Mark III
Employee Benefits

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GREENEVILLE
TENNESSEE

Employee
Benefits Plan

Plan Year: January 1, 2017 - December 31, 2017
Arranged and Enrolled by Mark III Brokerage, Inc.

Mark III
Employee Benefits
114 E. Unaka Ave.
Johnson City, TN 37601
(800) 532-1044 x307
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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 (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.

Mark III
Employee Benefits

AmeriFlex
Flexible Spending Account

Plan Year: January 1, 2017- December 31, 2017
Medical Reimbursement Plan Maximum: $2,600
Medical Reimbursement Plan Minimum: $200
Dependent Care Reimbursement Plan Maximum: $5,000
Run Out Period: 90 days following the end of the plan year to file for services rendered during the plan year.
Waiting Period: Coverage for new hires will be effective the first of the month following 30 days of continuous employment.

• Be advised that Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under their FSA plan.

How the AmeriFlex Plan Works
If you participate, you will elect to have a specific amount of pre-taxed money deducted from you paycheck each pay period. These dollars are subtracted from your gross earnings before taxes and put into a Flexible Spending Account to cover eligible out-of-pocket cost. Once you submit a claim for a qualified expenses, you will be reimbursed from this account.

- Lower your taxable income, pay less tax, increase your take-home pay.
- Participation is the equivalent to getting a raise.

The following table illustrates how you save by participating in a FSA			
Without This Plan		**With This Plan**	
Gross pay (annual)	$30,000	Gross pay (annual)	$30,000
Tax deductions (@25%)	$ 7,500	•Eligible expenses	$ 1,000
Take-home pay	$22,500	Taxable income	$29,000
•Eligible expenses	$ 1,000	Tax deductions (@25%)	$ 7,250
New take-home pay	$21,500	New take-home pay	$21,750
		•Result (increased take-home pay)	$ 250

Eligible Expenses
Medical Spending Account Eligible Expenses
A medical FSA is used to pay for healthcare expense not covered under you medical or other insurance plan. The IRS determines eligible expenses. IRS-qualified expenses may include:

- Co-pays, deductibles, and other payments you are responsible for under your medical plan

- Charges that my not be covered by your medical plan such as:
  - Routine exams
  - Dental care
  - Orthodontia
  - Eyecare; Lasik, glasses, contact lenses
  - Hearing aids
  - Well-baby care
- Miscellaneous expenses such as:
  - Many over-the-counter drugs; e.g., pain relief, sleep aids, allergy treatments
  - Transportation, tolls, and parking to receive medical care
  - Individual psychiatric or psychological counseling
  - Diabetic equipment and supplies
  - Durable medical equipment
  - Qualified medical products or services prescribed by a doctor

Some examples of ineligible expenses include insurance premiums, teeth whitening, prescription drugs for male pattern baldness, and most cosmetic procedures. A more comprehensive list of eligible medical and over-the-counter expenses is available on the AmeriFlex website. You can also refer to IRS Publication 502 for the complete llist of medical expenses for reimbursement. **A comprehensive list can be found at www.myameriflex.com under employee Flex Forms**

Dependent Day Care Spending Account Eligible Expenses
With a Dependent Day Care Account, you can set aside pre-tax payroll deductions to reimburse the expenses associated with day care for your qualified dependents.

Eligible expenses must meet the following qualifications:
- The care of the dependent must enable you and your spouse to be employed
- The amount to be reimbursed must not be greater than your spouse's income or your income, whichever is less
- The child must be under 13 years old and must be your dependent under federal tax rules
- The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (e.g., an older child)
- If the services are provided by a day care facility that cares for six or more children simultaneously, the facility must comply with state and local day care regulations
- Services must be for the physical care of the child, not for education, meals, etc.

Qualified dependent care expenses also include cost for the care of a spouse or dependent who is incapable of self-care, regularly spends at least eight hours per day in your home, has gross income below the exemption amount in IRS Code 151, is dependent on you for over half of their support, and is not anyone else's qualifying child (e.g., an invalid parent). The same rules that apply for child care apply to the care of other dependents, except the dependents need not be under age 13.

For more details on dependents day care eligible expenses, reference IRS Publication 503 - Child and Dependent Care Expenses, available on the AmeriFlex website.

Funding Your Account
The maximum amount you can contribute to your FSA depends on the type of account you select. Your employer determines the maximum annual election for your Medical Flexible Spending Account while the government sets the maximum amount for your Dependent Day Care Spending Account.

Determining Account Contributions
- Medical: Your employer determines the maximum allowable contribution for your Medical Flexible Spending Account. Within that maximum, you determine your contribution for yourself and your eligible dependents based on expenses your expect to incur in the upcoming plan year. Your annual contribution is then divided by your number of pay periods, and that amount will be deducted pre-tax each pay period.
- Dependent Day Care: The IRS has set the maximum allowable contribution per calendar year for a Dependent Day Care Spending Account as follows:
  - $5,000 for a married couple filing jointly
  - $5,000 for a single parent
  - $2,500 for a married person filing separately

The Use-It-or-Lose-It Rule
If you contribute dollars to a reimbursement account and do not use all the money you deposit, you will lose any remaining balance in the account at the end of the eligible claims period. You have 2 1/2 months after December 31, 2017 to file for claims reimbursement for claims incurred during the plan year. A very important thing to remember is that the rule exist because the IRS has established strict guidelines for plans with tax advantages.

Claims Process
To be reimbursed for any expense, you must first file a claim. You can file a claim in two ways, either manually or electronically. To file a claim manually, simply complete a claim form and mail or fax it to AmeriFlex along with substantiation of the claim. Acceptable forms of substantiation include itemized receipts and the Explanation of Benefits (EOB) from your insurance carrier.
Information required on all claim request include: the date of service, the product or service description drug names and numbers, the total dollar amount being requested, the service providers name, and, in the case of dependent day care request, the provider's signature and tax ID or Social Security number.
When you submit a claim by fax or mail, your reimbursement will either be mailed or direct-deposited into your bank account, whichever you prefer. To eliminate the hassle of paper, faxing, and the time delays of mailing, simply use your AmeriFlex Convenience Card.

The AmeriFlex Convenience Card
The AmeriFlex Convenience Card is a MasterCard debit card providing electronic access to your FSA funds. The card provides the convenience of a single debit card with access to all your accounts.
Your AmeriFlex Convenience Card gives you easy access to the funds in your Flexible Spending Account(s). It works just like any other debit card, but with three important differences:
- First, its use is limited to specific merchants* and to expenses deemed eligible by your plan

- Second, your cannot use it at an ATM or to obtain “cash back” when making a purchase
- Third, you are not given a PIN with this. Should a merchant or provider ask you for a PIN, simply explain that this card does not require one. If given the option between debit and credit at the terminal, choose credit

*Every merchant that accepts MasterCard is assigned an MCC Code based on their type of business. Only a limited number of these codes apply to merchants providing products or services eligible for FSAs. Use of the AmeriFlex Convenience Card is limited to the day care providers; medical care providers such as hospitals, doctor’s offices, optometrist, dentists, orthodontist, pharmacies, or other merchants providing prescription and over-the-counter eligible products; and CRA merchants such as parking garages or metro-card machines. In other words, your card cannot be used at non-qualified businesses such as gas stations, retailers, convenience stores, etc. For example: aspirin is an eligible expense in your Medical Flexible Spending account; however, you cannot purchase aspirin at your local convenience store because that type of business does not have an eligible MCC code. You would need to purchase your aspirin at you local pharmacy or other qualifying business to use the card. However, under new regulations, if the merchant has an IRS approved inventory management system that provides SKU level data on the item, it can automatically determine if an expense is eligible, eliminating the MCC code restriction. Check with your local retailer to find out if they already have or may be adding this system.

Your Card Account Balances and Transaction Receipts

- **What if there’s not enough money in my account?**

If you charge more than the available balance in your account, the transaction will be declined. You can find your balance online at www.myameriflex.com or by calling the AmeriFlex Interactive Voice Response System which is available 24/7. Review your account balance to avoid declined charges.

