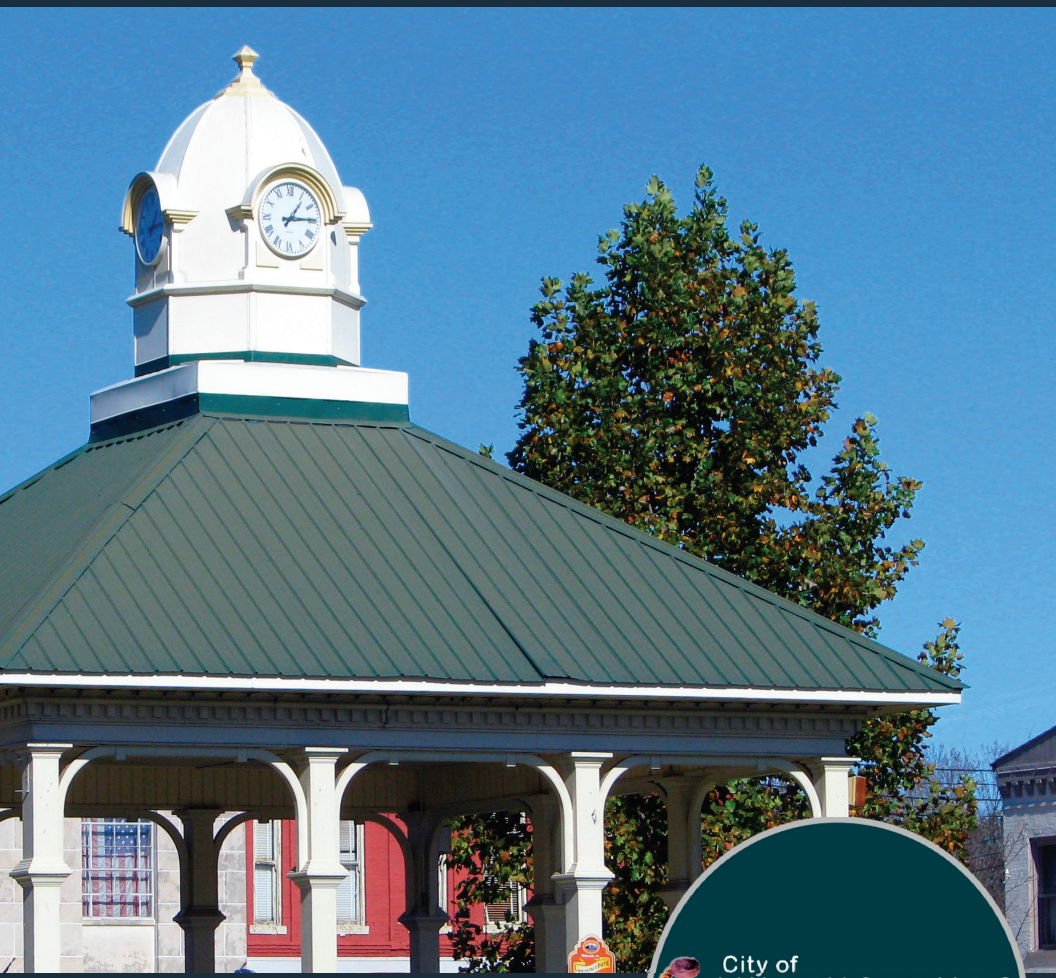
Mark III
Employee Benefits



City of
LAWRENCEBURG
TENNESSEE

Plan Year: January 1, 2018 - December 31, 2018
Arranged and Enrolled by Mark III Brokerage, Inc.

Employee Benefits

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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

Get reimbursed for out-of-pocket healthcare and child/aged adult day care 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,approximately $27.65 to $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, 2018 and ends on December 31, 2018. 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 following your plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

ELECTION CHANGES

Election changes are only allowed if you experience one of the following qualifying events:

- 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 manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

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.

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 are deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Plan Year is $2,650.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out-of-pocket health care expenses for yourself, your spouse and all of your tax 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

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 that you claim as dependents on your taxes. 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
  - Children who became disabled prior to age 19.
  - 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 than above**
- **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
- 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.
- Expenses incurred while on a Leave of Absence or Vacation.

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 back to your employer 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 your enrollment during the open enrollment period, 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

The Benefit Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense.
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*.

FlexibleBenefit ADMINISTRATORS

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.

Once your account is established, you can use the same user name and password to access your account via our Mobile App!

Follow the simple steps 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.
  - User Name
  - Password
  - Name
  - Email Address
  - **Employee ID** (Your SSN, no spaces/dashes)
  - Registration ID
    - **Employer ID FBALWRN** for City Employees/ **FBALCEC** for Emergency Communication Employees/ **FBALCHA** for Housing Authority Employees
    - **Your Benefits Card Number**
- Once completed, please proceed to your account.

