Table of Contents

Pre-Tax Benefits

After-Tax Benefits

For Your Reference

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled 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 31 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. Refer to your policy or certificate for each product for the exact terms and conditions.

Plan Arranged By:

Mark III
Employee Benefits

FlexibleBenefit ADMINISTRATORS

City of Lawrenceburg TN

Get reimbursed for out-of-pocket healthcare and expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars.) You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

ELIGIBILITY

Participation in the Plan Begins on January 1, 2017 and ends on December 31, 2017. You will be eligible to join the Plan if you are a full-time employee working at least 30 hours or more per week during the annual open enrollment. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period after the enrollment form is received. You must complete an enrollment form to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment form is not completed during open enrollment, your enrollment will be canceled and you will not be able to join until the next anniversary date of the Plan or if you have a qualifying event.

ELECTION CHANGES

Once you have enrolled in an FSA you may NOT make any changes to your election unless you have a change in status such as:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in Dependent Care Providers

REIMBURSEMENT SCHEDULE

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at

www.mywealthcareonline.com/fba to view the following features:

- FSA Login – view balances, check status and view claims history-download participation forms
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out of pocket health care expenses for yourself, your spouse and all of your dependents for healthcare services that are incurred during your plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." This is a broad definition that lends itself to creativity.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

Fees/Co-Pays/Deductibles For:

- Acupuncture
- Prescription Eyeglasses/ Reading glasses/ Contact lens and supplies/ Eye Exams/ Laser Eye Surgery
- Physician
- Ambulance
- Psychiatrist
- Psychologist
- Anesthetist
- Hospital
- Chiropractor
- Laboratory/ Diagnostic
- Fertility Treatments
- Surgery
- Dental/ Orthodontic Fees
- Obstetrician
- X-Rays
- Eye Exams
- Prescription Drugs
- Artificial limbs & teeth
- Birth control pills, patches
- Orthopedic shoes/ inserts
- Therapeutic care for drug and alcohol addiction
- Vaccinations & Immunizations
- Mileage
- Take-home screening kits
- Diabetic supplies
- Routine Physicals
- Oxygen
- Physical Therapy
- Hearing aids and batteries
- Medical equipment

OVER-THE-COUNTER EXPENSES

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- Antacids
- Pain relievers/aspirin
- Ointments & creams for joint pain
- Allergy & sinus medication
- First aid creams
- Cough & cold medications
- Laxatives
- Anti-diarrhea medicine

THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Plan Year is $2,550.

DAY CARE/AGED ADULT CARE REIMBURSEMENT

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives. This can include stepchildren, grandchildren, adopted or foster children; refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
  - Disabled spouse
  - Disabled child
  - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- **$5,000 ($2,500 if married filing separately)**
- Your wages for the year or your spouse's if less
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Without Flex Benefits	With Flex Benefits
Gross Monthly Income	$ 2,500.00	$ 2,500.00
Eligible Pre-Tax employer medical insurance	$ 0.00	$ 200.00
Eligible Pre-Tax Medical Expenses	$ 0.00	$ 60.00
Eligible Pre-Tax Dependent Child Care Expenses	$ 0.00	$ 300.00
Taxable Income	$ 2500.00	$ 1940.00
Federal Tax (15%)	$ 375.00	$ 291.00
State Tax (5.75%)	$ 125.00	$ 97.00
FICA Tax (7.65%)	$ 191.25	$ 148.41
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax medical expenses	$ 60.00	$ 0.00
After-Tax dependent child care expenses	$ 300.00	$ 0.00
Monthly Spendable Income	$ 1248.75	$ 1403.59

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by $154.84 every month! This means an annual tax savings of $1,858.08. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

- Au Pair
- Nannies
- Before and After Care
- Day Camps
- Babysitters
- Daycare for an Elderly Dependent
- Daycare for a Disabled Dependent
- Nursery School
- Private Pre School
- Sick Child Center
- Licensed Day Care Centers

Ineligible Expenses

- Overnight Camps
- Babysitting for Social Events
- Leave of Absence or Vacation
- Tuition Expenses Including Kindergarten
- Food Expenses (if separate from dependent care expenses)
- Care Provided By Children Under 19 (or by anyone you claim as a dependent)
- Days Your Spouse Doesn't Work (though you may still have to pay the provider)
- Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary.
- Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill.

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you in your Employee Guide or on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Please see the Employee Guide for more info.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible Health Care and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at www.mywealthcareonline.com/fba to help you determine your total expenses for the Plan Year.

Step 2

Complete the Enrollment Form (available from your Benefits Administrator), which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

BENEFITS CARD

You may also use your Benefits Card to pay for eligible expenses at approved service providers and merchants. Using your card allows you instant access to your funds with no out of pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. You may also elect to have an additional Benefits Card for your dependent(s) over the age of 18.

Please contact Flexible Benefit Administrators, Inc. to order additional cards

FlexibleBenefit ADMINISTRATORS

P.O. Drawer 8188 • Virginia Beach, VA 23450 • Toll Free (800) 437-3539 • Phone (757) 340-4567 • Fax (757) 431-1155
www.flex-admin.com

Your FBA Benefits Card

With your FBA Benefits Card you have immediate access to pay for your eligible medical expenses. This allows you to avoid the hassle of paying out of pocket for services and then filing a claim for and waiting for a reimbursement check.

Where can I use my card?

Your card can be used at any authorized medical provider who accepts MasterCard. A complete list of authorized providers and retailers is available at www.sig-is.org.

The debit card system is coded to only accept charges from qualified merchants (i.e. doctor's office, dentist's office, pharmacy, online pharmacy, etc.).

Debit card or Credit Card?

You have the option of choosing credit or debit when using your FBA Benefits Card. We recommend you utilize the card as a credit card. If you chose to use the debit option, please visit the online portal and select *My Cards* then *View PIN* to obtain your PIN for debit transactions.

Do I need to submit documentation for my card transactions?

Some transactions made when using the FBA Benefits Card do require you to submit documentation as per IRS Regulations. You only need to submit documentation to us if you receive a notice from our office requesting it. These notices will be sent to you by regular mail or email (if on file).

To receive these notifications by email, please visit the online portal and update your communication preferences.

Can I use my card for Dependent Care?

Yes, the card can be used to pay for eligible expenses from a qualified provider.

Do I need to submit the same documentation for repeat transactions?

If you have recurring expenses such as chiropractic care or allergy shots, you are able to have these transactions coded as recurring in our system. This allows us to automatically substantiate your transaction based on the documentation you will submit with the first charge.

Remember that recurring expenses can only be coded in our system if those transactions match the exact dollar amount at the same merchant/provider as the previous charge. Recurring expense coding will renew automatically from plan year to plan year.

How do I request an additional card for my dependents?

Please contact our office to request an additional card for your eligible dependents. Requests can be made by email, mail or by fax.

I received a request for documentation, what do I need to send?

IRS regulations require substantiation for any card swipe that does not equal a 'standard' co-payment amount (i.e. $10,$20,$35, etc.) or is not a recurring expense that was previously reviewed. Co-insurance will generally not match "standard" co-payment amounts.