- **Do I need the receipts?**

Possibly, so please save all of your itemized receipts for certain expenses, AmeriFlex may need additional information, including receipts, to verify eligibility of the expenses and to comply with IRS rules. That’s why it’s important for you to save all your receipts, then fax or mail them promptly if requested. Failure to comply could jeopardize the tax-exempt status of your account and cause the card to be deactivated.

FSA Election Changes

What if I want to make a change to my FSA Election?

The latest set of cafeteria plan regulations develops a process for determining if a participant is allowed to make a change in election during the plan year. A change in status must have occurred and that event must fall into one of the following categories:

- Changes in provider (Dependent Day Care only)
- Changes in cost of day care (Dependent Day Care only)
- Changes in legal marital status
- Changes in number of dependents
- Changes in employment status
- Changes in work schedule (increase or decrease in hours)
- Dependent satisfies (or ceases to satisfy) requirements for eligibility

The election change must be consistent with the status-change event. A change is consistent with the event for Medical Flexible Spending accounts if the following occurs:

- The employee, spouse, or dependent is gaining or losing eligibility for health coverage
- The election change corresponds with that gain or loss of coverage

Employee Termination/Claims Procedures
AmeriFlex will deactivate the terminated employee's AmeriFlex Convenience Card on the Date of Termination listed above. Claims may be incurred up the Date of Termination. However, the IRS defines "participation" as "making pre-tax contributions to the plan," therefore if the employee's last payroll deduction occurs after their Date of Termination, they may continue to incur claim through the date of their last payroll deduction. Those claims must be submitted for processing on a Manual Claim Form and can be submitted for a period of 90 days from the date of last payroll deduction or through the end of the eligible claims period (as defined in the Summary Plan Description), whichever occurs first.

Tax Implications
Will pre-taxing have an Impact on Social Security benefits?
Reductions in your taxable pay may lead to a reduction in Social Security benefits; however, for most employees, the reduction in Social Security benefits is insignificant when compared to the value of paying lower taxes now.

Dependent Day Care
On your tax return you must report the correct name, address, and taxpayer identification number (TIN) of your dependent care provider. If your dependent care provider is exempt from federal income taxation, you are not required to report the TIN; however, you must report the correct name and address of the exempt provider and write "tax exempt" in the space provided for the TIN.

Tax Credits vs. Dependent Care Spending Accounts
If you participate in a Dependent Care Spending Account, you cannot claim credits on your income tax return for the same expenses. Also, any amount reimbursed under this plan will reduce the amount of other dependent care expenses that you can claim for purposes of tax credits. Before you enroll in a Dependent Day Care Account, evaluate whether the federal income tax credit or the Dependent Care Spending Account is best for you. Refer to the following federal tax forms and publications for more information (available at www.irs.gov):
- Form 2441 (Child and Dependent Care Expense);
- Form 1040 Schedule EIC and IRS Publication 596 (Earned Income Credit);
- Form 8812 and IRS Publication 972 (Child Tax Credit)
- Frequently Asked Questions

List of Eligible Expenses
1. **Abortion/Yes:** Fees paid to obtain a legal abortion are medical expenses;
2. **Acupuncture/Yes:** Fees paid for acupuncture are eligible medical expenses;
3. **Adoption/Maybe:** You can include medical expenses you paid for your child before adoption, if the child qualified as your dependent when the services were rendered. Fees for medical expenses or any fees relating to the adoption process incurred prior to the beginning of adoption negotiations are not eligible. Medical expenses associated with an adopted baby's birth incurred by the birth mother are also not eligible;

4. **Air Conditioning, Air Purifier, Humidifier/Maybe:** The cost of an air conditioner recommended by a physician as treatment for a specific medical condition is an eligible expense. If the value of the home increases then these amounts are not reimbursable;
5. **Alcoholism Treatment/Yes:** Payments to a treatment center for alcohol or drug addiction are eligible medical expenses. This includes meals and lodging provided by the center during medical treatment. You may include transportation cost incurred to attend Alcoholic Anonymous (AA) meetings recommended by the attending physician, when submitted with supporting documentation;
6. **Ambulance/Yes:** Fees submitted for ambulance service are covered;
7. **Anesthesiology/Yes:** Fees for anesthesiology are covered;
8. **Arch Support/Maybe:** Qualifies as a medical expense only if prescribed by a physician as a treatment and when submitted with documentation supporting a specific medical condition;
9. **Artificial Insemination/Yes:** See fertility
10. **Artificial Limb/Yes:** Expenses for the purchase of an artificial limb qualify as medical expenses;
11. **Artificial Teeth/Yes:** You can include in medical expenses the amount you pay for artificial teeth;
12. **Asthma Equipment/Yes:** Nebulizers or peak flow meters prescribed for treatment of asthma are eligible expenses;
13. **Birth Control/Yes:** Expenses associated with the purchase of birth control purchased over the counter or prescribed by a doctor are eligible expenses (e.g., IUD, diaphragm, Norplant, condoms);
14. **Birthing Coach/No:** Expenses associated with a birthing assistant/coach for women in labor are not considered eligible medical expenses;
15. **Bleaching of Teeth/No:** Bleaching of teeth is not an eligible medical expense;
16. **Blood donation/Yes:** Expenses associated with blood donation qualify as medical expenses;
17. **Braille Books/Magazines/Yes:** The cost of braille books and magazines for use by visually impaired persons qualifies as a medical expense. Eligible expense include only the amounts over the cost of the products in its standard form;
18. **Breast Augmentation/No:** Expenses related to breast augmentation (such as implants or injections) are not reimbursable because the procedure is considered cosmetic in nature;
19. **Breast Implant Removal/Maybe:** The removal of breast implant that are defective or are causing a medical problem are reimbursable;
20. **Breast Pump (purchase or rental)/Maybe:** The cost of a breast pump is considered a medical expense if the pump needs to be used to treat a medical condition;
21. **Breast Reduction/Maybe:** Medical expenses related to breast reduction surgery are reimbursable only if the physician substantiates that the procedure is medically necessary. i.e., to prevent or treat an illness or disease;
22. **Capital Expenses/Maybe:** Amounts paid for special equipment to be installed in you home for improvement qualify as medical expenses if there is documentation from a physician that the equipment is mainly needed for or as a result of a specific medical condition. If the capital expenditure increases the value of the property, excess value is not reimbursable. Improvements made to accommodate a residence for a person's disability do not usually increase the value of the residence, and the full cost is usually reimbursable. Only reasonable cost to accommodate a personal residence for a disabled condition

are considered medical care. Additional cost for personal motives, such as for architectural or aesthetic reasons, are not reimbursable;

23. **Car Modification/Maybe:** Special hand controls and other special equipment installed in a car for use by a disabled person qualify as medical expenses;
24. **Childbirth Classes (lamaze)/Maybe:** Some of the expenses may qualify; Expenses for instructions relating to the birth of the child are eligible for the mother to be. Fees for instructions in topics such as newborn care are not eligible. Expenses for the coach or significant other do not qualify;
25. **Chiropody/Yes:** Fees paid to a chiropodist (chiropractic foot doctor) for medical care are eligible expenses;
26. **Chiropractors/Yes:** Fees paid to chiropractor are eligible;
27. **Christian Science Practitioner/Maybe:** Fees paid to a Christian Science Practitioner are eligible expenses when treatment is rendered for a specific medical condition;
28. **Circumcision/Yes:** Circumcision is a covered medical expense. This procedure is also covered if performed in the member's home by a rabbi;
29. **COBRA Premiums/No:** Premiums paid for COBRA benefits are not a covered expense;
30. **Collagen Injections/Maybe:** Collagen injections are considered to be cosmetic, however, may be covered if medically necessary (e.g., for treatment of severe acne);
31. **Contact Lenses, Solutions, Supplies, and Warranties/Yes:** Expenses, including shipping and handling incurred for the purchase of contact lenses, qualify if the contact lenses are need for medical reasons. Amounts paid for contact lens solutions and supplies qualify as medical expenses. Fees paid for eye exams are also eligible;
32. **Copays/Coinsurance/Yes:** A copay or coinsurance fee qualifies as a medical expense;
33. **Cosmetic Treatment/Maybe:** Generally, medical expenses paid for unnecessary, i.e., elective, cosmetic treatment are not covered. (This applies to any procedure that is directed at improving the patient appearance and that does not meaningfully promote the proper function of the body or prevent or treat an illness or disease.) Examples if non-covered cosmetic surgery procedures include breast augmentation, chemical electrolysis, face lift, hair transplant, liposuction, and tattoo removal. Expenses incurred for cosmetic surgery necessary to improve a deformity arising from or directly related to a congenital abnormality, a personal injury or a disfiguring disease qualifies as eligible medical expenses;
34. **Counseling/Maybe:** Amounts paid for counseling which is medically necessary to treat a specific medical or mental illness is covered. Marriage counseling and Family counseling are not covered expenses;
35. **CPR Classes/No:** CPR classes are not considered "medically necessary"; therefore, the expense is not reimbursable under FSA;
36. **Dancing Lessons/Maybe:** Amounts paid for dancing lessons do not normally qualify as medical expense. But the expense may qualify if recommended to treat a specific medical condition (such as part of a rehabilitation program after surgery);
37. **Deductible/Yes:** Deductible qualify as medical expenses;
38. **Dental Treatment/Yes:** Amounts paid for dental treatments qualify as medical expenses. This includes fees paid to dentist for X-rays, fillings, braces, extractions, dentures, caps, crowns, fluoride treatments, implants, etc. In