Getting Started is Easy!

If you are having difficulty creating your user account or you have forgotten your password to an existing account, please contact us at 800-437-3539 or flexdivision@flex-admin.com.

We're Going Mobile for You!

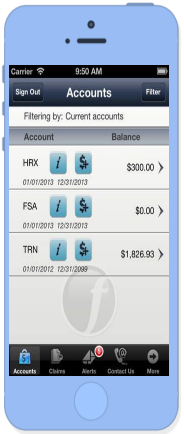
Mobile App for

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

CITY OF LAWRENCEBURG

Dental Highlight Sheet

Ameritas

Dental Plan Summary **Effective Date: 1/1/2018**

Plan Benefit	
Type 1	100%
Type 2	80-90-100%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 3 Family Maximum
Maximum *(per person)*	$1,000 per calendar year
Allowance	90th U&C
Dental Rewards®	Included
Waiting Period	None
Annual Open Enrollment	None

Orthodontia Summary - Adult and Child Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Sealants (age 16 and under)	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Amalgams	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Restorative Composites	• Crown Repair
• Periapical X-rays	• Denture Repair	• Endodontics (nonsurgical & surgical)
• Cleaning (2 per benefit period)	• Simple Extractions	• Periodontics (nonsurgical & surgical)
• Fluoride for Children 18 and under (1 per benefit period)	• Complex Extractions	• Implants
• Space Maintainers	• Anesthesia	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

	Semi-Monthly Rates
Employee Only (EE)	No Cost (Paid by the City)
EE + Family	$26.60

Ameritas Information

We're Here to Help! This plan was designed specifically for the associates of **CITY OF LAWRENCEBURG.** At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: **800-487-5553**. For plan information any time, access our automated voice response system or go online to ameritas.com.

Dental Rewards®

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

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Dental Rewards amount is added to the following year's maximum
Maximum Carryover	$1,000	Maximum possible accumulation for Dental Rewards

CITY OF LAWRENCEBURG

Dental Highlight Sheet

Ameritas

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at **800-487-5553**.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Incentive Coinsurance

Plans with coinsurance levels that progressively increase are designed to reward your loyal employees: The longer they stay on the plan, the higher their coinsurance. As long as plan members have at least one dental claim submitted each benefit period, they continue to advance one coinsurance level until they reach the plan's highest benefit level. If a plan member fails to have at least one dental claim submitted during any benefit year, he or she will revert back to the beginning coinsurance benefit. If that happens, members can progress back to higher coinsurance levels in subsequent years by submitting at least one dental claim each benefit year.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

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 15%-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
11090 White Rock Rd
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 1,688,780 million new cancer cases were expected to be diagnosed in 2017. [1]

Group Voluntary Cancer

If you suddenly are 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.

*Employee only
**List of covered diseases on the following page

[1] Cancer Facts & Figures, American Cancer Society, 2017

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.

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

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.

[2] Cancer Facts & Figures, American Cancer Society, 2017.

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

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 (Employee 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 21, 2020. 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.

This information is for use in enrollments which are sitused in Tennessee.

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.allstate.com or allstatebenefits.com

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.
- Immediate effective date – Coverage will be effective the date the employee signs the application
- 24-Hour Coverage.

Eligibility

Issue Ages
Employee at least age 18
Spouse at least age 18
Children under age 26
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.

Guaranteed-Issue

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

Coverage may be continued with certain stipulations. See certificate for details.

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	Benefit
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* *At least 10%. but not more than 25% of body surface covered* *At least 25%. but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $100 $200 $500 $1,000
Third Degree *Less than 10% of body surface covered* *At least 10%. but not more than 25% of body surface covered* *At least 25%, but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $1,000 $5,000 $10,000 $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* *Resulting in extraction*	 $150 $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	
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. We will pay the amount shown once each 12-month period for each covered person for the following:

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

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

AC G

City of Lawrenceburg	
	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.®

We've got you under our wing.®
aflacgroupinsurance.com | 1.800.433.3036

Underwritten by:
Continental American Insurance Company
2801 Devine Street | Columbia, South Carolina 29205

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

Published: Feb-15 AC78150214-092839 --- RB1-CU-TN-AC78-24PP-HIGH-24HR-WB - ZZXX13499

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 semiprofessional.

• 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.

AGCM378TN-10-BK R2 IV (5/17)

Aflac Group Critical Illness Plan

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Premiums are paid through convenient payroll deduction.
- Guaranteed-issue coverage 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 up to $25,000 for spouse.
- An annual Health Screening benefit is included.
- The plan is portable, which means you can take your coverage with you if you change jobs or retire (with certain stipulations).
- Includes an Additional Benefits Rider with benefits for the following:
    - Coma
    - Paralysis
    - Severe Burn
    - Loss of Sight
    - Loss of Hearing
    - Loss of Speech
- Includes a Heart Event Rider

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-issue coverage is available for all eligible employees. The following options are available:

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

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 and all children of the insured who are younger than 26 years of age are eligible for coverage. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. Spouses are eligible for benefit amounts equaling **50%** of the employee amount, not to exceed the $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 up to $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

Coverage may be continued with certain stipulations. See certificate for details.