When submitting your documentation, please ensure it includes the following:

- Date of Service
- Patient/Dependent's Name
- Amount Charged
- Provider/Merchant's Name
- Prescription Number/Name (if applicable)
- Nature of Expense

Remember cash register receipts are only acceptable for over-the-counter items and Prescription Expenses.

Can I use my card for my orthodontic payments?

Absolutely! Once you receive your ortho contract, just send a copy to our office and we will update your account. Each month that you charge your orthodontic contract payment to your card it will be automatically approved. Remember that your card swipe must match the payment plan in your contract in order for it to be automatically approved.

Why was my card declined?

There are several reasons your card may be declined.

- No available balance
- Ineligible Service Provider
- Expired Card
- Card has been Deactivated

We encourage you to review your account activity through the online portal and mobile app to ensure you have an available balance. If you need assistance with a card being declined please contact our office.

Did You Know?

How do I activate my card?

Your new card will be activated upon your first swipe. Your plan year election will automatically load on your card with your new annual election amount.

When does my card expire?

Your card is valid for three years as long as you are enrolled in the plan. We will mail you a new card prior to the new plan year if your card expires.

How do I replace a lost or stolen card?

You can report your card lost/stolen and order a replacement card through our online portal or by contacting our office at 800-437-3539.

How do I review my card transactions?

Our online portal and mobile app offer you real time access to your account transactions and balance. Log-in to mywealthcareonline.com/fba or download the mobile app for your smartphone or tablet from Google Play or iTunes Store by searching for *FBA Mobile*.

Get **CONNECTED** *with your account… wherever, whenever.*

***Introducing**… our convenient participant web site! With the online WealthCare Portal you can view your account status, submit claims and report your benefits card lost/stolen right from your computer.*

Follow the simple steps outlined below to establish your secure user account.

- Get started by visiting www.mywealthcareonline.com/fba and click the new user link.
- You will be directed to the registration page.
- Follow the prompts to create your account.
  - Name
  - Email Address
  - Employee ID (Your SSN, no spaces/dashes)
  - Employer ID (FBALWRN or your benefits card number)
- Once completed, please proceed to your account.

Contact Us: 800-437-3539

Or email flexdivision@flex-admin.com

We're Going Mobile for You!

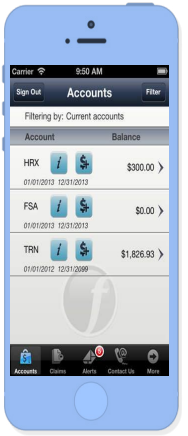
Mobile App for

Flexible Benefit Administrators, Inc.

The mobile app from FBA provides a single access point for you to manage your FSA / HRA/HSA/Transit benefit accounts! Now get up to the minute info when you want it, where you want it... on the go!

FEATURES

- Check your account details
- View recent transactions
- Confirm reimbursements
- Upload receipts by taking a photo
- View account notices and alerts
- Contact FBA through the app



Download for your Apple Product

Download for your Android Product

Ameritas Dental Plan

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

TYPE I - PREVENTIVE AND DIAGNOSTIC* - Type I benefits are payable at 100% U & C* **No deductible applies**

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

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

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

TYPE III- MAJOR PROCEDURES* - Type III Benefits are payable at 50% U & C* **$50.00 deductible applies**

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

ORTHODONTIA* - Paid at 50% U & C* with a $1,000 lifetime maximum. **No deductible applies**

LATE ENTRANT PROVISION
*There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

80-90-100% INCENTIVE PLAN
Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type I (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each calendar year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80%

* U & C- Usual and Customary

coinsurance level during the next calendar year and must begin to progressively advance to the next level as described above.

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

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

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

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

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES
You are eligible for insurance if you are a full-time active employee working at least 37.5 hours per week.

ELIGIBLE DEPENDENTS
Provides Coverage On:

- Your Spouse
- Children up to age 26

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

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

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

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

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

ORTHODONTIA LIMITATIONS (This is not a complete list)
No benefit is payable for expenses incurred:
- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

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

SEMI- MONTHLY RATES

Employee Only	No Cost (Paid by the City)
Family	$23.07

FOR CLAIMS/CUSTOMER SERVICE QUESTIONS CONTACT AMERITAS AT:
800-487-5553
Website: www.ameritasgroup.com
This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan

Outline of Benefits – Gold Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)
Copayment: $10.00 Exam
$10.00 Materials[1]
$25.00 Contact Lens Fitting Fee

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

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

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

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam *(by an Ophthalmologist)*	12 Months	Covered in Full	Up to $34.00
Comprehensive Exam *(by an Optometrist)*	12 Months	Covered in Full	Up to $26.00
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to $32.00
Bifocal	12 Months	Covered in Full	Up to $46.00
Trifocal	12 Months	Covered in Full	Up to $57.00
Lenticular	12 Months	Covered in Full	Up to $90.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lense Fitting Fee[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames (Standard)[3]	24 Months	Up to $150.00	Up to $78.00

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

Discount Features

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

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

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

Discounts on Non-Covered Exams and Materials

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

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

Refractive Surgery

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

Items or Services Not Covered

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

Please confirm the details of your employer's plan prior to seeking services.

5. Discounts and maximums may vary by lens type. Please check with your provider.
*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Master Policy and Certificate of Coverage by contacting your Human Resources/Employee Benefits Office.

SEMI-MONTHLY COST - FULL SERVICES PLAN

Employee Only	$ 4.87
Employee + 1 Dependent	$ 9.45
Employee + Family	$13.88

Member Services, Provider Listings and Claims Services:
(800) 507-3800
(916) 852-2277 fax

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

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

Claim Administration
P.O. Box 967
Rancho Cordova, CA 95741

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

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

SUPERIOR VISION

See yourself healthy.

Allstate Benefits Group Cancer Plan

In the United States, about 1,685,210 million new cancer cases were expected to be diagnosed in 2016. [1]

Group Voluntary Cancer

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

Meeting Your Needs:

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

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

Benefit Coverage Highlights

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

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

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

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

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

*Primary insured only
**List of covered diseases on the following page

[1] Cancer Facts & Figures, American Cancer Society, 2016

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

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

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

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

Government or Charity Hospital
A $100 benefit will be paid for each day a covered person is confined to:
(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or (2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

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

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

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

[2] Cancer Facts & Figures, American Cancer Society, 2016.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospice Care
A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified

disease, is expected to live 6 months or less and the attending physician has approved services:
(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

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

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

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

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

(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.
(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)
If, while coverage is in force, the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

Bone Marrow or Stem Cell Transplant*
A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person.
(1) A transplant which is other than non-autologous.
(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.
(3) A transplant which is non-autologous for the treatment of Leukemia.

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

ADDITIONAL BENEFIT

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

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)
A one time benefit of $3,000 will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care**

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

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

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

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

*This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.

** This benefit pays a benefit for a covered confinement in a hospital intensive-care unit due to cancer or specified disease from the first day of coverage.

Issue Ages: 18 and older while actively at work.