addition, the installation and monthly rental charges for fluoride treatments to home water qualify as medical expenses when prescribed by a physician or dentist. However, the amount should be limited to the cost allocable to the current plan year;

39. **Denturist/Yes:** Fees paid to a denturist qualify as health care expenses when services are for the treatment of a specific medical condition;
40. **Dermatology/Yes:** Fees paid to a dermatologist for medical care qualify as medical expenses;
41. **Diabetic Equipment and Supplies/Yes:** Medical expenses may include amounts paid for the following equipment and supplies for treatment of diabetes; glucose monitor, urine/blood test strips, insulin, and syringes and alcohol swabs.
42. **Diagnostic Services/Yes:** Fees paid for diagnostic services, as prescribed by a physician, are eligible medical expenses.
43. **Diapers - Diaper services/Maybe:** Amounts paid for adult diapers or a diaper service, qualify as a medical expense if prescribed by a physician to relieve the effects of a specific medical condition. Diaper expenses for handicapped individuals beyond infancy are also covered.
44. **Dietitian/Maybe:** Fees paid to a dietitian are eligible when referred by a physician for treatment of a specific medical condition.
45. **DNA Testing/No:** DNA testing for paternal responsibility is not considered an eligible expense.
46. **Domestic Partners/Maybe:** Medical expense incurred by domestic partners are usually not eligible for reimbursement from an FSA. Members should consult with their plan sponsors on domestic partner coverage.
47. **Drug Addiction** - See Alcoholism
48. **Durable Medical Equipment (DME)/Yes:** The cost associated with the purchase or rental of durable medical equipment that is prescribed by a medical practitioner to alleviate or treat a specific medical condition qualifies as an eligible expense. Cost can include: bed wetting alarm, blood pressure kit, chair*, crutches, hearing aids, medical alert equipment, and oral hygiene equipment. *Reimbursement is only for the amount that exceeds the cost of a similar or regular product. Letter of medical necessity only needed for items that have a dual purpose (e.g. chair, sheets, oral hygiene equipment).
49. **Ear Piercing/No:** Expenses associated with ear or body piercing are not eligible medical expenses.
50. **Educational Classes/No:** Educational classes are not eligible medical expenses (care for a newborn, breast feed, cope with diabetes, etc.).
51. **Electrolysis/No:** See Cosmetic Treatment
52. **Eyeglasses/Supplies (e.g. storage case, replacement cost), Warranties/ Yes:** Amounts paid for prescription vision/sports eyewear, supplies (i.e. eyeglasses, goggles, sunglasses) for a medical condition qualify as a medical expense. Fee paid for eye exams are also eligible. Tinting of prescription eyewear qualifies as an eligible medical expense.
53. **Exercise Equipment/Maybe:** Exercise equipment may be covered when prescribed by a physician as treatment for a specific medical condition. Exercise equipment used for improvement of general health is not covered.
54. **Fertility/Yes:** Medical expenses associated with the treatment of infertility, including shots, in vitro fertilization and artificial insemination incurred by the member, are reimbursable. Semen and embryo storage associated with an active attempt to conceive are also eligible for reimbursement. Note: donor expenses incurred by the member (egg donation, sperm donation) are eligible during active

treatment only, if expenses are not covered by a medical plan. The cost of an ovulation kit qualifies as an eligible medical expense.

55. **Flu Shot/Yes:** Flu shots are eligible medical expenses.
56. **Guide Dog or Animal/Yes:** The cost of a guide dog or other animal to be used by the visually impaired or hearing impaired qualifies as a medical expenses. The cost of a dog or other animal trained to assist persons with other disabilities can also be covered. Amounts paid for the care of these specially trained animals are also available.
57. **Gynecologist/Yes:** Fees paid to a gynecologist for medical care are eligible medical expenses.
58. **Health Club/Maybe:** Dues paid to a health club, YMCA, YWCA or spas are allowable when the member submits documentation from the attending physician stating that the membership expenses are for treatment of a specific medical condition. Reimbursement should be only for the individual membership and for the component that is related to a single year. Any dues that carry over to a subsequent year would violate this IRS rule of constructive receipt. Health club dues, YMCA/YWCA dues or amounts paid for steam baths for your general health or to relieve physical or mental discomfort not related to a particular medical condition are not eligible medical expenses.
59. **Health Screenings/Yes:** See Diagnostic Services
60. **Holistic-Homeopathy Practitioner/Maybe:** Fees paid to a holistic or homeopathy doctor are eligible when treatment is provided for a specific medical condition.
61. **Hospital Services/Yes:** Amounts paid for hospital services that are not covered under a medical plan qualify as medical expenses (e.g., upgrade from semi-private to private room, fees charged for parents to stay with a child, etc.). (also see Lodging/Trips)
62. **Human Guide/Yes:** Expenses for a human guide - to take a blind child to school for example - are reimbursable.
63. **Hypnosis/Maybe:** Hypnosis is considered a medical expense when it is prescribed by a physician as treatment for a specific medical or mental condition.
64. **Insurance Premiums/No:** Amounts paid as premiums to purchase health care coverage are not eligible medical expenses. This includes COBRA, Medicare A&B premiums.
65. **Laboratory Fees/Yes:** Amounts paid for laboratory fees that are part of your medical care are eligible expenses.
66. **LASIK Eye Surgery/Yes:** Expenses associated with LASIK/PRK or radical keratotomy surgery to correct impaired vision are eligible.
67. **Late Fees Payments/No:** Late fees associated with payment of medical expenses are not eligible.
68. **Lead Paint/Asbestos Removal/Maybe:** Cost of removing lead-based paints/ asbestos from surfaces in a home to prevent a child who has (or has had) lead poisoning from eating the paint are eligible expenses. The cost of repainting is not reimbursable.
69. **Learning Disability** - See Schools, Special
70. **Legal Fees/Maybe:** Legal fees may qualify as medical care if they bear a direct or proximate relationship to the provision of medical care to you, your spouse or your dependent.
71. **Lifetime Care Advance Payments/No:** Prepayments of life care fees or founders fees paid monthly or as lump sum under an agreement with a

retirement home are not eligible expenses. These payments are considered premiums.

