a repatriation benefit; a felonious assault benefit; and an accelerated death benefit. Death benefits are paid to your beneficiary. After you retire with an unreduced or reduced retirement benefit, you receive Basic Group Life Insurance coverage at no cost to you, provided you meet the eligibility requirements under your retirement plan.

Optional Life Insurance

If you need more life insurance coverage than is available through your basic group life insurance, you can supplement your coverage through the Optional Life Insurance Program. You can purchase additional coverage for yourself, your spouse, and your dependent children. You pay the premiums for this additional coverage through payroll deductions. You have 31 days from the date of employment to apply for Optional Group Life Insurance in order to receive guaranteed issue. If you apply for Optional Group Life Insurance more than 31 days after the start date of employment, you must furnish evidence of insurability for yourself and all dependents you wish to insure.

Beneficiary Designation

It is important to keep your beneficiary designation current to ensure that benefits are paid promptly and according to your wishes. If you have married, divorced or lost a loved one, you may wish to complete a new beneficiary change form. These forms can be obtained through the Human Resources Department.

Minnesota Life Group Optional Term Life and AD&D Insurance Plan

The Virginia Retirement System (VRS) Optional Group Life insurance program gives you the opportunity to purchase additional insurance at favorable group rates on yourself and your family. Optional group life is term insurance. Term insurance generally provides the largest immediate death protection for your premium dollar. The program is administered by the Virginia Retirement System, and is provided under a group policy issued by the Minnesota Life Insurance Company.

COST OF COVERAGE

Monthly premium is based on age and salary. Please see the Minnesota Life benefit book for more information.

EFFECTIVE DATE OF COVERAGE

An employee may apply for optional life insurance at any time. However, if the employee is enrolling within 31 days of employment, coverage is guaranteed and no medical underwriting is required. Insurance coverage is effective on the signature date. If an employee is enrolling after 31 days of employment coverage begins on the date of the approval.

What Amounts of Coverage are Available in Optional Life?

There are 4 options under the VRS Optional life plan. The amount of coverage a member and the family receives corresponds with the option selected.

	Employee	Spouse	Children
Option	Insurance Amount	Insurance Amount	15 days- Max. age
1	1x Salary	1/2 x Employee Salary	\$10,000
2	2x Salary	1 x Employee Salary	\$10,000
3	3x Salary	1 1/2 x Employee Salary	\$20,000
4	4x Salary	2 x Employee Salary	\$30,000

- An **Employee** may select coverage options for one, two, three, or four times their salary (rounded to the next highest \$1,000), up to a maximum of \$750,000.

- Insurance for **Spouse** is one half of the amount of the employee's coverage, up to a maximum of \$375,000.

--Approval is required for spouse coverage under Options 2-4 even if an application is completed within 31 days of eligibility.

- **Children's** coverage is based on the option the employee selects. The amount of insurance is for each eligible child.

In addition to these amounts selected to be paid upon a regular death, Optional life insurance also includes accidental death and dismemberment benefits, as well as an accelerated benefit.

- The accidental death benefit pays an additional benefit equal to the amount of Optional life coverage selected if death is a result of an accident.
- The dismemberment benefit pays an amount equivalent to either one-half or the entire amount of optional life insurance should an insured lose sight or suffer a severed limb as a result of an accident or a combination of both.
- The accelerated benefit allows an insured to receive all or a portion of their insurance while they are living. Any insured diagnosed with a terminal illness with a life expectancy of 12 months or less may apply to accelerate their benefit and receive payment while they are living.

What is the Cost of Optional Life?

Premiums for the Employee and the Spouse are based upon each individual insured's age. The rates in the table are per thousand dollars of coverage.

Employee and Spouse Rates

Age of Insured Member or Spouse	Rate per every thousand dollars
34 and under	\$.05
35-39	.06
40-44	.09
45-49	.14
50-54	.20
55-59	.33
60-64	.65
65-69	1.15
70 and over	2.06

Child(ren) Rates- unmarried dependents up to age 21; or up to age 25 if the unmarried dependent is a full-time student. There is no age limit if the unmarried dependent is disabled.

Option	Insurance Amount (each child)	Flat Monthly Rate
1	\$10,000	\$0.80
2	\$10,000	\$0.80
3	\$20,000	\$1.60
4	\$30,000	\$2.40

How to Apply for Optional Life?

- Complete an Optional Life Enrollment Application (VRS-39) and
- Send it in with an Evidence of Insurability (VRS-32) form.

If you apply for Optional life within 31 days from the date of employment, you may receive up to Option 4 on a guarantee issue basis, but not greater than \$375,000, whichever is less. "Guarantee issue" means that the applicant will receive coverage without proof of insurability for any option that does not exceed \$375,000. If an option is selected that provides coverage in excess of \$375,000, the applicant will be required to submit an Evidence of Insurability form (VRS-32) to be reviewed by the Company. Coverage will be limited to \$375,000 until your VRS-32 is approved.