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

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

Portability Privilege - Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled “Termination of Coverage,” we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination, and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

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

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

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

Pre-Existing Condition, Exclusions and Limitations - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. A Pre-Existing Condition is a disease or condition for which symptoms existed within the 12-month period prior to the effective date. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit. Children born within 10 months of the effective date are not covered for any continuous hospital intensive care unit

confinement that occurs or begins during the first 30 days of such child's life.

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

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

This coverage does not constitute comprehensive health insurance coverage (often referred to as major medical coverage) and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than August 1, 2018. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

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

Allstate Benefits, *The Workplace Marketer ©*
1776 American Heritage Life Drive, Jacksonville, Florida 32224

Customer Care Center: 1.800.521.3535
www.alls efits.com

Allstate®
Benefits

Allstate Benefits Group Voluntary Cancer Premiums

Low Option without Optional Benefits	
Insureds	**Semi-Monthly**
Employee	*$10.04*
Employee + Child(ren)	*$13.86*
Employee + Spouse	*$15.48*
Family	*$19.29*

Low Option with Optional Benefits	
Insureds	**Semi-Monthly**
Employee	*$13.03*
Employee + Child(ren)	*$18.41*
Employee + Spouse	*$20.75*
Family	*$26.12*

High Option without Optional Benefits	
Insureds	**Semi-Monthly**
Employee	*$15.55*
Employee + Child(ren)	*$21.83*
Employee + Spouse	*$23.76*
Family	*$30.02*

High Option with Optional Benefits	
Insureds	**Semi-Monthly**
Employee	*$18.54*
Employee + Child(ren)	*$26.38*
Employee + Spouse	*$29.03*
Family	*$36.85*

Aflac Group Accident Plan

Plan Features

- Benefits are payable regardless of any other insurance programs.
- Coverage is guaranteed-issue, provided the applicant is eligible for coverage.
- The plan features benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits are available for spouse and/or dependent children.
- There's no limit on the number of claims an insured can file.
- Premiums are paid by convenient payroll deduction.
- Coverage is effective on the first of the month following the enrollment form approval date, provided payroll deductions begin during that month.
- 24-Hour Coverage.

Eligibility

Issue Ages

Employee	at least age 18
Spouse	at least age 18
Children	under age 26

Class I

All full-time benefit-eligible employees who are working at least 30 hours or more per week are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26. Seasonal and temporary employees are not eligible.

Class II

A Class I primary insured is eligible for Class II coverage if he:

- Was previously insured under Class I; and
- Is no longer employed by the policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate.

Only dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

The employee may purchase Accident Plus coverage for his spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

A spouse is the person married to the insured on the effective date of this coverage. A spouse means the legal spouse who is at least age 18. A spouse must not be hospitalized or unable to perform his or her normal duties or activities on the date of application and the effective date of coverage.

Dependent child means natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

Guaranteed-Issue

During the initial enrollment, and for newly eligible employees, coverage is guaranteed-issue, provided the applicants are eligible for coverage. Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Accident Benefits - High Option

Complete Fractures		Closed Reduction Benefits
	EMPLOYEE	SPOUSE/CHILD(REN)
Hip/Thigh	$4,500	$4,000
Vertebrae	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (Depressed)	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand/Wrist	$2,250	$2,000
Foot/Ankle/Knee Cap	$2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (Mandible)	$1,800	$1,600
Skull (Simple)	$1,575	$1,400
Upper Arm/Upper Jaw	$1,575	$1,400
Facial Bones (Except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320

If the fracture requires open reduction, we will pay 150% of the amount shown.

A *fracture* is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown.

Multiple fractures refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture. However, we will pay no more than 150% of the benefit amount for the fractured bone which has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown for the affected bone.

The maximum amount payable for the Fracture Benefit per covered accident is 150% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations	Closed Reduction Benefits	
	EMPLOYEE	SPOUSE/CHILD(REN)
Hip	$4,000	$3,000
Knee (not kneecap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

If the dislocation requires open reduction, we will pay 150% of the amount shown.

Dislocation refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan.

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 150% of the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint.

The maximum amount payable for the Dislocation Benefit per covered accident is 150% of the benefit amount for the dislocated joint that has the higher dollar amount.

If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident:

- The insured is injured,
- The injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations	
Up to 2" long	$50
2"–6" long	$200
More than 6" long	$400
Lacerations not requiring stitches	$25

The laceration must be repaired with stitches by a doctor within 14 days after the accident. The amount paid will be based on the length of the laceration.

If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	$250
Removal of foreign body from eye (requiring no surgery)	$50
Tendons/Ligaments* (treatment within 60 days, surgical repair within 90 days) *Single* *Multiple* If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	 $400 $600
Ruptured Disc (treatment within 60 days, surgical repair within one year) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400

Burns *(treatment within 14 days, first degree burns not covered)*	
	Benefit
Second Degree	
Less than 10% of body surface covered	$100
At least 10%, but not more than 25% of body surface covered	$200
At least 25%, but not more than 35% of body surface covered	$500
More than 35% of body surface covered	$1,000
Third Degree	
Less than 10% of body surface covered	$1,000
At least 10%, but not more than 25% of body surface covered	$5,000
At least 25%, but not more than 35% of body surface covered	$10,000
More than 35% of body surface covered	$20,000
Concussion (A *concussion* or *Mild Traumatic Brain Injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head.(Note: *Concussion* and *MTBI* are used interchangeably. The concussion must be diagnosed by a doctor.)	$200
Coma (state of profound unconsciousness lasting 30 days or more)	$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	$1,000
Exploratory Surgery (without repair, i.e., arthroscopy)	$250
Emergency Dental Work (injury to sound, natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50

Medical Fees *(for each accident)*	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for X-rays or doctor services.

For benefits to be payable, because of a covered accident, the insured must be injured and receive initial treatment from a doctor within 14 days after the accident.

We will pay the Medical Fees Benefit:

- For treatment received due to injuries from a covered accident **and**
- For each covered accident up to one year after the accident date.

Emergency Room Treatment	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room **and**
- Receives initial treatment within 14 days after the covered accident.

This benefit is payable only once per 24-hour period and only once per covered accident.

We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit	
Employee or Spouse	$75
Child(ren)	$45

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, **and**
- Is held in a hospital for observation for at least 24 hours, **and**
- Receives initial treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-Up Treatment	$25

We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 14 days of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy	$25

We will pay the amount shown for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 14 days of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-up Treatment benefit is paid.

Air Ambulance	$500
Ambulance	$100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

Transportation (within 90 days)	
Train or Plane	$300
Bus	$150

If hospital treatment or diagnostic study is recommended by your physician and is not available in the insured's city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood/Plasma	$100

If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis	$500

If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids—including false teeth—are not covered.

Appliance $100

We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

Family Lodging Benefit (per night) $100

If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, we will pay the amount shown for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness $60

This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams.
- Mammograms.
- Pap smears.
- PSA tests.
- Ultrasounds.
- Blood screenings.
- Eye examinations.
- Immunizations.
- Flexible sigmoidoscopies.

Hospital Admission $1,000

We will pay the amount shown, when because of a covered accident, the insured:

- Is injured,
- Requires hospital confinement, **and**
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day) $200

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day)	$400

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, **and**
- Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same Injury is 30 days.