72. **Lodging - Trips/Maybe:** The cost of meals and lodging at a hospital or similar institution qualify as medical expenses if the main reason for being there is to receive medical care. Expenses incurred for transportation to another city are eligible health care expenses if the trip is primarily for and essential to receiving medical services. You may also be able to include up to $50 (refer to IRS Publication 502) per person, per night for lodging. You cannot include in medical expenses amounts you pay for a trip or vacation taken for a change in environment, improvement of morale or general improvement of health, even if a doctor recommends the trip.
73. **Marijuana/No:** Expenses associated with marijuana when purchased or used under state laws for treatment of a medical condition are not eligible for reimbursement. This drug remains illegal under federal law and does not qualify as a Sect. 13 medical expense.
74. **Massage Therapy/Maybe:** Massage therapy is covered if the member submits documentation from a physician confirming that massage therapy is prescribed as treatment of a specific medical condition. The physical should also include the frequency and duration of the therapy. Massage therapy for general health does not qualify as a medical expense.
75. **Maternity Charges/Yes:** Amounts paid to physicians for delivery charges qualify as eligible expenses.
76. **Maternity Clothes/No:** The cost of maternity clothing is not an eligible expense.
77. **Mattresses/Maybe:** Amounts paid for a mattress or special bedding for a person with documentation supporting a medical condition is a medical expense, but only for the amount that exceeds the cost of similar regular bedding. Proof of the cost of regular bedding is necessary to pay the expense.
78. **Meals/Maybe:** Meals associated with inpatient medical care are eligible expenses.
79. **Medical Plan Information/Yes:** Payments for services to keep your medical information so that it can be retrieved from a computer data bank are an eligible medical expense. Fee associated with copying medical records are also eligible.
80. **Medical Services/Yes:** Eligible medical expenses for treatment of specific medical conditions include fees paid to Doctors, Surgeons, Specialist, or other medical practitioners.
81. **Medicines/Yes:** Eligible medical expenses include amounts paid for prescribed medicines and drugs. A prescribed drug is one that requires a written order by a medical practitioner and is dispensed through a pharmacy for its use by an individual. You may include expenses you pay for delivery charges, postage and handling of mail-order prescribed drugs. Also see Over-the-Counter Drugs section.
82. **Mentally Retarded (Special Home For)/Maybe:** Expenses associated with keeping a mentally retarded dependent in a special home (not the home of a relative) on the recommendation of a psychiatrist to help the person adjust to life in a mental hospital to community living is an eligible expense.
83. **Mouth Guards/Yes:** Occlusal guards prescribed by a dentist to prevent a person from grinding his/her teeth at night are eligible expenses.
84. **Neurologist Fees/Yes:** Fees paid to a neurologist for treatment of a specific condition qualify as medical care and are eligible for reimbursement.
85. **Nursing Home/Maybe:** Medical expense associated with the cost of medical

care provided in a nursing home or home for the aged for an employee, spouse or dependent are eligible for reimbursement (i.e., with a bill from a provider or facility for medical services). This includes the cost of meals and lodging in the home of the main reason for being there is to receive medical care. Non-medical expenses are not eligible.

86. **Nursing Services/Yes:** Wages and other amounts paid for nursing services are eligible medical expenses. This includes services connected with caring for the patient's condition, such as dispensing medications changing dressings, bathing and grooming the patient. Only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, these amounts must be divided up between the times spent performing household and personal services and the time spent for nursing services. However certain expenses for household services or for the care of a qualifying individual incurred to allow an employee to work may qualify for the child and dependent care credit. See Publication 503, Child and Dependent Care Expense.
87. **Nutritional Supplements/Maybe:** Special foods or nutritional supplements are only covered if there is supporting documentation from a physician that they were prescribed as treatment for a specific medical condition.
88. **Optometrist/Yes:** See Contact Lenses & Eye Glasses
89. **Organ Donor/Yes:** Donor's expenses that are paid by the FSA enrollee are eligible for reimbursement.
90. **Orthodontia/Yes:** Out-of-Pocket orthodontia expenses are eligible for reimbursement. AmeriFlex's policy is to reimburse only the prepaid amount corresponding to the member's current enrolled plan year. Prepaid expenses are subject to proof of payment (i.e., cancelled check, bill from provider indicating payments or credit card receipts). You will also be required to initially submit a copy of the orthodontia treatment contract.
91. **Orthopedic Shoes/Yes:** Amounts paid for special shoes are eligible medical expenses, but for the amount that exceeds the cost of regular footwear.
92. **Over-the-Counter Medication/Yes:** See Over-the-Counter section
93. **Oxygen/Yes:** Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition is eligible.
94. **Parking** - See transportation
95. **Personal Trainers/Maybe:** Fees paid to personal trainers are eligible for reimbursement if recommended by a medical practitioner to treat a specific medical condition. The use of personal trainers for improvement of general health is not covered.
96. **Personal Use Items/Maybe:** Personal use items used primarily to prevent or alleviate physical or mental defect or illness are an eligible medical expense when accompanied with documentation supporting a specific medical condition. For example, the full cost of a wig purchased upon advice of a physician for the mental health of a patient who has lost all of his/her hair from disease, can be included as medical expenses.
97. **Physical Exam for Caregiver/No:** Expenses for a physical exam for a potential caregiver are not expenses for the care of a qualifying individual, nor do they fit into the definition of a household expense.
98. **Physical Therapy/Yes:** Physical therapy is covered only if the member submits documentation from a physician confirming that physical therapy is prescribed as treatment for a specific medical condition. The physician should also include the frequency and duration of the therapy..

99. **Prescription Drugs/Yes:** See Medicines
100. **Prosthesis/Yes:** See Artificial Limb
101. **Psychiatric/Yes:** Amounts paid for psychiatric care are eligible for reimbursement. This includes fees associated with the care of a qualifying individual in a specially equipped medical center where the dependent receives medical care when prescribed by a physician.
102. **Psychoanalysis/Yes:** Amounts paid for psychoanalysis qualify as medical expenses.
103. **Psychologist/Yes:** Fees paid to a psychologist for medical care are eligible medical expenses when submitted with documentation supporting a specific medical condition.
104. **Reasonable & Customary/Yes:** Amounts that exceed Reasonable & Customary fees qualify as medical expenses.
105. **Schools, Special/Maybe:** Payments to a special school for a mentally impaired or physically disabled person qualify as eligible health care expenses if the main reason for using the school is relieving the disability. Cost can include: teaching Braille to a visually impaired child, teaching lip reading to a hearing impaired child, giving remedial language training to correct a condition caused by a birth defect. The cost of meals, lodging and ordinary education supplied by a special school can be covered medical expenses only if the main reason for the child being there is the resources the school has for relieving the mental or physical disability.
106. **Smoking Cessation Program/Yes:** Expenses associated with the cost of a stop-smoking program are eligible health care expenses and do not require letter of medical necessity.
107. **Speech Therapy/Yes:** Expenses associated with speech therapy are eligible when prescribed as treatment for medical condition (e.g., autism or dyslexia).
108. **Sperm Storage/Maybe:** Fees paid for storage of sperm for treatment of infertility are eligible health care expenses. Storage fees paid for non-medical reason are ineligible.
109. **Stem Cell Storage/Maybe:** This expense is reimbursable if used in treatment of a specific medical condition. The cost to collect, freeze and store stem cells would also be eligible as long as a specific medical condition is present. The amount that is not covered under regular medical coverage would be a reimbursable expense.
110. **Sterilization/Yes:** The cost of obtaining a legal sterilization or to reverse sterilization is an eligible health care expense.
111. **Substance Abuse** - See Alcoholism
112. **Sunglasses/Maybe:** The cost of prescription sunglasses are allowable.
113. **Surrogate Mother/Maybe:** Flexible Spending Account members who fulfill the role of surrogate mother may submit for reimbursement for qualified medical expenses incurred that is not covered by insurance. Medical expenses incurred by a third party, i.e., a surrogate mother, are not considered eligible expenses. Fees paid to an agency to search for a surrogate mother are not considered eligible for reimbursement.
114. **Swim Therapy/Maybe:** Expenses associated with swim therapy or a swim club membership when prescribed be a medical practitioner as treatment for a specific medical condition (e.g., rheumatoid arthritis) are eligible health care expenses. Swim lessons to learn fundamentals of swimming are not eligible health care expenses.