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.

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

If diagnosis occurs after age 70, benefits are reduced by 50%.

Additional Occurrence Benefit – We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

Re-occurrence Benefit - We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless 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, an Insured may receive a maximum of **$100** for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the Insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for Dependent Children. The covered health screening tests include but are not limited to:

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

Additional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Coma	100%
Paralysis	100%
Severe Burns	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

If diagnosis occurs after age 70, benefits are reduced by 50%.

Heart Event Rider

Covered Surgeries and Procedures	Percentage of Face Amount
Category 1	
Coronary Artery Bypass Surgery	100%
Mitral valve replacement or repair	100%
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%
Pacemakers	10%

If diagnosis occurs after age 70, benefits are reduced by 50%.

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

LIMITATIONS AND EXCLUSIONS

If diagnosis occurs after age 70, benefits are reduced by 50%.

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate 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:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane;
- 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 below).

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.

Pre-Existing Condition Limitation

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.

Additional Benefit Rider Limitations and Exclusions

If diagnosis occurs after age 70, benefits are reduced by 50%.

All limitations and exclusions that apply to the Critical Illness plan also apply to the rider. The Waiting Period and Pre-existing condition limitation apply from the date the rider is effective.

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

Benefits are not payable for loss if these conditions result from another Critical Illness.

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.

Heart Event Rider Limitations and Exclusions

If diagnosis occurs after age 70, benefits are reduced by 50%.

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

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 pre-existing 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.

Notices
This booklet is a brief description of coverage, not a contract. Read your certificate 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 best interest to maintain your 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.

AGCM328-TN-BK R1 IV (5/17)

***Guaranteed-Issue Amounts** - \$10,000 for Employee and \$5,000 for Spouse*

GROUP CRITICAL ILLNESS

CI[G]

City of Lawrenceburg - SemiMonthly (24pp/yr)

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

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

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

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.

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Published: Jan-15 Series 20000 CI150126-162643 --- RB1-VA-CI20-24PP-HSB100-70BENERED-CBP-SSH-HRT-BTAP-TNT+3BF - ZXX08394

AUL Short Term Disability Plan

THE NEED FOR DISABILITY INSURANCE

Protect your paycheck

You insure your home, car and other valuable possessions, so why not also protect what pays for all those things? Your income. Without it, think about how your mortgage/rent, groceries or credit card bills would get paid. That's where disability insurance can help.

A disability can happen to anyone at any time and it can last for a short or long period of time. Purchasing disability insurance through your workplace is a way to replace a portion of your pre-disability earnings if you get sick or hurt and are unable to work. Being prepared can help ease the financial burden for you.

Things to think about

A severe injury or illness can leave you unable to work for years. Workers' compensation only covers injuries that happen on the job and, to qualify for coverage, you must meet certain eligibility requirements. Additionally, medical insurance will only help cover your medical costs.

You might be able to dip into savings or borrow money from loved ones, but if you don't have these options, can you really afford not to have disability insurance?

Protect yourself and your income with disability insurance.

Disability insurance can provide you with the income protection you need. Consider purchasing it today.

Let's figure it out

Everyone's circumstances are different. This calculator can help you figure out how much you need to protect your lifestyle and the lifestyles of those you love if you become disabled.

Estimate your essential monthly expenses

Living expenses	Amount
Monthly housing *(e.g., mortgage, rent, insurance, taxes)*	
Utilities *(e.g., telephone, electricity, gas, oil, cable, TV, Internet)*	
Food	
Transportation *(e.g., car payments, gasoline, insurance)*	
Subtotal =	
Debt expenses	
Education *(e.g., tuition, books, supplies)*	
Health care *(e.g., out-of-pocket costs, insurance premiums)*	
Debt payments *(e.g., credit cards, other debt)*	
Subtotal =	
Other expenses	
Dependent care	
Life insurance premiums	
Subtotal =	
Minimum monthly amount to cover with disability insurance	**$**

Note: Products issues and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company.

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 6 months : $500

6 months 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
65-69	$2.880
70+	$3.880

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)
Columbia, South Carolina
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

11090 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

View Benefit Information &
Download Forms at:
www.markiiibrokerage.com/cityoflawrenceburgtn

OR

scan this QR with your smartphone!*

***-3rd party iOS or Android app required**

Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits

114 E. Unaka Ave.
Johnson City, TN 37601

Ginger Durbin
ginger@markiiieb.com
(800) 532-1044 x207

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