This benefit is payable in addition to the Hospital Confinement Benefit.

Accidental Death & Dismemberment (within 90 days)			
	Employee	Spouse	Children
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

- Loss of a hand – The hand is cut off at or above the wrist joint; **or**
- Loss of a foot – The foot is cut off at or above the ankle; **or**
- Loss of sight – At least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; **or**
- Loss of a finger/toe – The finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death – If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

- An airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; **or**
- A railroad train which is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

GROUP ACCIDENT+ INSURANCE
Policy Series CA7800

ACG

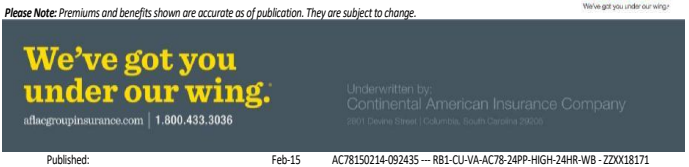
City of Lawrenceburg

HIGH OPTION - 24 HOUR PLAN	Semimonthly (24pp/yr)
Employee	$8.10
Employee and Spouse	$11.58
Employee and Dependent Children	$15.45
Family	$18.93

Wellness Benefit included in Rates

Aflac
We've got you under our wing.

Please Note: *Premiums and benefits shown are accurate as of publication. They are subject to change.*



Published: Feb-15 AC78150214-092435 --- RB1-CU-VA-AC78-24PP-HIGH-24HR-WB - ZZXX18171

Limitations and Exclusions

We will not pay benefits for injury, total disability, or death contributed to, caused by, or resulting from:

- ***War –*** *participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.*
- ***Suicide –*** *committing or attempting to commit suicide, while sane or insane.*
- ***Sickness –*** *having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.*
- ***Self-Inflicted Injuries –*** *injuring or attempting to injure yourself intentionally.*
- ***Racing –*** *riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.*
- ***Intoxication –*** *being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a Doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.)*
- ***Illegal Acts –*** *participating or attempting to participate in an illegal activity, or working at an illegal job.*
- ***Sports –*** *participating in any organized sport –professional or semi-professional.*
- ***Cosmetic Surgery –*** *having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a covered accident***.**

Terminations

An employee's coverage will terminate on whichever occurs first:

- *The date the plan is terminated, for Class I insureds;*
- *The 31st day after the premium due date if the required premium has not been paid;*
- *The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or*
- *The date he is no longer a member of the Class eligible for coverage.*

Insurance for dependents will terminate on the earliest of the following:

- *The date the Plan is terminated, for dependents of Class I insureds;*
- *The 31st day after the premium due date, if the required premium has not been paid;*
- *The date the spouse or dependent child ceases to be a dependent; or*
- *The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.*

If the master policy and/or certificate terminates, we will provide coverage for claims arising from covered accidents that occurred while the plan was in force.

Definitions

***Accidental Injury** or **Injuries** means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of covered accident.*

***Actively at Work** is defined as your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.*

***Calendar Year** is defined as January 1 through December 31 of the same year.*

***Covered Accident** means an unforeseen and unexpected traumatic event resulting in bodily Injury. An event meets the qualifications of covered accident if it:*

- *Occurs on or after the Plan's Effective Date,*
- *Occurs while coverage is in force, **and***
- *Is not specifically excluded.*

***Dependent child** means dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.*

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the child's 26th birthday.

***Doctor** is defined as a person who is:*

- *Legally qualified to practice medicine,*
- *Licensed as a physician by the state where treatment is received, **and***
- *Licensed to treat the type of condition for which a claim is made.*

A doctor does not include you or your family member.

***Employee** is a person who meets eligibility requirements in the master policy, and who is covered under this plan. The employee is the primary insured under this plan.*

***Family member** (as referenced under the definition of Doctor and the Family Lodging Benefit) includes the employee's spouse, who is defined as an employee's legal wife or husband, as well as the following members of the insured's immediate family:*

- *Son.*
- *Daughter.*
- *Mother.*
- *Father.*
- *Sister.*
- *Brother.*

This includes step-family members and family-members-in-law.

***Hospital** refers to a place that:*

- *Is legally licensed and operated as a hospital;*
- *Provides overnight care of injured and sick people;*
- *Is supervised by a doctor;*
- *Has full-time nurses supervised by a registered nurse;*
- *Has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; **and***
- *Maintains permanent medical history records.*

*A hospital is **not:***

- *A nursing home;*
- *An extended-care facility;*

- *A convalescent home;*
- *A rest home or a home for the aged;*
- *A place for alcoholics or drug addicts;* ***or***
- *A mental institution.*

Hospital Intensive Care Unit *refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured, Hospital intensive care units must be:*

- *Separate and apart from the surgical recovery room;*
- *Separate and apart from rooms, beds, and wards customarily used for patient confinement;*
- *Permanently equipped with special life-saving equipment to care for the critically ill or injured;* ***and***
- *Under constant and continuous observation by nursing staffs assigned to the intensive care units on an exclusive, full-time basis.*

Psychiatrist *is a doctor of medicine who specializes in the diagnosis and treatment of mental disorders.*

Psychologist *is a clinical mental health professional who works with patients and is not a doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.*

Rehabilitation Unit *is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.*

Spouse *is the legal wife or husband who is at least age 18 and who is named on the enrollment application. Coverage on your spouse terminates when he or she attains age 70.*

Treatment or Medical Treatment *is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.*

Your Occupation *means the occupation in which you are regularly engaged at the time you become disabled.*

Notices

This booklet is a brief description of coverage, not a contract. Read your policy carefully for exact plan language, terms, and conditions.

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

Notice to Consumer*: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.*

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

Aflac Group Critical Illness Plan

What is the need for Critical Illness Insurance?

Heart attack, stroke, or end-stage renal failure that requires dialysis may all be life-changing events. Major medical coverage will help with a portion of the medical expenses, but what about the out-of-pocket costs?

Consider an employee who has a stroke. Will major medical insurance, life insurance, or disability insurance help pay for helpful aids for stroke patients, such as a home wheelchair access ramp?

The employee can heal from the covered critical illness. Critical Illness insurance can help with the out-of-pocket and daily living costs.

Group Critical Illness insurance provides a lump sum benefit upon the diagnosis of not only one covered illness, but for each covered critical illness.

Plan Features

- Lump sum benefits paid directly to the insured, unless otherwise assigned, following the diagnosis of each covered critical illness.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-Issue available to employee and spouse.
- Each dependent child is covered at 50% of the primary insured amount at no additional charge.
- Benefit amounts are available from $5,000 up to $50,000 for employees and $25,000 for spouse.
- An Annual Health Screening benefit is included.
- The plan is portable, which means employees can take their coverage with them if they change jobs or retire.
- Level premium rates are based upon the applicant's age as of the time of application. Rates cannot be individually increased on a particular insured due to a change in age, health, or individual claim.
- Additional Benefits Rider
    - Coma
    - Paralysis
    - Severe Burn
    - Loss of Sight
    - Loss of Hearing
    - Loss of Speech
- Heart Event Rider

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-Issue

Guaranteed-Issue is offered during the initial enrollment and for new hires. The following options are available for Guaranteed-Issue for the first three years.