115. **Taxes/Yes:** Taxes incurred for medical services or products qualify as eligible health care expenses (e.g., sales tax and state hospital bill surcharges).
116. **Telephone/Maybe:** Expenses associated with enhancing a telephone to accommodate a deaf person or person with disabilities are eligible health care expenses.
117. **Telephone Consultation (Physician's Fees)/Yes:** Fees charged by physicians for telephone consultation are eligible health care expenses. The phone charge is also an eligible expense.
118. **Television/Maybe:** Expenses associated with the cost of modifying a television to assist a handicapped person are eligible health care expenses. Cost may include an adapter that attaches to a regular television. It may also include the cost of a specifically equipped television. Eligible reimbursement is the cost associated with the specialization over the cost of a similar standard model.
119. **Transplants/Yes:** See Organ Donor
120. **Transportation/Maybe:** Amounts paid for transportation primarily for, and essential to, medical care qualities as medical expenses when submitted with documentation supporting a specific medical condition. Included are: ambulance services, buses, car rentals, parking fees, plane fare, taxis, tolls, and personal fare - (.23 a mile) effective calendar year 1/1/12. Transportation expenses can be covered for a nurse who provides medical services to the patient who is traveling to get medical care and is unable to travel alone. Transportation expenses to see a mentally ill dependent are covered, if the visits are recommended as part of the treatment. Commuting expenses for a physically disabled person are not covered. IRS Publication 502 indicates that transportation expenses to travel to another city will not qualify as an eligible expense when a member elects the destination.
121. **Tuition/Maybe:** Expenses charged for medical care included in the tuition of a college or private school are eligible health care if the charges are separately stated in the bill provided by the school. Medical coverage premiums attached to a college tuition or private school bill do not qualify as an eligible expense.
122. **Tutoring/Maybe:** Tutoring fees paid on a doctor's recommendation for a child's tutoring by a specialized teacher qualify as medical expenses with documentation supporting a specific medical condition.
123. **Umbilical Cord Blood/Maybe:** Expense is reimbursable if used in treatment of a medical condition. The amount not covered under regular medical coverage would be a reimbursable expense. The cost to collect, freeze and store umbilical cord blood would be eligible as long as a medical condition is present.
124. **UVR Treatments/Yes:** UVR treatments are eligible expenses when recommended by a physician for a medical condition. (e.g., chronic psoriasis)
125. **Vaccinations/Yes:** Amounts paid for vaccinations or immunizations against disease are eligible medical expenses.
126. **Vasectomy/Yes:** Medical expenses paid for a legal vasectomy are covered.
127. **Varicose Vein Surgery/Maybe:** Expenses associated with the removal of varicose veins prescribed by a doctor for the treatment of a specific medical condition are eligible health care expenses. Removal for cosmetic purposes is not an eligible expense.
128. **Weight Loss Drugs/Maybe:** Weight loss drugs prescribed by a physician to treat a medical condition (e.g., morbid obesity, hypertension) are eligible for reimbursement. Weight loss drugs associated with general weight loss are not eligible for reimbursement.

129. **Weight Loss Programs/Maybe:** Medical expenses paid for a weight loss program prescribed by a doctor for treatment of a specific medical condition (e.g., high blood pressure, heart disease) are covered. Reimbursement should be only for the component that is related to a single calendar year. The member should submit documentation from the attending physician prescribing the weight loss program confirming that it was medically necessary for a specific medical condition and not for general health enhancement.
130. **X-rays/Yes:** X-ray fees associated with medical care qualify as eligible health care expenses.

Over-The-Counter Medications

Allergy Prevention & Treatment - Benadryl, Sudafed, Actifed, Claritn, ChloraTrimaton, and Nasalcrom.

Anesthetics - Sucrets and other throat lozenges; Bactine and its equivalent, Aspercreme, and other topical anesthetics.

Antifungal - Femstat, Gyne-Lotrimin, Micatin, Monistat, etc., and their generic equivalents. Antimicrobial EZ scrub and similar disinfectants used on the body only. Antibacterial soap not included.

Anti-itch - Caldecort, Cort-aid, Lanacort, etc., and their generic equivalents. Hydorcortisone.

Antihistamine - Benadryl, Claritn, Allerest, Chlor-Trimeton, Dimetane, Sudafed Plus, Tavist, Triaminic, Drixoral, Actifed, and their generic equivalents. Ivy Block for poison ivy. Nasalcrom and similar antihistamine nasal sprays.

Contraceptives (over-the-counter) - Yes. IRS officials have informally said that the cost of over-the-counter contraceptives, such as condoms and spermicides are reimbursable if they aren't a drug or biological.

Decongestant - Afrin, Chlor-Trimeton, Duration, Dristian, Neo-Synephrine, Orrivin, Sudafed, Triaminic, etc., and their generic equivalents.

Diagnostic tests - Home-based kits for pregnancy, blood glucose for diabetes, and similar test kits.

Family planning - Contraceptives of any kind, pregnancy testing and ovulation testing kits.

Head lice treatment - RID and similar head lice treatments.

Hemorrhoid - Preparation H, Plazo, and similar treatments.

Pain relief - Actron, Advil, Aleve, Motrin, Nuprin, Orudis, Tylenol etc., and their generic equivalents.

Parasite treatments - Pin-X, EZ Scrub, and other such items for intestinal worms, ringworm etc.

Sleep aides - Unisom, Sominex, Excedrin PM, Nyquil, etc., and their generic equivalents.

Smoking cessation - Nicotine gum, lozenges and patches.

Sprain/strain - Bandages, Ben-Gay, and similar medication, and other items used to treat sprains and strains.

Stomach and digestive ailments - Medications used to treat heartburn, upset stomach, constipation, diarrhea, etc. AXID, Imodium, Pepcid, Pepto-Bismol, Prilosec, Tagamet, etc. and their generic equivalents. Enemas, Ex-Lax, and other laxatives.

Sunburn care - Solarcaine, and equivalent generics.

Swimmer's ear - Swim-ear and equivalent generics.

Vision care items - Contact lens solution, reading glasses, glass eye, eye drops

such as Visine and Ocuclear.
Wart removal - Compound W and similar medication
Would care/First Aid - Antibiotic cream, Bactine, band-aids, and other 'first-aid' wound care treatments

Eligible with Doctor's Note:
Acne treatments - Clearasil, Stridex, sodium sulfocetamide, benzoyl peroxide products and similar treatments. Facials, aesthetician treatments, etc., and skin care treatments, if accompanied by a doctor's note indicating they are for treatment of acne.
Iron supplements - If accompanied by a doctor's note indicating the are for treatment active anemia.
Calcium supplements - If accompanied by a doctor's note indicating they are for treatment of osteoporosis.

Over-the Counter Medications (partial list of OTC-eligible items by brand name)

Abreva	Correctol	Lotrimin	Phillips
Actidil	CQ	Maalox	Pin-X
Acitifed	Delsym	Maltsupex	Premysym PMS
Actron	Destin	Marizine	Preparation H
Advil	DexAlone	Metamucil	Prilosec
Afrin	Di-Gel	Micatin	Primatene
Afrinol	Diabe-Tuss DM	Midol	Privine
Aleve	Diametane	Mitrolan	Prodium
Alka-Mints	Dimetapp	Monistat	Propagest
Alka-Seltzer	Doan's	Motrin	Pseudo 60's
Allerest	Donnagel	Mycelex-7	Rheaban
AternaGel	Doxidan	Mylanta	Robitussin
Amphojel	Dramanine	Naphcon A	Rolaids
Arco-Lase	Dristan	Nasalcrom	Safe Tussin 30
Ascriptin	Drixoral	Natur-vent	Senokot
Aspirin	Dulcolax	Nature's Remedy	Sinarest
Axid AR	Duration	Neo-Synephrine	Sine-Off
Backache Caps	Ecotrin	Nicoderm	Singlet
Bactine	Efidac	Nicorette	Sinulin
Balmax	Emetrol	Nicotine Patches	Sinutab
Bassaljel	Ex-Lax	Nicotrol	St. Joseph
Bayer	Excedrin	Nix	Sucrets
BC Powder	Femstat 3	Nolahist	Sudafed
Benadryl	FiberCon	Nostrills	Surfak
Benamist	Fleet Sof-Lax	Novahistine	Surpass Antacid