Likewise, Spouse coverage is guaranteed for Option 1 (1/2 of the employee's salary) if application is made within 31 days the spouse first becomes eligible for Optional life. If the employee selects Option 2, 3, or 4, the spouse will be asked to furnish evidence of insurability for the Company's approval before the spouse can be covered for the higher amount. If the Evidence of Insurability is not approved, your spouse will continue to be insured for the amount provided under Option 1 (half the employee's salary).

If both you and your spouse are eligible for Optional life as employees, you may not elect spouse coverage. Likewise, either you or your spouse, not both, may elect coverage for your children.

Child(ren) also may receive coverage at the level corresponding to the option you select. Children's coverage also does not require proof of insurability if their coverage is applied for within 31 days of their becoming eligible to be insured.

Application for Optional life may also be made at anytime more than 31 days after either the employment date or eligible date. The employee merely completes an enrollment application (VRS-39) and sends it in with their completed evidence of insurability (VRS-32) form.

Applications may be obtained either from your employer's benefits administrator or from Minnesota Life. Their address is PO Box 1193, Richmond, VA, 23218-1193. Minnesota Life's phone number is 1-800-441-2258.

NOTE: Any existing Employee (and or Dependents) which apply for term life coverage (did not apply when initially eligible) MUST complete a Health Statement.

Will I Be Able to Continue My Optional Life at Retirement?

Yes. You may continue your Optional life insurance if you are retiring, or terminating service but deferring retirement. You must have been insured with Optional life for 60 months before leaving service. Premiums to continue your coverage would be at the same rates as that for an active employee.

You may continue optional life as a retiree at either Option 1 or Option 2, subject to a maximum equal to the smaller of the amount of optional insurance in force on the eligible date, or \$275,000.

Election to continue must be made within 31 days of leaving service. Optional coverage you are carrying above these amounts may be converted to an individual policy.

Insurance amounts and the corresponding maximums begin to reduce at age 65 and all insurance terminates at age 80.

Spouse coverage is also available at the corresponding Option 1 and Option 2 levels of insurance selected by the retiree to continue. The insurance on the spouse continues to be one half of the amount of the retiree's coverage. Premium is based on the same rates under the VRS group plan.

Dependent children may continue to be insured by the retiree at the same Options previously insured prior to retirement.

What Happens to My Optional Life With Termination?

If you terminate your employment, and are not eligible to continue Optional coverage as a retiree, your Optional insurance terminates. However, coverage may be converted to an individual policy. The conversion privilege may be exercised without proof of insurability if election to convert is made within 31 days of the termination.

Spouse and dependent children coverage also ends when your coverage terminates, but they can then be converted into an individual policy.

Who Are Beneficiaries for Optional Life?

The beneficiaries of an employee's Optional life insurance are the same as those designated for the VRS Basic group life insurance.

The employee is the beneficiary the spouse and the children's optional life coverage.



457 Retirement Savings Plan

Retirement Savings Plan

Participation in a 457(b) plan allows employees to defer pre-tax dollars through payroll deduction. During calendar year 2014, \$17,500 may be contributed. Special catch-up provisions may apply for employees over the age of 50. To learn more about how you can save for retirement, you may contact the following representatives:

Nationwide Retirement Solutions

Tom Bussard

1-877-677-3678 ext. 4358353

(Fax): 855-203-4095

Lynn Robinette

434-534-5673

VALIC

Michael Rawls

1-800-892-5558 ext. 87365

(Fax): 804-897-5512

Contact Information for Questions or Claims

The information in this Employee Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various benefit plan descriptions. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Still Have Questions?

If you cannot get your questions answered by the carrier directly or are not sure where to find an answer, please do not hesitate to contact Kelly Parrish in the Human Resources Department at 556-5831 or by emailing kparrish@co.goochland.va.us

When You Have Questions

The majority of questions or issues you may encounter can be resolved through the insurance carrier customer service and websites. The websites are all designed for you to have access to your entire plan and claims information, including information for any of your enrolled dependents.

It's simple for you to register and login to each of the sites. All carriers are reducing the number of call service representatives and their websites have become terrific interactive and informational tools for you to get most of your questions answered. The websites include the following information:

Claims Information: View expanded claims information and receive a report detailing your health care expenditures.

Eligibility: See who's covered under your plan and what benefits they are eligible for.

ID Cards: Request ID cards or print temporary ID cards for you and your covered family members.

Provider Directory: Look up doctors and facilities and find participating providers.

Benefit Plan Design: View your specific benefits summary.

Forms: Download and print necessary forms

Type of Insurance	Carrier	Website/Phone
Medical/Vision	Anthem 24/7 Nurseline	www.anthem.com/tlc 1-800-552-2682 1-800-337-4770
Dental	Delta Dental	http://www.deltadentalva.com 1-888-335-8296
Employee Assistance Program	Anthem	www.anthem.com/tlc 1-855-223-9277
FSA	Chard-Snyder	www.chard-snyder.com 1-800-982-7715
Voluntary Insurance Claims	Unum	1-800-359-5244, Ext. 6023
HSA	HSA Administrators	1-888-354-0697
Voluntary Insurance Enrollment	Mark III	www.markiiieb.com 1-800-532-1044