Up to $10,000 for employees and up to $5,000 for spouses with no participation requirement.

Modified Guaranteed-Issue

For employee amounts over $10,000 and spouse amounts over $5,000:

All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the Guaranteed-Issue limit.

Individual Eligibility

Issue Ages

Employee	18-69
Spouse	18-69
Children	under age 26

Benefit-eligible employees, working at least 30 hours or more weekly, with at least 0 days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, his spouse is eligible for coverage and all children of the insured who are younger than 26 years of age are eligible. Seasonal and temporary workers are not eligible to participate.

Class I
All full-time and part-time benefit-eligible employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

Class II
A Class I primary insured is eligible for Class II coverage if he:

- Was previously insured under Class I; and
- Is no longer employed by the policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate.

Only dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. The spouse amount is 50% of the employee amount not to exceed $25,000 maximum benefit. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary Insured and is limited to face amounts of $5,000 and $25,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 50% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured.

Children-only coverage is not available. Please see the Definitions section for a complete definition of *dependent children.*

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Terminations

An employee's insurance will terminate on the earliest of the following:

1. The date the plan is terminated, for Class I insureds;
2. The 31st day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for dependents of Class I insureds;
2. The 31st day after the premium due date, if the required premium has not been paid;
3. The date the spouse or dependent child ceases to be a dependent; or
4. The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

Group Critical Illness Benefits

First Occurrence Benefit – After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness if the date of diagnosis is while coverage is in force **and** the certificate does not exclude the illness or condition by name or by specific description.

We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

Covered Critical Illnesses	
Illnesses Covered Under Plan	**Percentage of Face Amount**
Heart Attack	100%
Major Organ Transplant	100%
Kidney Failure (End-Stage)	100%
Stroke	100%
Coronary Artery Bypass Surgery+	25%

Separate Diagnosis Benefit – We will pay benefits for each **different** critical illness after the first when the following conditions are met: The two dates of diagnosis must be separated by at least 6 months.

Reoccurrence Benefit – Once benefits have been paid for a critical illness, we will pay additional benefits for that **same** critical illness when the dates of diagnosis are separated by at least 12 months.

+ Payment of the partial benefit for coronary artery bypass surgery will reduce by 25% the benefit for a heart attack.

Health Screening Benefit $100

After the Waiting Period, we will pay $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Health screening tests include, but are not limited to, the following:

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

Additional Benefits Rider

Covered Illnesses	
Illnesses Covered Under Plan	**Percentage of Maximum Benefit**
Coma	100%
Paralysis	100%
Severe Burn	100%
Loss Sight	100%
Loss of Hearing	100%
Loss of Speech	100%

We will pay the specified critical illness benefit if the insured is diagnosed with one of the specified critical illnesses shown in the rider schedule if the date of diagnosis is after the waiting period, the date of diagnosis occurs while the rider is in force, and the specified critical illness is not excluded by name or specific description in the rider. We will not pay benefits under the rider if these conditions result from another specified critical illness.

Heart Benefit

Covered Surgeries and Procedures	
Coronary Artery Bypass Surgery	100%
Mitral valve replacement or repair	100%

Illnesses Covered Under Plan	Percentage of Maximum Benefit
Category 1**	
Aortic valve replacement or repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Category 2	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent implantation	10%
Cardiac catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemaker Placement	10%

We will pay the applicable category I or category II benefit if the insured is treated with one of the procedures shown on the rider schedule as long as the date of treatment is after the waiting period, treatment is incurred while the rider is in force, treatment is recommended by a physician, **and** it is not excluded by name of specific description in the rider. Benefits are not payable under the rider for loss if these conditions result from another specified critical illness other than heart attack. For heart attack, we will pay applicable benefits. Payment of initial, reoccurrence, or separate diagnosis benefits are subject to the benefit provisions section of the certificate.

This 100% represents the combination of total of applicable benefits available in the rider ***and* benefits available in the certificate (for the same conditions). When combined, benefits from the rider and certificate ***will not exceed 100%*** of the maximum applicable benefit. Note that the 25% Coronary Artery Bypass Surgery (CABS) partial benefit in your base certificate is increased to 100% with this rider. The CABS benefit in this Rider, combined with the benefit in your base certificate, equal 100% of the maximum benefit—***not 125%.***

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Category I and a Category II procedure are performed at the same time, benefits are eligible only at the 100% (higher) event and will not exceed the applicable face amount shown on the benefit schedule in the certificate. An insured is eligible to receive only one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least 6 months for benefits to be payable for multiple covered procedures.

Rate sheet prepared by Web User on 11/11/2014
11:50:55 AM. Tennessee Payroll Premium rates are
Semi-Monthly.
Aflac Group coverage is underwritten by Continental American Insurance Company (CAIC). 1-800-433-3036

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON-TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.68	$3.60	$4.53	$5.45	$6.38	$7.30	$8.23	$9.15	$10.08	$11.00
30-39	$3.28	$4.80	$6.33	$7.85	$9.38	$10.90	$12.43	$13.95	$15.48	$17.00
40-49	$4.85	$7.95	$11.05	$14.15	$17.25	$20.35	$23.45	$26.55	$29.65	$32.75
50-59	$6.73	$11.70	$16.68	$21.65	$26.63	$31.60	$36.58	$41.55	$46.53	$51.50
60-69	$9.75	$17.75	$25.75	$33.75	$41.75	$49.75	$57.75	$65.75	$73.75	$81.75

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON- TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.68	$3.14	$3.60	$4.06	$4.53	$4.99	$5.45	$5.91	$6.38
30-39	$3.28	$4.04	$4.80	$5.56	$6.33	$7.09	$7.85	$8.61	$9.38
40-49	$4.85	$6.40	$7.95	$9.50	$11.05	$12.60	$14.15	$15.70	$17.25
50-59	$6.73	$9.21	$11.70	$14.19	$16.68	$19.16	$21.65	$24.14	$26.63
60-69	$9.75	$13.75	$17.75	$21.75	$25.75	$29.75	$33.75	$37.75	$41.75

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.15	$4.55	$5.95	$7.35	$8.75	$10.15	$11.55	$12.95	$14.35	$15.75
30-39	$4.18	$6.60	$9.03	$11.45	$13.88	$16.30	$18.73	$21.15	$23.58	$26.00
40-49	$7.90	$14.05	$20.20	$26.35	$32.50	$38.65	$44.80	$50.95	$57.10	$63.25
50-59	$11.58	$21.40	$31.23	$41.05	$50.88	$60.70	$70.53	$80.35	$90.18	$100.00
60-69	$17.05	$32.35	$47.65	$62.95	$78.25	$93.55	$108.85	$124.15	$139.45	$154.75

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.15	$3.85	$4.55	$5.25	$5.95	$6.65	$7.35	$8.05	$8.75
30-39	$4.18	$5.39	$6.60	$7.81	$9.03	$10.24	$11.45	$12.66	$13.88
40-49	$7.90	$10.98	$14.05	$17.13	$20.20	$23.28	$26.35	$29.43	$32.50
50-59	$11.58	$16.49	$21.40	$26.31	$31.23	$36.14	$41.05	$45.96	$50.88
60-69	$17.05	$24.70	$32.35	$40.00	$47.65	$55.30	$62.95	$70.60	$78.25

Rates do not include cancer benefit.