Benylin	Gas Aid	Nuprin	Tagament HB
Benzedrex	Gas-X	Nyquil	Tavist
Bonine	Gaviscon	Nytol	TheraFlu
Bufferin	Goody's	OcuHist	Titralac
Caladryl	Gyne-Lotrimin	Orajel	Triaminic
Calamine Lotion	Halfprin	Orrvin	Tronolane
Caldecort	Halls	Orudis KT	Tums
Cepacol	Hemroids	Otrivin	Tylenol
Chloraseptic	Hydrocortisone	Pamprin	Unifiber
Chlor-Trimeton	Imodium	Pediacare	Unisom
Citrucel	Ivy Block	Pediatric Vicks	Vagistat-1
Claritin	Kaopectate	Pepsid	Vanquish
Colace	Kondremul	Pepto-Bismol	Vasocon-A
Cortaid	Konsyl	Percogesic	Vicks
Commit	Lactaid	Perdiem	Zantac
Comtrex	Lamisil	Peri-Colance	
Contac	Lanacort	Pertussin	
Coricidin	Legatrin	Phazyme	

- **24/7 Interactive Voice Response (IVR):** 888.868.3539
- **Toll-Free Phone:** 888.868.3539 (option 0, 8:30 a.m. to 8:00 p.m. EST)
- **Web:** www.myameriflex.com (select Employees from the flex menu, then view your account activity)
- **For Claims:**

  Email: claims@myameriflex.com

  Fax: 888.631.1038, Attention: Claims Department

  Mail: PO Box 269009, Plano, TX 75026

Ameritas Dental Plan - PPO & Non-PPO Options

Effective Date: January 1, 2017

PPO vs. Non-PPO
The deductible and coinsurance levels for dental procedures are the same for both the PPO and Non-PPO plan. The main differences are the allowance for each procedure.

Under the PPO plan, the procedure allowance is based on the Maximum Allowable Charge (MAC). This means if you go to a PPO provider, you will pay the coinsurance based on the discounted fee Ameritas has negotiated with that provider. However, if you go to a provider that is not in the network, Ameritas will only reimburse the Maximum Allowable Charge (MAC) and you will be responsible for the difference in cost. Therefore, you are highly encouraged to use an in-network provider to benefit from the plan.

Under the Non-PPO plan, you can see any provider. However, if you visit an out-of-network provider, the provider can charge their standard fee and Ameritas will reimburse based on the 90th percentile of Usual & Customary charges (U&C). This means 9 out of 10 dentist's charges fall within the amount Ameritas allows for each procedure.

Combined Calendar Year Deductible
$50.00 per individual for Type 2 - Basic Procedures and Type 3 - Major Procedures (3 times family limit). After the date that 3 covered family members have each satisfied their individual deductible the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

Type 1 - Preventive and Diagnostic
PPO - Type 1 benefits are payable at 100% MAC. **No deductible applies.**
Non-PPO - Type 1 benefits are payable at 100% U&C. **No deductible applies.**

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

Type 2 - Basic Procedures
PPO - Type 2 benefits are payable at 80% MAC $50.00 deductible applies.
Non-PPO - Type 2 benefits are payable at 80% U&C. $50.00 deductible applies.

- Oral Surgery
- Restorative Amalgam & Resin
- Limited Exams
- Anesthesia
- Denture Repair
- Sealants (under 17)

Type 3 - Major Procedures

PPO - Type 3 benefits are payable at 50% MAC. $50.00 deductible applies.
Non-PPO - Type 3 benefits are payable at 50% U&C. $50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Dentures, Partials
- Bridges, Pontics
- Restorative (Inlays & Crowns)
- Prosthodontics - Fixed Pontics or Abutment
- Occlusal Guard

Orthodontia - Children and Adults

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

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

Annual Maximum Benefit

• Type I, 2, and 3 Procedures - $1,000 per calendar year per person.
• Orthodontia Procedures - $1,000 Lifetime per person (carryover does not apply)

Annual Maximum Carryover

1. Visit a dentist between January 1 and December 31 of each year.

2. Submit a claim for a covered procedure prior to **March 1** of the following year.

3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1000. This benefit allows you to accumulate up to a $2,000 **annual dental maximum**.

Dental Exclusions (Deferment Period)

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

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

Eligible Employees
You are eligible for insurance if you are a full-time active employee working at least 32 hours per week.

Eligible Dependents
Provides Coverage On:
• Your Spouse
• Children are covered up to age 26 under Tennessee State legislation regardless if a college student.

Late Entrant Provision
There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

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

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

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

Section 125
This policy is provided as part of the Policyholder's Section 125 Plan. A member may change their election only during an annual enrollment period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

Orthodontia Limitations (not a complete list)
No benefit is payable for expenses incurred:

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

Limitations/Exclusions (not a complete list)

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

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

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

Bi-Weekly Rates		
	PPO Plan*	**Non-PPO Plan**
Employee Only	**$13.07**	**$13.07**
Employee & Spouse	**$26.78**	**$26.78**
Employee & Children	**$29.82**	**$29.82**
Family	**$44.70**	**$44.70**

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

Customer Service

1-800-487-5553

Web Address

www.ameritas.com

AMERITAS GROUP

We're Ameritas. We're for people.®

This insurance is underwritten by Ameritas Life Insurance Corp.

Superior Vision Plan

Effective Date: January 1, 2017

Outline of Benefits – Gold Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)
Copayment: $10.00 Exam
$10.00 Materials
$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 contracts with a large number of national and regional optometric chain locations.

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

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and 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[1]**	**NON-NETWORK[1]**
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 Lens Fitting Fee[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty[3]	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
Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

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

The following options have out-of-pocket maximums 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-reflextive coat	$50	$50
Polycarbonate	$40	20% off retail
High-index 1.6	$55	20% off retail
Photochromic	$80	20% off retail

Discounts on Non-Covered Exams and Materials
Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

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

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

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

BI-WEEKLY COST - FULL SERVICES PLAN

Employee Only	$ 4.50
Employee + 1 Dependent	$ 8.72
Employee + Family	$ 12.81

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

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

Customer Service/Corporate Office
11101 White Rock Rd.
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

Vision Care Direct

VISION CARE DIRECT
The vision plan your eye doctor recommends™

A vision plan that delivers the best of both worlds—an Eye Health Exam Option PLUS a Materials Vision Plan!

Many diseases and illnesses can be caught in their earliest stages through a comprehensive eye-health examination performed by an independent eye care professional. Illnesses such as cancer, stroke, hypertension, diabetes and glaucoma… just to name a few. **Catching illnesses before symptoms manifest can not only reduce medical claim costs, but it can also save lives!**

This is why it is important to promote annual eye-health examinations to your employees as a key component of your overall wellness program. Give your employees a **low cost, high-impact benefit** by electing the Eye Health Exam Option PLUS Materials Vision Plan from **Vision Care Direct**!

Plan Benefits from Participating In-Network Doctors
(After fee at time of service/Up to plan limits)

Eye Exam	Paid in full
Lenses (per pair)	
Single	Paid in full
Bifocal	Paid in full
Trifocal	Paid in full
Lenticular	Paid in full
Progressive	Platinum PK plans: $180 allowance All other plans: allowance equal to retail price of standard trifocal lens
Polycarbonate for Kids	Paid in full for dependent children up to age 18
Contact Lenses	
Note: contact lens benefit can be chosen in lieu of glasses. Professional fees may be extra.	
Elective – lenses only	Allowance of $105, $130, $160 or $200
Medically necessary**	Allowance of $250
Frame	Allowance of $100, $130, $160 or $200

Fees at time of service based on plan(s) selected:

Exam:	$15
Materials:	$15
Polycarbonate for Kids:	$25

No materials fee for contact lenses

Locate a VCD provider in your area at **www.VisionCareDirect.com**
Out-of-network is available at a significantly reduced reimbursement amount.

For sales assistance contact Stacy Nutter at (615) 767-8149 or stacy.nutter@visioncaredirect.com.

Vision Care Direct is a Membership Plan not insurance. There is no consumer risk.

* For a complete listing of benefits, exclusions and limitations, please reference the benefit summary.
**Medically necessary contacts require prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary.