Rates include $100 Health Screening Benefit.

Limitations and Exclusions, Definitions, and Notices

Limitations and Exclusions

The plan contains a 30-day waiting period. This means that we will not pay benefits to an insured who has been diagnosed or had a health screening test performed before his coverage has been in force 30 days from the effective date. If a critical Illness is first diagnosed during the waiting period, we will only pay benefits for loss beginning after coverage has been in force for 12 months. Or, the insured may elect to void the certificate from the beginning and receive a full premium refund.

Pre-Existing Conditions Limitations*

Pre-existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment or caused symptoms for which an ordinarily prudent person would seek medical advice or treatment.

We will not pay benefits for any condition or critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition.

A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A condition will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Exclusions

We will not pay for loss due to any of the following:
- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; or
- Pre-Existing Conditions (except as stated above).

No benefits will be paid for loss which occurred prior to the effective date.

No benefits will be paid for diagnosis made or treatment received outside of the United States.

Additional Benefits Rider Exclusions:

The coverage in this plan summary contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before his or her coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that medically related specified critical illness will apply only to loss commencing after 12 months from the effective date; or, you may elect to void the certificate from the beginning and receive a full refund of premium. The date of diagnosis of a specified critical illness must be separated from the date of diagnosis of a subsequent different critical illness by at least 6 months. The applicable benefit amount will be paid if the date of diagnosis is after the waiting period; the date of diagnosis occurs while the rider is in force; and the cause of the illness is not excluded by name or specific description. Benefits will not be paid for loss due to: (1) Intentionally self-inflicted injury or action; (2) Suicide or attempted suicide while sane or insane; (3) Illegal activities or participation in an illegal occupation; (4) War, whether declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or (5) Substance abuse. No benefits will be paid for diagnosis made outside the United States. No benefits will be paid for loss which occurred prior to the effective date of the rider. Unless amended the by Additional Benefits Rider, certificate definitions and terms and other provisions apply.

Heart Event Rider Exclusion:

The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium.

Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness.

Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Payment of the Category I benefit will terminate the rider. If a Category II benefit is paid first this will reduce the benefit amount payable for a subsequent Category I procedure. If a Category I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the Initial Face Amount shown on the Rider Schedule. The total amount of benefits payable under the rider is limited to the initial face amount at your applicable age.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's effective date, resulted in the insured receiving medical advice or treatment.

We will not pay benefits for any surgical procedure occurring within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition.

A claim for benefits for loss starting after 12 months from an insured's effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date. Any benefits for coronary artery bypass surgery denied under the coverage due to preexisting conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

EXCLUSIONS

No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for loss which occurred prior to the effective date of coverage. Diagnosis must be made and treatment received in the United States.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

Definitions

The Effective Date of your insurance will be the date shown on the certificate schedule.

Employee means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband.

Dependent Children means your natural children, step-children, legally adopted children or children placed for adoption, who: are unmarried; are chiefly dependent on you or your spouse for support; are younger than age 26. "Children" also includes dependent children, regardless of age, who: are mentally or physically handicapped; became or become handicapped prior to age 26; and cannot support themselves because of their handicap.

If your children are covered under this Rider, your children born after the effective date of the certificate will also be covered from the moment of live birth. No notice or additional premium is required.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria:
1. New and serial eletrocardiographic (EKG) findings consistent with myocardial infarction; 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after the coverage effective date. Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia. We will pay a benefit for stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable waiting period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

End-Stage Renal Failure means the end-stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The kidney failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a critical illness. It doesn't include an insured or their family member.

Additional Benefit Rider Definitions

Coma means a state of unconsciousness for 30 consecutive days with:
• No reaction to external stimuli; • No reaction to internal needs; and• The use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician.

A **full-thickness or third-degree burn** is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.

Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

Heart Rider Definitions

Category I – Specified Surgeries of the Heart

Open Heart Surgery means undergoing open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. Benefits are paid for the following open heart surgery procedures only:

Coronary Artery Bypass Surgery (also coronary artery bypass graft surgery, or bypass surgery) is a surgical procedure performed to relieve angina and to reduce the risk of death from coronary artery disease.

Off-Pump Coronary Artery Bypass (OPCAB) is a form of bypass surgery that does not stop the heart or use the heart-lung machine.

Coronary Artery Bypass Grafting (CABG) is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this rider.

Mitral Valve Replacement or Repair is a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.

Aortic Valve Replacement or Repair is a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.

Surgical Treatment of Abdominal Aortic Aneurysm is a procedure performed to prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stent implantation, or other surgical and nonsurgical procedures.

Category II Benefits (Invasive, Procedures and Techniques of the Heart) are paid for the following procedures only:

AngioJet Clot Busting is used to clear blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up, and simultaneously drawing it out.

Balloon Angioplasty (or Balloon Valvuloplasty) is used to open a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

Laser Angioplasty is similar to Balloon Angioplasty. A laser tip is used to burn/break down plaque in the clogged blood vessel.

Atherectomy is used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Stent Implantation is where a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.

Cardiac Catheterization (also Heart Catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest, where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

Pacemakers refers to the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when a heart's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate. Only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II benefits exclude all procedures not specifically listed above.

Notice to Consumer:
This booklet is a brief description of coverage, not a contract. Read your policy carefully for exact plan language, terms, and conditions.

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

The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

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

AUL Short Term Disability Plan

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

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

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.[1]
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.[1]
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.[1]

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

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.[2]
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

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

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

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

1 National Safety Council, Injury Facts, 2003 Edition
2 American Cancer Society, Cancer Facts & Figures 2004
3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update
4 American Lung Association, Lung Disease Data 2003
5 National Underwriter, May 2002

Class Description
All Full-Time Eligible Employees working a minimum of 37.5 hours per week, electing to participate in the Voluntary Short Term Disability Insurance.

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

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly benefit is $500.

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

Benefit Duration
This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks.

Basis of Coverage
24 Hour Coverage, on or off the job.

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

Annual Enrollment
Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1000 monthly benefit without medical questions, subject to pre-existing exclusion. Employees may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

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

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

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career)

Exclusions and Limitations

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

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

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200

South Portland, ME 04106

Fax: 1-844-287-9499

OneAmerica.claims@customdisability.com

Toll Free Phone 1-855-517-6365

For a copy of your policy certificate or claim form, please visit www.markiiibrokerage.com/cityoflawrenceburgtn

ONEAMERICA®

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

AUL Short Term Disability
Semi-Monthly Rates

Benefit Duration*:*
13 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.28
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.53
$1,600	$16.57
$1,700	$17.60
$1,800	$18.64
$1,900	$19.67
$2,000	$20.71

AUL Long Term Disability Plan

LTD Class Description
All Full-Time Eligible Employees working a minimum of 37.5 hours per week, electing to participate in the Voluntary Long Term Disability Insurance.