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VISION CARE DIRECT
The vision plan your eye doctor recommends™

Eye Health Exam Option PLUS Materials Vision Plan
Voluntary Rates, BI-WEEKLY

· Vision Care Direct is a membership plan, not insurance

Complete Eye Health Exam for Employees and their Covered Dependents

Exam Only Plan	Employee Only	Employee +1	Employee/Children	Employee/Family
Comprehensive Eye-Health Exam 12 months	$1.63	$2.62	$3.02	$5.14

Voluntary Materials Plans (Employee can select one or more plans at their option and cost):

Frame/contact lens allowance	Employee Only	Employee +1	Employee/Children	Employee/Family
Platinum Materials Only PK Plan ($180 Progressive lens allowance) **Lens/Frame Benefits every 12 months**				
$100 frame or $105 contact lens	$4.34	$6.94	$8.01	$13.62
$130 frame or $130 contact lens	$5.49	$8.79	$10.14	$17.25
$160 frame or $160 contact lens	$6.65	$10.63	$12.28	$20.87
$200 frame or $200 contact lens	$8.19	$13.10	$15.11	$25.70
Gold Materials Only PK Plan (Single vision, bifocal, trifocal or lenticular lens) **Lens/Frame Benefits every 12 months**				
$100 frame or $105 contact lens	$3.28	$5.24	$6.05	$10.28
$130 frame or $130 contact lens	$4.43	$7.09	$8.18	$13.90
$160 frame or $160 contact lens	$5.58	$8.94	$10.31	$17.53
$200 frame or $200 contact lens	$7.12	$11.39	$13.14	$22.36

Member pays $15 at time of service for exam and/or $15 for materials plus excesses above allowances and add-ons.
Dependent children up to age 18 pay $25 at time of service for polycarbonate.
Materials fee does not apply to contact lens.

Vision Care Direct is a provider-based plan. You can locate a provider at www.VisionCareDirect.com.

VISION CARE DIRECT
The vision plan your eye doctor recommends™

Benefit Summary

Description of Benefits dependent on selection at time of enrollment.

EXAM BENEFIT (Not applicable on Materials Only PK Plans)			
Description of Benefits	**Plan Covers**	**Member Responsibility**	**Out-of-network Maximum**
Comprehensive eye-health vision examination includes refraction, and dilation if indicated.	100% after exam fee	$15	Up to $40 after in-network exam fee is deducted

MATERIALS BENEFIT (Not applicable on Exam Only Plan)			
Description of Benefits	**Plan Covers**	**Member Responsibility**	**Out-of-network Maximum**
Spectacle Lens	100% for glass or plastic (CR-39) for single vision, bifocal, trifocal (FT25-28) or lenticular	$15	Up to maximum listed after in-network materials fee is deducted:
Progressive lens allowance - all complete plans except Platinum PK Complete or Platinum Materials Only PK	Up to retail price of standard trifocal lens regardless of Rx	Overage	Single: $30 Bifocal: $45 Trifocal: $55
All Platinum plans	$180 benefit for progressive lenses	Overage	Lenticular: $75
Cosmetic upgrades and add-ons	Not covered	Usual and customary fee	Progressive: $60
Polycarbonate for Kids Polycarbonate lenses for dependent children up to age 18	100% for dependent children up to age 18	$25	No out-of-network benefit
Contact Lens In lieu of frames and spectacle lens (including multi-focal contacts) Allowance applies to fitting fees.	Elective: selected allowance Medically necessary: $250	Overage above allowance Materials fee does not apply	Up to $80 for elective or medically necessary
Frame Allowance	Any frame from provider's inventory	Overage above allowance	Up to $35

ADDITIONAL BENEFITS - ALL PLANS			
LASIK/REFRACTIVE BENEFIT Ask your VCD provider for participating providers in your area or call 877-488-8900	Up to 15% discount	Cost after discount	Not applicable

GENERAL LIMITATIONS AND EXCLUSIONS

This vision plan is designed for routine eye care and materials expense incurred while the membership is in force. Plan benefits cannot be combined with any other discounts, promotional offers or other advertised specials including, but not limited to, discounts, coupons, or two-for-one materials specials offered by the providers at their individual offices. Members must choose between using their Vision Care Direct benefits or the provider's special offers. **Unused benefits do not roll over into next benefit period.** We do not provide benefits for the following:

- Services and materials not included on Benefit Summary including cosmetic items and add-ons
- Orthoptics or vision training and any associated supplemental testing
- Subnormal vision aids, non-prescription or aniseikonic lenses
- Contact lenses for cosmetic enhancement such as changing eye color except as covered in the Benefit Summary
- Oversized 61 and above lens or lenses
- Experimental or non-conventional treatment or device
- Medical or surgical treatment of the eyes other than qualifying discount on refractive surgery
- Any injury or illness covered by Workers Compensation or similar law
- Two pairs of glasses in lieu of bifocals, trifocals, or progressives
- Care for services or materials received while traveling in a foreign country without a detailed receipt in English
- Charges incurred after membership ends

CONTACT INFORMATION

National Sales, Claims & Administration Office Ph: (877) 488-8900 Fx: (801) 466-4113 Email: admin@visioncaredirect.com

Vision Care Direct is a provider-based plan. You can locate a provider at www.VisionCareDirect.com.

StandardRates.TN.RateTableD.Vol.4T.102913.945a.DS

Allstate Benefits Group Cancer Plan

In the United States, about 1,685,120 new cancer cases were expected to be diagnosed in 2016. [1]

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

Meeting Your Needs:
Allstate Benefits 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
- 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

Issue Ages: 18 and older while actively at work

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 †

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

***Primary insured only**
****List of covered diseases on the following page**
[1] Cancer Facts & Figures, American Cancer Society, 2016
† Enrolling after your initial enrollment period requires evidence of insurability

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, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis and Primary Biliary Cirrhosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Family Member Lodging and Transportation
Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.
1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.

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

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

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

ADDITIONAL BENEFITS

Wellness
A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15-3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; 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 (Low and High) or $10,000 (Mid) benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care (Low and High Plans Only)**
A benefit will be paid for each day for the following types of intensive care confinement:
1. **Hospital Intensive Care Unit Confinement $600*** - This benefit is for hospital intensive care unit confinement for cancer and 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 covered confinement in a hospital intensive-care unit due to cancer or specified disease from the first day of coverage.***

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 your 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 an incapacitated dependent 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 be refunded, coverage will terminate and claims will not be paid.

Limits, Exclusions, and Exceptions - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not been made. 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.

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 January 15, 2019. Group Cancer and Specified Disease benefits are provided by policy **GVCP3**, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

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

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

Customer Care Center: 800-521-3535
www.allstate.com or AllstateBenefits.com

Low Option without Optional Benefits	
Insureds	**Bi-Weekly Rates**
Employee	*$9.28*
Employee + Child(ren)	*$12.80*
Employee + Spouse	*$14.30*
Family	*$17.80*

Low Option with Optional Benefits	
Insureds	**Bi-Weekly Rates**
Employee	*$12.04*
Employee + Child(ren)	*$17.00*
Employee + Spouse	*$19.16*
Family	*$24.12*

Mid Option with Cancer Initial Diagnosis	
Insureds	**Bi-Weekly Rates**
Employee	*$13.74*
Employee + Child(ren)	*$19.46*
Employee + Spouse	*$21.70*
Family	*$27.42*

High Option without Optional Benefits	
Insureds	**Bi-Weekly Rates**
Employee	*$14.36*
Employee + Child(ren)	*$20.16*
Employee + Spouse	*$21.94*
Family	*$27.72*

High Option with Optional Benefits	
Insureds	**Bi-Weekly Rates**
Employee	*$17.12*
Employee + Child(ren)	*$24.36*
Employee + Spouse	*$26.80*
Family	*$34.02*

Aflac Group Critical Illness

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

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

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

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

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

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

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5000 to $50,000 for employees. The benefit amount for spouses range from $5,000 to $25,000.
- Each dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

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

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

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week;
- Have been employed for at least 0 continuous days by the enrollment date; **and**
- Are not a seasonal or temporary employee.

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

What core benefits does the Aflac critical illness plan feature?