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

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

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

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

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

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

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

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

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

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

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling 800-553-5318.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career)

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

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

AUL Long Term Disability	
Monthly Benefit	**Semi-Monthly Rate**
$500	$3.20
$1,000	$6.40
$1,500	$9.60
$2,000	$12.80

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

American United Life Insurance Company

c/o Custom Disability Solutions

600 Sable Oaks Drive, Suite 200

South Portland, ME 04106

Fax: 1-844-287-9499

OneAmerica.claims@customdisability.com

Toll Free Phone 1-855-517-6365

For a copy of your policy certificate or claim form, please visit www.markiiibrokerage.com/cityoflawrenceburgtn

Plan Highlights

Group Basic Life and AD&D, Supplemental and Dependent Life Insurance

City of Lawrenceburg

ELIGIBILITY

You are a member if you are an active employee of the City of Lawrenceburg and regularly working at least 30 hours each week OR an active Mayor or City Council member of the City of Lawrenceburg.

Dependents: You must be insured in order for Dependents to be covered.

Dependents are:

- your legal spouse not legally separated or divorced from you or your domestic partner.
- your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).

*natural and adopted children; stepchildren and foster children in your custody.

Age limit does not apply to handicapped children.

- A person may not have coverage as both an Employee and Dependent.
- Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Basic Life and AD&D

$30,000

Supplemental Life

Choose from a minimum of $10,000 to a maximum of $300,000 in $10,000 increments

Amounts of life insurance equal to $150,000 or more may be subject to an earnings cap.

Dependent Life

Spouse $10,000

(spouse amount may not exceed 50% of employee amount)

Dependent Child(ren)

Birth to age 20 : $4,000

(up to age 26 if a full-time student)

GUARANTEED ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee: $150,000

Spouse: $10,000

Child: all child amounts are guaranteed issue

CONTRIBUTION REQUIREMENTS

Basic Life (and AD&D):

Coverage is 100% employer paid.

Supplemental Life:

Coverage is 100% employee paid.

Spouse: Coverage is employer paid

Dependent Child(ren): Coverage is employer paid

AD&D SCHEDULE

For Accidental Loss of:	Amount Payable:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Speech and hearing	100%
One hand or One foot	50%
Sight of one eye	50%
Speech or hearing	50%

BENEFIT REDUCTION DUE TO AGE (applicable to employee/spouse coverage)

Age	Original Benefit Reduced To
70	50%

RATE

See attached Rate Sheet.

FEATURES

- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Air Bag Benefit
- Portability
- Seat Belt Benefit
- Waiver of Premium

VALUE ADDED SERVICES

- Travel Assistance Service

EXCLUSIONS

AD&D EXCLUSIONS:

AD&D benefits will not be payable for a loss: caused by suicide or intentionally self-inflicted injuries; caused by or resulting from war or any act of war, declared or undeclared; to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor;

sustained during an insured's commission or attempted commission of an assault or felony; to which the insured's acute or chronic intoxication is a contributing factor; or to which the insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6422, et al.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

City of Lawrenceburg

Basic Life (Employer Paid)
Flat $30,000

AD&D (Employer Paid)
Flat $30,000

DEPENDENT (Employer Paid)
Spouse- $10,000
Child- $ 4,000

SUPPLEMENTAL
Increments of $10,000 up to $300,000

Age of EE	Rates/$1,000
18-24	$0.070
25-29	$0.070
30-34	$0.080
35-39	$0.100
40-44	$0.170
45-49	$0.240
50-54	$0.410
55-59	$0.730
60-64	$1.150
65+	$2.880

To calculate your premium:
1. Amount Elected: Write this amount on the Additional Life requested amount line on your Enrollment and Change Form. Line 1: _____

2. Line 1 divided by $1,000 = Line 2. Line 2: _____

3. Select your rate from the rate table and enter on Line 3. Line 3: _____

4. Line 2 multiplied by Line 3 = Your monthly cost. Line 4: _____

Presented by: Mark III Brokerage Inc.

TOKIO MARINE GROUP

Boston Mutual Life Insurance Employee Life Option (ELOP) Life Plus

BML Whole Life Coverage is effective on the date the application is signed.

GUARANTEED BENEFITS, LEVEL PREMIUMS AND POLICY VALUES
The Employee Life Option is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in whole life insurance with the advantages of cash accumulation at current interest rates. This policy is an endowment at 95 with coverage to age 95.

AFFORDABLE, FLEXIBLE PROTECTION
You choose the amount of insurance or the amount of premium that best suits your needs and budget. All eligible employees and their spouses through age 72 may purchase coverage under the Basic Plan. Weekly deductions range from $2.00-$30.00 per week.

Insurance is also available for your spouse, unmarried dependent children and grandchildren even if you choose not to buy coverage on yourself.

POLICY VALUES*
As long as premiums are paid, your ELOP Basic Plan offers a guaranteed cash value that can grow over the years. The cash value can be used to supplement retirement income, for emergency cash, as an education fund or to provide a paid-up insurance benefit. While this value can never be less than the guaranteed amount, ELOP gives you the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when your policy is issued is guaranteed for the first year. On each policy anniversary date, you will receive an annual statement outlining your policy's accumulated value and changes in the interest rate, if any.
* *The actual cash value may be decreased by loans or withdrawals.*

CONSTANT COVERAGE
ELOP participants are protected worldwide, 24 hours a day. Your policy is owned by you and supplements any other insurance you may have.

BENEFITS YOU CAN KEEP
Once purchased, your ELOP plan remains in force as long as premiums continue to be paid; and your permanent plan premiums cannot be increased. If you change jobs or retire, as long as you continue to pay premiums, your insurance will remain in force without interruption. Boston Mutual will bill you at home and you may choose from several payment options — annual, semi-annual, quarterly, monthly coupon book or monthly automatic check plan.

ACCIDENTAL DEATH BENEFIT (ADB)
This option could *double or even triple* your ELOP death benefit. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage

(up to $100,000). This extra protection is available at affordable rates. Any Basic Plan participant age 5 years through age 60 is eligible for this benefit.

PAYOR WAIVER OF PREMIUM
This benefit pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55 at a cost of 10% of the basic premium for each policy. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.

QUESTIONS AND ANSWERS

CAN I BUY THIS PLAN ON MY OWN?
No! This plan is available only to employees of companies that provide the convenience of payroll deduction for the ELOP plan. Because your employer has chosen to offer ELOP, you receive the advantages of more liberal underwriting and the convenience of payroll deduction. All of this results in savings that reduce the cost of the policies.

DOES THIS POLICY REPLACE MY PRESENT GROUP INSURANCE?
No! ELOP coverage is independent of and supplements your present group insurance program.

IF I LEAVE MY EMPLOYER WHAT HAPPENS TO MY ELOP PLAN?
You can take the ELOP plan with you when you leave with no change in cost or benefits. We will bill you at home.

WHAT HAPPENS IF I CAN'T PAY MY PREMIUM AS A RESULT OF A LEAVE OF ABSENCE OR TERMINATION FROM MY EMPLOYER?
Your policy includes the "Automatic Premium Loan" provision which will be used to pay your premium at the end of your grace period, provided you have accumulated cash value.

WHAT OPTIONS DOES MY ELOP POLICY PROVIDE AT RETIREMENT?
Depending on how long your policy has been in force, you have the following options: (1) continue your premium payments and value accumulation; (2) opt for a paid-up policy; (3) decide to turn your policy in for its accumulated cash value.

CAN I INCREASE MY COVERAGE IN THE FUTURE?
You may apply for additional coverage in the future if you are actively at work with the employer - sponsored company and will be subject to the ELOP underwriting guidelines.

CAN I TAKE A LOAN ON MY POLICY?
Yes. You may borrow all or part of your loan value at an 8% fixed interest rate.

DOES THE ELOP COVERAGE HAVE A SURRENDER CHARGE?
If you discontinue your plan before the 21st policy year, there will be a surrender charge. The amount of this charge decreases every year. No charge is made if you decide to terminate your coverage after it has been in force for at least 20 years.

WILL ELOP BENEFITS BE PAID FOR SUICIDE?
If suicide occurs during the first 2 years your policy is in effect, benefits will not be paid, but any premiums paid will be refunded. After 2 years, benefits will be paid if death is caused by suicide.

CONSIDER....

IF YOU HAVE A FAMILY
The ELOP plan enables you to build a cash reserve for yourself, your spouse and your children for less than 1 hour's pay per week. It is a sound way to protect your family without exceeding your present budget.

IF YOU'RE SINGLE WITH NO DEPENDENTS
For a single working person insurance is the foundation for future financial planning. The longer you wait to buy insurance the more expensive it will be. The flexibility of the ELOP plan enables you to expand your coverage to meet future responsibilities.

IF YOU ARE OLDER AND NEARING RETIREMENT
A lot of obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your ELOP plan can be continued after retirement.

No matter where you are in your life and career, you will benefit from ELOP – Life Insurance that Works for Life.

GUARANTEED ISSUE

Employee: up to $15 per week

Spouse: up to $3/ $5* per week
•Must be able to answer NO to "During the past six months, has your spouse been seen or treated, including testing, in a hospital or any other medical facility, exluding physicians' offices for routine medical care?"

*Employee must purchase $5 in order for the spouse to be eligible for $5

Children: up to $3 per week
•Child must be between ages 15 days and 25 years old to be eligible for coverage.

Grandchildren: up to $3 per week
•Grandchildren must be between ages 15 days and 15 years old to be eligible for coverage.

For questions concerning this policy please contact:

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, MA 02021

(800) 669-2668 • (781) 828-7000
Extension 222 - Customer Service

Web site: www.bostonmutual.com

BOSTON MUTUAL
LIFE INSURANCE COMPANY SINCE 1891

Policy Series ICC13 END-95(ESO) (3/13) and END-95 (ESO) 3/13

Continuation of Benefits

FBA Flexible Spending Accounts

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Spending Accounts at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting the COBRA option.

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not inccurred prior to the date of termination. For more detailed information, please call your ***Benefits Department at 931-762-4459****.*

Ameritas Dental & Superior Vision

Under the Ameritas Dental & Superior Vision plans, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the dental or vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child turns 26 years old. You will receive notification from Interactive Medical Systems with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact your ***Benefits Department at 931-762-4459.***

Reliance Standard Term Life

Conversion: *The conversion privilege gives an Insured the right, under certain conditions, to continue life insurance protection under a non-term permanent insurance policy. We require no medical examination or other evidence of insurability – regardless of age or state of health – as long as application is made and the first premium is paid within 31 days of termination of insurance coverage.*

Portability Of Insurance: *If the Insured's coverage terminates because he/she ceases to be eligible (other than termination of the policy, the Insured's retirement or if applicable, the Insured Dependent having reached the maximum age), he/she may elect to continue coverage in effect prior to ceasing to be eligible up to the plan maximum amount of coverage stated in the policy or $500,000, whichever is less. Evidence of insurability is not required. Dependent coverage, if applicable, may not be ported independent of the Insured. The Insured must have been covered for twelve (12) months (including time insured under the prior group policy, if applicable), cannot be approved for Waiver of Premium, terminated under Waiver of Premium for age and portability must be elected within thirty-one (31) days from the date coverage terminates. Provided premium payment is made, ported insurance will terminate on the first of the following to occur: (1) two (2) years from the date the coverage was ported; (2) policy termination; (3) the date the Insured is covered under another group plan; or (4) the date the Insured reaches the age specified; unless otherwise reflected under the benefit Descriptions on the Plan Description & Summary of this proposal. Premium for this coverage will be based on rates charged for ported coverage and billed directly to the Insured on a quarterly basis.*

To get additional information, please contact Reliance Standard Insurance Company at ***1-800-351-7500.***

AUL Disability

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for one year without evidence of insurability. You have 31 days from your date of termination to apply for portability by calling ***1-800-553-5318.***

To Continue Other Policies

You may continue your Aflac Group Accident, Aflac Group Critical Illness, Allstate Benefits Cancer and Boston Mutual Whole Life policy by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home.

For more information, contact:

Aflac at ***1-800-433-3036***
Allstate Benefits at ***1-800-521-3535***
Boston Mutual at ***1-800-669-2668***

Contact Information for Questions and Claims

Aflac
(CAIC a proud member of the Aflac family of insurers)
2801 Devine Street • Columbia, South Carolina 29205
Customer Service
1-800-433-3036
Aflacgroupinsurance.com

Allstate Benefits
1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your certificate please call:
1-800-521-3535
For questions concerning your claim please call:
1-800-348-4489
or e-mail claimsresearch@allstate.com

American United Life (AUL)
Claims Toll-Free Number
1-855-517-6365
Customer Service
1-800-553-5318

Ameritas Dental
Customer Service
1-800-487-5553
www.ameritas.com

Boston Mutual Life Insurance Company
120 Royall Street • Canton, MA 02021
1-800- 669-2668
1-781- 828-7000
www.bostonmutual.com

Flexible Benefit Administrators

509 Viking Drive, Suite F
PO Box 8188
Virginia Beach, VA 23450
1-800-437-FLEX (1-800-437-3539)
Fax: (757) 431-1155
FlexDivision@flex-admin.com
www.mywealthcareonline.com/fba

Reliance Standard Term Life

General Customer Service, Claims and Evidence of Insurability status can be answered 24/7 on our website www.RelianceStandard.com or through our automated Customer Care System by calling 1-800-351-7500.

Customer Care Representatives are available also at that toll-free number weekdays from 8:00 AM – 7:00 PM Eastern Time. You may also email Customer Care directly at: Customer.Service@rsli.com.

Superior Vision Services

11101 White Rock Road
Rancho Cordova, CA 95670
1-800-507-3800
www.superiorvision.com
Non-Network Claims Submission:
P.O. Box 967
Rancho Cordova, CA 95741

Mark III Brokerage

114 E. Unaka Ave.
Johnson City, TN 37601
1-800-532-1044 x207
www.markiiibrokerage.com/cityoflawrenceburgtn