- **First Occurrence Benefit**

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

- **Additional Occurrence Benefit**

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

- **Reoccurrence Benefit**

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

- **Heart Benefit**

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

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

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

- **Health Screening Benefit**

  After the waiting period, you may receive a maximum of $100 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

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

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

You should know that the plan includes:

- A **30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.
- A **pre-existing condition limitation.** A *pre-existing condition* is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.
- **Certain exclusions.** No benefits are payable for loss resulting from:
  - Intentionally self-inflicted injury or action;
  - Suicide or attempted suicide while sane or insane;
  - Illegal activities or participation in an illegal occupation;
  - War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
  - Substance abuse; **or**
  - Diagnosis and/or treatment received outside the United States.

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

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

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. AGC1500865 R1 (10/16)

Continental American Insurance Company • Columbia, South Carolina

800.433.3036 | aflacgroupinsurance.com

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

Guaranteed Issue Amount = $20,000 EE / $10,000 Spouse

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

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.47	$3.33	$4.18	$5.04	$5.89	$6.74	$7.60	$8.45	$9.30	$10.16
30-39	$3.03	$4.44	$5.84	$7.25	$8.66	$10.07	$11.47	$12.88	$14.29	$15.70
40-49	$4.48	$7.34	$10.20	$13.07	$15.93	$18.79	$21.65	$24.51	$27.37	$30.24
50-59	$6.21	$10.80	$15.40	$19.99	$24.58	$29.17	$33.77	$38.36	$42.95	$47.54
60-69	$9.00	$16.39	$23.77	$31.16	$38.54	$45.93	$53.31	$60.70	$68.08	$75.47

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

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.47	$2.90	$3.33	$3.75	$4.18	$4.61	$5.04	$5.46	$5.89
30-39	$3.03	$3.73	$4.44	$5.14	$5.84	$6.55	$7.25	$7.95	$8.66
40-49	$4.48	$5.91	$7.34	$8.77	$10.20	$11.64	$13.07	$14.50	$15.93
50-59	$6.21	$8.51	$10.80	$13.10	$15.40	$17.69	$19.99	$22.29	$24.58
60-69	$9.00	$12.70	$16.39	$20.08	$23.77	$27.47	$31.16	$34.85	$38.54

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

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.91	$4.20	$5.50	$6.79	$8.08	$9.37	$10.67	$11.96	$13.25	$14.54
30-39	$3.86	$6.10	$8.34	$10.57	$12.81	$15.05	$17.29	$19.53	$21.77	$24.00
40-49	$7.30	$12.97	$18.65	$24.33	$30.00	$35.68	$41.36	$47.04	$52.71	$58.39
50-59	$10.69	$19.76	$28.83	$37.90	$46.97	$56.04	$65.10	$74.17	$83.24	$92.31
60-69	$15.74	$29.87	$43.99	$58.11	$72.24	$86.36	$100.48	$114.60	$128.73	$142.85

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

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.91	$3.56	$4.20	$4.85	$5.50	$6.14	$6.79	$7.44	$8.08
30-39	$3.86	$4.98	$6.10	$7.22	$8.34	$9.45	$10.57	$11.69	$12.81
40-49	$7.30	$10.14	$12.97	$15.81	$18.65	$21.49	$24.33	$27.17	$30.00
50-59	$10.69	$15.22	$19.76	$24.29	$28.83	$33.36	$37.90	$42.43	$46.97
60-69	$15.74	$22.80	$29.87	$36.93	$43.99	$51.05	$58.11	$65.17	$72.24

Rates do not include cancer benefit.

Rates include $100 Health Screening Benefit.

AUL Short-Term Disability Plan

Effective Date: January 1, 2017

Why should you consider purchasing disability insurance protection at your workplace?

Many of us lead busy lives and seldom take time to think about life's risks. Consider the following reasons many people purchase disability insurance:

- Lost wages
- Daily living expenses, such as mortgage/rent, utilities, car payment, food, childcare, eldercare, hobbies, pet care

Advantages of shopping at work include:

- Affordable group rates
- Convenient payroll deduction
- Guaranteed issue for timely applicants
- Easy access

Less than 5% of disabling accidents and illnesses are work related. The other 95% are not, meaning Workers' Compensation doesn't cover them.

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2011.asp)

90% of disability are caused by illness.

(Source: Council for Disability Awareness, http://www.disabilitycanhappen.org/chances_disability_stats.asp., August 2012.)

64% of wage earners believe they have a 2% or less chance of being disabled for 3 months or more during their working career. The actual odds for a worker entering the workforce today are about 30%.

(Source: Social Security Administration website, ssa.gov, Fact Sheet, March 18, 2011.)

Less than half (35.6%) of the 2.9 million workers who applied for Social Security Disability Insurance (SSDI) benefits in 2011 were approved.

(Source: Social Security Administration website, ssa.gov, Monthly Statistical Snapshot, December 2012.)

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

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

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

Monthly Benefit
You can choose 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. The 13 week benefit is what is offered.

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

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.

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

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 1-800-553-5318.

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.

Please refer to the Mark III website for a copy of your certificate or claim form www.markiiibrokerage.com/townofgreenevilletn

Customer Service
800-553-5318

Disability Claims
855-517-6365
Fax: 1-844-287-9499
Disability Claims Email: claims@customdisability.com

www.employeebenefits.aul.com

AUL Short-Term Disability
Bi-Weekly Rates

Benefit Duration*:*
13 Weeks

Monthly Benefit	Bi-Weekly Premium	Monthly Benefit	Bi-Weekly Premium
$500	$4.78	$1,300	$12.43
$600	$5.74	$1,400	$13.38
$700	$6.69	$1,500	$14.34
$800	$7.65	$1,600	$15.29
$900	$8.60	$1,700	$16.25
$1,000	$9.56	$1,800	$17.21
$1,100	$10.51	$1,900	$18.16
$1,200	$11.47	$2,000	$19.12

AUL Long-Term Disability Plan

LTD Class Description
All Full-Time Eligible Employees working a minimum of 30 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.

This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date
Or
Continuity of Coverage will apply if the employee was insured under the employers prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

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

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

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

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

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.

Voluntary Long Term Disability	
Monthly Benefit	**Bi-Weekly Rate**
$500	$2.95
$1,000	$5.91
$1,500	$8.86
$2,000	$11.81

Customer Service
800-553-5318
Disability Claims
855-517-6365
Fax: 1-844-287-9499
Disability Claims Email: claims@customdisability.com
www.employeebenefits.aul.com

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

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

Continuing Your Benefits

Ameriflex HealthCare Reimbursement Account

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

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 incurred prior to the date of termination. For more detailed information, please call your ***Human Resources Department at (423) 639-7105***.

Ameritas Dental & Superior Vision or Vision Care Direct Plans

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

If you and your dependents are enrolled in the dental or vision plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you may contact your ***Human Resources Department at (423) 639-7105.***

Other Plans/Policies

You may continue your Aflac Group Critical Illness, Allstate Cancer, AUL Short-Term Disability, AUL Long-Term Disability, and/or Boston Mutual Whole Life policies by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home. For more information, contact

Aflac Group at 800-433-3036,

Allstate Benefits at 800-521-3535
(see "Portability Privilege" on page 31),

AUL at 800-553-5318
(see "Portability" on page 42 & 46),

Boston Mutual at 800-669-2668 x222

Contact Information for Questions and Claims

Aflac
(CAIC a proud member of the Aflac family of insurers)
Columbia, South Carolina 29205
Customer Service
800-433-3036
www.aflacgroupinsurance.com

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

Ameriflex Reimbursement Account
888-868-3539

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

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

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

Mark III Employee Benefits
114 E Unaka Ave.
Johnson City, TN. 37601
1-800-532-1044 x307
www.markiiieb.com
sara@markiiieb.com

Superior Vision Services
11101 White Rock Road,
Rancho Cordova, CA 95670
1-800-507-3800
www.superiorvision.com

Non-Network Claims Submission:
P.O. Box 967
Rancho Cordova, CA 95741

Vision Care Direct
Stacy Nutter
Tennessee Sales Director
Vision Care Direct
615-767-8149 (cell)
615-250-3445 (fax)
Stacy.Nutter@VisionCareDirect.com
www.VisionCareDirect.com